SUMMARY PLAN DESCRIPTION ("SPD") OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN ("PLAN") AND SUMMARIES OF MATERIAL MODIFICATIONS ("SMM") (Amended and Restated Effective as of January 1, 2018)

Attached are the following documents:

1. SPD effective January 1, 2018, with notations reflecting certain changes under the Second SMM. Please review all provisions of the Second SMM to the SPD and do not rely upon these notations. (Pages 2 through 955)
2. First SMM to the SPD (Pages 956 through 960)
3. Second SMM to the SPD (Pages 961 through 1139)

Page number references are those in the top right corner.

If you are reviewing an electronic version of this document, PDF bookmarks are available.

NOTICE:

Final

(1) This document has been amended by the First and Second Summaries of Material Modifications (SMM). Changes include, but are not limited to, the addition of: (a) Oxy Retiree Medical Program for Anadarko Retirees, and (b) Oxy Retiree Dental Program for Anadarko Retirees. Please see the First and Second SMMs for more information on these and other changes.

(2) Please disregard any references to the Anadarko Benefits Center in this document as it has been replaced by the OxyLink Employee Service Center which may be reached at 800-699-6903 (US) or 918-610-1990 (Outside US).

Summary Plan Description

of the

Group Health Benefit

under the

Anadarko Petroleum Corporation Retiree Health Benefits Plan

(Amended and Restated Effective as of January 1, 2018)

Revision Date: January 1, 2018

This Summary Plan Description of the Group Health Benefit is one of two components of the full Summary Plan Description of the Anadarko Petroleum Corporation Retiree Health Benefits Plan. Apart from the Group Health Benefit, other group health benefits are provided to eligible individuals under the Plan. Such benefits are described in a separate summary plan description document that constitutes the other component of the full Summary Plan Description of the Plan.

NOTICE: The Second Summary of Material Modification (SMM) removed Programs 1-4 (see red highlight below) effective December 31, 2020 and added in two new programs effective January 1, 2021. Please see the Second SMM for more information and the replacement programs.

How to Use this Summary Plan Description of the Group Health Benefit under the APC Retiree Health Plan

The Anadarko Petroleum Corporation Retiree Health Benefits Plan ("***APC Retiree Health Plan***") offers group medical, dental and prescription drug coverage to eligible retirees and their dependents, as well as certain surviving dependents of deceased employees, under the portion of the APC Retiree Health Plan called the "Group Health Benefit". Coverage under the Group Health Benefit is provided through variety of "***Programs***", as listed at the bottom of this page, based on whether the covered person (a) has *not* yet attained Medicare-eligibility due to age ("***Pre-65 Programs***") or (b) has already attained Medicare-eligibility due to age ("***Post-65 Programs***").[1]

A Summary Plan Description of the Group Health Benefit ("***SPD***") has been prepared in order to summarize the provisions of the Group Health Benefit under the APC Retiree Health Plan. The SPD consists of 7 documents, which are all contained in this portable document format or "*PDF*." To move around in the document, please click on the "*Bookmarks*" tab which should be on the left side of the PDF.[2] The first document of the SPD is entitled "*Primary Document – Wrap-SPD – Group Health Benefit under the APC Retiree Health Plan (2018)*" ("***Primary Document***"). The Primary Document contains eligibility and enrollment provisions of the Plan and summarizes other Plan provisions and terms which are generally applicable to all Programs (except as otherwise noted). The remaining 6 documents, which are numbered 1 through 6 below (each a "***Program Document***"), include specific provisions applicable to each Program.

If you desire to know about the benefits and coverage terms under a particular Program, please reference both the Primary Document and the applicable Program Document. Please also see "*Article II – Interpretation*" of the Primary Document for a discussion of how the Primary Document and the Program Documents operate together and which prevails in the event of a conflict. As reflected in Appendix G of the Primary Document, the Programs and their related Program Documents are as follows:

Program	#	Program Document
UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program (*Pre-65 Program only*)	1	UnitedHealthcare HDHP Choice Plus Plan Booklet (2018), Group Number 755494
UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program (*Pre-65 Program only*)	2	UnitedHealthcare HDHP Options Plan Booklet (2018), Group Number 755494
UnitedHealthcare HDHP Out of Area Options Plan Medical Benefits Program (*Pre-65 Program only*)	3	UnitedHealthcare HDHP Out of Area Options Plan Booklet (2018), Group Number 755494

[1] The Summary Plan Description of the Group Health Benefit is one of two components of the full Summary Plan Description of the APC Retiree Health Plan. Apart from the Group Health Benefit, other group health benefits are provided to eligible individuals under the Plan. Such benefits are described in a separate summary plan description document that constitutes the other component of the full Summary Plan Description of the Plan.

[2] If you cannot see the Bookmarks tab, please go to "View", select "Show/Hide", then select "Navigation Panels", then select "Bookmarks."

Program	#	Program Document
UnitedHealthcare Dental Benefits Program (*Post-65 Program and, for certain dependents only, a Pre-65 Program*)	4	UnitedHealthcare Dental PPO Plan Booklet (2015) (Plan Number P9568), Group Number 755494
UnitedHealthcare Medicare Prescription Drug Program (*Post-65 Program only*)	5	UnitedHealthcare MedicareRx for Groups (PDP), Evidence of Coverage (2018), Group Number 00334
	6	UnitedHealthcare RxSupplement, Certificate of Coverage (2018), Group Number 00334

If you have any questions regarding the Group Health Benefit under the APC Retiree Health Plan, please call the Anadarko Benefits Center at 1-866-472-4711.

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

TABLE OF CONTENTS

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

Introduction

Anadarko Petroleum Corporation (the "**Plan Sponsor**") maintains the Anadarko Petroleum Corporation Retiree Health Benefits Plan (the "**Plan**") for the benefit of the Eligible Retirees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers. The Plan is an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"). The Plan Sponsor has amended and restated the Plan effective as of January 1, 2018.

The "Group Health Benefit" (as defined herein) is provided as a benefit under the Plan, in accordance with the applicable terms, conditions and limitations of the Plan. Terms of the Group Health Benefit pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Group Health Benefit, are set forth in this wrap-around summary plan description document ("**Wrap-SPD**") and in the Group Health Program Documents (as defined herein) which are attached hereto as Appendix G, incorporated hereunder in their entirety by reference, and, together with the Wrap-SPD, constitute the "summary plan description" of the Group Health Benefit ("**Group Health SPD**" or "**SPD**"), as required by ERISA.

Please review this Group Health SPD carefully, including the Group Health Program Documents, before you assume that any expense you incur will be eligible for payment or reimbursement under the Group Health Benefit. You should pay particular attention to the provisions in this Group Health SPD, including the Group Health Program Documents, concerning any exclusions, limitations on coverage and precertification requirements.

The masculine gender of words used in this Wrap-SPD include the feminine gender, and words used in the singular include the plural, and vice-versa, when applicable. The capitalized terms used in this Wrap-SPD shall have the meanings set forth in Article I and as provided elsewhere herein; provided, however, the definitions of certain capitalized terms contained in this introduction are provided solely for convenience of reference within this introduction. Any reference to an "Appendix" in this Wrap-SPD shall mean an Appendix to this Wrap-SPD unless otherwise stated.

FOREWORD

The benefits provided under the Group Health Benefit are for the exclusive benefit of the Eligible Retirees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers of the Plan (or the Group Health Benefit in particular). These benefits are intended to be continued indefinitely, however, the Plan Sponsor reserves the unilateral right and discretion to make any changes, without advance notice, to the Group Health Benefit which it deems to be necessary or appropriate, in its discretion, to comply with applicable law, regulation or other authority issued by a governmental entity. The Plan Sponsor also reserves the unilateral right and discretion to amend, modify, or terminate, without advance notice, all or any part of the Group Health Benefit and to make any other changes that it deems necessary or appropriate in its discretion. Changes in the Group Health Benefit may occur in any or all parts of the Group Health Benefit, including, but not limited to, benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like, under any or all of the Group Health Programs identified in Appendix B. You should not, therefore, assume that the benefits which are provided under the Group Health Benefit will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Plan Sponsor's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator and the Claims Fiduciary, as applicable, each reserve the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provisions of the Group Health Benefit, in their discretion, including correcting any error or defect, supplying any omission, reconciling any inconsistency, and making all findings of fact including, without limitation, any factual determination that may impact eligibility or a claim for benefits. Benefits under the Group Health Benefit will be paid only if the Plan Administrator or Claims Fiduciary, as applicable, determines in its discretion that the Participant is entitled to them. All decisions, interpretations and other determinations of the Plan Administrator or Claims Fiduciary, as applicable, will be final, binding and conclusive on all persons and entities subject only to the claims appeal procedures of the Group Health Benefit. There will be no *de novo* review of any such decision, interpretation or determination by any court. Any review of such decision, interpretation or determination will be limited to determining whether the decision, interpretation or determination was so arbitrary and capricious as to be an abuse of discretion under ERISA's standards.

ARTICLE I
DEFINITIONS

The following terms, where capitalized, will have the meanings set forth below when used in this Wrap-SPD and thus supersede any other meanings for the same terms set forth in the Group Health Program Documents, unless a different meaning is plainly required by the context:

1.1 Affiliate means a corporation or other entity which is controlled by the Plan Sponsor, or under common control with the Plan Sponsor, as determined by the Plan Sponsor after taking into consideration the common control rules under Section 3(40)(B) of ERISA (multiple employer welfare associations).

1.2 Beneficiary means a Beneficiary under the Group Health Benefit as defined under the terms of the respective Group Health Program.

1.3 Benefits Committee means the Anadarko Petroleum Corporation Health & Welfare Benefits Administrative Committee, which is a committee of one or more Employees appointed by the Plan Sponsor to act as named fiduciary and Plan Administrator of the Plan (including the Group Health Benefit). References herein to the Benefits Committee or Plan Administrator shall include, when appropriate, any Employee, Claims Administrator, or other person or entity who has been delegated the appropriate authority by the Benefits Committee as Plan Administrator in accordance with Section 10.4.

1.4 Board of Directors means the Board of Directors of the Plan Sponsor.

1.5 CEO means the then current Chief Executive Officer of the Plan Sponsor.

1.6 CFO means the then current Chief Financial Officer of the Plan Sponsor.

1.7 Claims Administrator means the third party administrator, insurance company or other person or entity, as set forth in Appendix C, as designated by the Plan Administrator to process claims and/or perform other administrative duties under the Group Health Benefit or a Group Health Program.

1.8 Claims Fiduciary means the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a Group Health Program. The applicable Claims Administrator for a Group Health Program will be the "Claims Fiduciary" for such Group Health Program.

1.9 COBRA Administrator means, as set forth in Appendix C, the third party designated by the Plan Administrator to perform COBRA administration under the Plan on behalf of the Plan Administrator.

1.10 Code means the Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code will also refer to any successor provision thereof.

1.11 Dependent means a dependent (including a Spouse or Domestic Partner) of an Eligible

Retiree who is eligible for coverage under the Group Health Benefit, as such term is defined in Appendix F.

1.12 Disclosure Administrator means the individual or entity, as designated in Article XIV, to whom the Plan Administrator has delegated the authority, duty and discretion to furnish, on its behalf, the disclosures with respect to the Group Health Benefit that are required by Section 104(b)(4) of ERISA and which are requested in accordance with Section 10.5 of this Wrap-SPD.

1.13 Domestic Partner means an Eligible Retiree's domestic partner as defined in Appendix F.

1.14 Effective Date means the effective date of the amendment and restatement of the Plan, *i.e.*, January 1, 2018.

1.15 Eligible Retiree means a Retiree or Former Employee who meets the eligibility requirements for participation in the Group Health Benefit as set forth in the Group Health SPD.

1.16 Employee means any individual who is (1) in an employer-employee relationship as a "common law" employee with the Employer and (2) on the United States payroll records of the Employer for purposes of federal income tax withholding, unless otherwise specified under the Group Health Program Document or Policy for a Fully-Insured Program.

Except as otherwise specified under the Group Health Program Document or Policy for a Fully-Insured Program, the term "Employee" will not include any person during any period that such person was classified in the Employer's records as a "non-employee" or considered by the Employer to be a limited-benefit employee, an independent contractor, agent, leased employee, contract employee, temporary-staffing employee or worker, or similar classification, regardless of whether any agency (governmental or otherwise) or court determines that any such person is, or was, a common law employee of an Employer, even if such determination has a retroactive effect. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Section 414(n)(2) of the Code, whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, (b) an "independent contractor" means any person rendering service directly or indirectly to the Employer and whom the Employer treats as an independent contractor by reporting payments on IRS Form 1099 (or its successor) for the person's services, and (c) a "contract employee" means a person who is employed by a third-party entity which is retained by the Employer through a contract for services, pursuant to which such person indirectly renders services to, or for the benefit of, the Employer.

Furthermore, the term "Employee" will not include (i) an employee who is a non-resident alien and who receives no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)), (ii) a "foreign inpatriate", which means an individual whose home country is outside the United States, but who has been seconded from an Affiliate of the Plan Sponsor to the Plan Sponsor for an employment assignment of at least three months in the United States, or (iii) any sole proprietors, partners in a partnership and 2% shareholders of a S corporation.

1.17 Employer means the Plan Sponsor or any of its Affiliates which have adopted the Plan (or the Group Health Benefit in particular) with the consent of the Plan Sponsor. The adopting

Employers of the Group Health Benefit are listed in Appendix A, as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

1.18 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

1.19 Former Employee means an Employee who terminates employment with a corporation or other entity that, on the date of such employment termination, is a participating Employer in the Group Health Benefit.

1.20 Fully-Insured Program means the following Group Health Program that is fully-insured with an insurance carrier:

- UnitedHealthcare Medicare Prescription Drug Program.

1.21 Group Health Benefit means the portion of the Plan which provides medical, dental and prescription drug coverage through the Group Health Programs, the terms of which are described herein and in the Group Health Program Documents. References to "Group Health Benefit" which are applicable as of a date that is prior to January 1, 2016 shall be interpreted to mean the Plan (or predecessor coverage), as in effect on such date.

1.22 Group Health Program means a program of benefits that is offered by the Plan Sponsor (and/or another Employer) under the Group Health Benefit to provide certain employee group health benefits coverage to eligible individuals which would be an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. The Group Health Programs (which consist of the Pre-65 Group Health Programs and the Post-65 Group Health Programs), constitute a part of the Group Health SPD, which, in turn, is incorporated into the Wrap-Plan and constitutes a part of the Plan. Each Group Health Program under the Group Health Benefit is identified in Appendix B. The Plan Sponsor may add or delete a Group Health Program from the Group Health Benefit by amending Appendix B.

1.23 Group Health Program Document means a written arrangement, including (a) a benefits booklet, summary of coverage, plan document or summary plan description, (b) a group insurance policy issued by an insurance carrier to the Plan Sponsor (or other Employer), or (c) a certificate of coverage, schedule of benefits, notice or other instrument, under which a Group Health Program is established, operated or maintained. Each of the documents enumerated in items (a), (b) and (c) (above) is attached to this Wrap-SPD as part of Appendix G and incorporated herein by reference. A Group Health Program Document (or any portion thereof) will not, in and of itself, constitute either the written "Plan document" or the "summary plan description" of the Plan or the Group Health Benefit, as required by ERISA, notwithstanding any references in any Group Health Program Document to the contrary; however, such Group Health Program Document does contain certain terms of the Group Health Benefit and the Plan. Any reference to a Group Health Program Document also refers to any amendment, endorsement, rider or attachment thereto.

1.24 Group Health SPD or **SPD** means this Wrap-SPD and each Group Health Program Document as attached hereto and incorporated hereunder by reference, as all such documents may be amended from time to time, and which, together, constitute the "summary plan description" of the Group Health Benefit, as required by ERISA. The Group Health SPD is incorporated into the

Wrap-Plan by reference and constitutes a part of the Plan.

1.25 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

1.26 HRA means the Anadarko Health Reimbursement Arrangement, effective as of January 1, 2016, and as further amended from time to time, which is provided under the Plan. Certain terms of the HRA are described in the HRA SPD.

1.27 HRA SPD means the "Summary Plan Description of the Anadarko Health Reimbursement Arrangement under the Anadarko Petroleum Corporation Retiree Health Benefits Plan" (including any appendices, exhibits, or other attachments thereto), as amended from time to time. The HRA SPD is incorporated into the Wrap-Plan by reference and constitutes a part of the Plan.

1.28 Medicare means Subchapter XVIII of Chapter 7 of Title 42 of the United States Code.

1.29 Medicare Eligibility Due to Age means eligibility for coverage under Part A and Part B of Medicare on the basis of attainment of age sixty-five (65).

1.30 Participant means an Eligible Retiree who meets the requirements for eligibility as set forth in Article III and who properly enrolls for coverage under the Plan. The term "Participant" also includes any eligible Dependent of a person specified in the previous sentence who is properly enrolled for coverage under the Plan. A person will cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan. With respect to the HRA, the term "Participant" has the same meaning as the term "Covered Person", which is defined in the HRA SPD.

1.31 Participant Contribution means the contribution required to be paid by a Participant, if any, for Group Health Benefit coverage, as determined under each Group Health Program. The term "Participant Contribution" includes, but is not limited to, contributions used for the provision of benefits under a self-funded arrangement of the Plan Sponsor or an Employer as well as contributions used to purchase coverage that is provided under insurance contracts or policies, if any.

1.32 Plan means the Anadarko Petroleum Corporation Retiree Health Benefits Plan, which consists of (a) the Wrap-Plan, (b) the Policies set forth in the Policy Appendix to the Wrap-Plan, (c) the HRA SPD, and (d) the Group Health SPD, as items (b) through (d) are incorporated into the Wrap-Plan by reference, as such Plan may be amended from time to time. The Wrap-Plan, the Policies, the HRA SPD, and the Group Health SPD each contain certain terms of the Plan and together constitute the complete Plan.

1.33 Plan Administrator means the person or entity which has the authority and responsibility to manage and direct the operation of the Plan (including the Group Health Benefit) in its discretion. However, the Plan Administrator may assign or delegate duties to third parties with respect to the Group Health Benefit, such as the Claims Administrator or the Claims Fiduciary, under the terms of the Wrap-Plan or the Group Health SPD (including any Group Health Program Document), or by means of a separate written agreement. The Plan Administrator is the plan "administrator" for purposes of Section 3(16)(A) of ERISA. The Benefits Committee shall be the

"Plan Administrator". References herein to the "Plan Administrator" or "Benefits Committee" shall include, when appropriate, any Employee, Claims Administrator, or other person or entity who has been delegated the appropriate authority by the Plan Administrator in accordance with Section 10.4.

1.34 Plan Sponsor means Anadarko Petroleum Corporation or its successor in interest.

1.35 Plan Year means each twelve (12) consecutive month period commencing January 1st and ending on December 31st.

1.36 Post-65 Group Health Program means a Group Health Program listed in Section 2 of Appendix B.

1.37 Pre-65 Group Health Program means a Group Health Program listed in Section 1 of Appendix B.

1.38 Retiree means an Employee who retires from employment with a corporation or other entity that is an Employer on the date of the Employee's retirement from employment.

1.39 Retirement Date means either (a) the date of a Retiree's termination of employment with the Employer due to retirement or (b) the date of a Former Employee's termination of employment with the Employer.

1.40 Rule of 45 means that a Retiree (a) was employed by his legacy retiree group on December 31, 2006, and (b) on December 31, 2007, (i) he was employed by Anadarko Petroleum Corporation, and (ii) his age and Years of Service totaled at least forty-five (45).

1.41 Spouse means a person to whom an Eligible Retiree is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable Federal law (including, but not limited to, the Code and ERISA), and any regulations promulgated under such applicable Federal law, but will not include an individual divorced from the Eligible Retiree under a court-approved divorce decree. The term "Spouse" will also include a common law spouse if the Eligible Retiree and spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Eligible Retiree must provide proof of a ceremonial or common law marriage if requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state. Notwithstanding the foregoing, if the applicable Group Health Program Document for a Fully-Insured Program provides a definition of "Spouse" that is inconsistent with the definition in this Section 1.41, the definition in such Group Health Program Document will control for purposes of that Fully-Insured Program.

1.42 Summary Plan Description means, collectively, the HRA SPD and the Group Health SPD, as such documents may be amended from time to time and which, together, constitute the full "summary plan description" of the Plan as required by ERISA. The Summary Plan Description is incorporated into the Wrap-Plan by reference and constitutes a part of the Plan.

1.43 Wrap-Plan means the wrap-around Plan document (including any appendices attached thereto), as amended from time to time.

1.44 Wrap-SPD means this wrap-around summary plan description document (including the appendices hereto) which describes the Group Health Benefit, as amended from time to time.

1.45 Years of Service means years of employment service with the Plan Sponsor or other Employer (or a predecessor of either), as determined by the Plan Sponsor in accordance with its procedures established for such purpose.

ARTICLE II
INTERPRETATION

Notwithstanding any reference in a Group Health Program Document that such Group Health Program Document, in and of itself (or any portion thereof), constitutes a "summary plan description" of the Plan, as required by ERISA, the official summary plan description of the Group Health Benefit consists of this Wrap-SPD and the Group Health Program Documents incorporated herein by reference (*i.e.*, the Group Health SPD). If a term or provision of this Wrap-SPD conflicts with a term or provision of a Group Health Program Document, the term or provision of this Wrap-SPD will control unless specifically stated otherwise herein. Further, if a term or provision of this Wrap-SPD, a Group Health Program Document or a Policy conflicts with any term or provision of the Wrap-Plan, then the term or provision of the Wrap-Plan will control unless specifically stated otherwise in the Wrap-Plan.

Notwithstanding the foregoing, if there is a conflict between a term or provision of the Wrap-Plan, a Policy, this Wrap-SPD or a Group Health Program Document, and such conflict involves a term or provision required by ERISA, the Code or other controlling law, on the one hand, and a term or provision not so required on the other, the term or provision required by controlling law will control. This determination will be made by the Plan Administrator. The terms and provisions of this Wrap-SPD will not enlarge the rights of a Retiree, Participant, Dependent or Beneficiary to any benefit available under a Group Health Program.

The terms and provisions of the Plan include the terms and provisions of the Wrap-Plan, the Policies listed in the Policy Appendix to the Wrap-Plan, the HRA SPD, and the Group Health SPD (including the Group Health Program Documents), as amended from time to time.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

Retirees, Former Employees and their Dependents will be eligible to participate in the Group Health Benefit in accordance with the eligibility provisions of Appendix F.

3.2 Enrollment.

(a) *Post-65 Group Health Programs.* All participation in the Post-65 Group Health Programs was frozen on December 31, 2015, notwithstanding anything in this Wrap-SPD, the Wrap-Plan or any Group Health Program Document to the contrary. Consequently, no Retiree, Former Employee, Dependent or any other individual may initially enroll in a Post-65 Group Health Program on or after January 1, 2016.

(b) *Pre-65 Group Health Programs.* Enrollment in a Pre-65 Group Health Program by an Eligible Retiree or eligible Dependent shall be administered and become effective as specified in Appendix F. The Plan Administrator may establish procedures in accordance with Appendix F and the Pre-65 Group Health Programs for such enrollment. The Plan Administrator will provide enrollment forms or telephonic or online enrollment procedures that must be completed by the prescribed deadline prior to commencement of coverage under a Pre-65 Group Health Program.

3.3 Termination of Participation.

A Participant will cease being a Participant in the Group Health Benefit, and coverage under the Group Health Program for the Participant and his covered Dependents and Beneficiaries will terminate, as specified in Appendix F.

ARTICLE IV
FUNDING

Notwithstanding anything to the contrary contained herein or in a Group Health Program Document, participation in the Group Health Benefit by a Participant and the payment of benefits under the Group Health Benefit will be conditioned on such Participant Contributions towards the cost of coverage under the Group Health Benefit at such time and in such amounts as the Plan Administrator will establish from time to time. The Plan Administrator shall designate the applicable method by which the Participant must make any Participant Contributions, and the Participant must consent in writing (including electronically, as applicable), or as otherwise required under the Plan Administrator's procedures, to such payment method to remain covered under the Group Health Benefit. Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Group Health Benefit, or to maintain any fund or segregate any amount for the benefit of any Participant, Retiree, Dependent or Beneficiary, except to the extent specifically required under the terms of a Group Health Program. No Participant, Retiree, Dependent or Beneficiary will have any right to, or interest in, the assets of any Employer as the result of coverage under the Group Health Benefit until actually paid. The Group Health Benefit shall not be "funded" for purposes of ERISA.

Benefits or premiums for the Group Health Benefit will be provided through insurance contracts or through the general assets of the Employer in accordance with the terms of the relevant Group Health Program. An Employer will have no obligation, but will have the right, to insure or reinsure or to purchase stop loss coverage, where applicable, with respect to any Group Health Program under the Plan. To the extent that the Group Health Benefit is provided through an Employer's purchase of insurance, payment of any benefits under such Group Health Program will be the sole responsibility of the insurer, and the Employer will have no responsibility for such payment.

NOTICE: Effective December 30, 2020, the Second Summary of Material Modification removed Section 5.1(b).

ARTICLE V
BENEFITS

5.1 Terms and Conditions.

(a) *Generally.*

The actual terms and conditions of eligibility, coverage, exclusions and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Group Health Benefit, are set forth in the Group Health Program Documents and this Wrap-SPD. Any maximum benefit amounts, deductibles, copayments and out-of-pocket maximum amounts, as well as the reimbursement percentages for eligible charges, under the Group Health Benefit are contained in the Group Health Program Documents, as they may be amended from time to time, subject to Section 2(e)(iii) of Appendix F and subsection (c), below. The Group Health Program Documents, as then currently in effect, are incorporated in their entirety by reference into this Wrap-SPD which, in turn, is incorporated by reference into the Wrap-Plan.

(b) *Coverage of Certain Dental Care.*

Notwithstanding anything to the contrary in the applicable Group Health Program Document(s) for the UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program, the UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program, and the UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program (collectively, for purposes of this Section 5.1, the "**UHC Medical Programs**"), effective as of January 1, 2018 through December 31, 2018:

(i) Dental implants, bone grafts, and other implant-related procedures that are associated with hypodontia, oligondontia, or anodontia are not excluded from coverage and are therefore covered benefits under the UHC Medical Programs, subject to the other applicable terms of the Plan; and

(ii) The treatment of congenitally missing teeth (when the cells responsible for the formation of the tooth are absent from birth), or malpositioned or supernumerary (i.e., extra) teeth, including when part of a congenital anomaly such as cleft lip or cleft palate, is not excluded from coverage and is therefore a covered benefit under the UHC Medical Programs, subject to the other applicable terms of the Plan.

(c) In addition to any exclusions from coverage set out in the applicable Group Health Program Document, the Group Health Benefit will exclude from coverage any charges incurred by a Participant with respect to which the Participant (i) is not obligated to pay, (ii) is not billed, or (iii) would not have been billed but for the coverage of such charges under the terms of the Group Health Benefit. Consequently, if the Claims Fiduciary determines that a health care provider is waiving, reducing or forgiving (or has waived, reduced, or forgiven) any portion of its charges for covered services or supplies provided to a Participant, or any portion of any copayment, deductible, or coinsurance amount that the Participant is required to pay for such provider's covered services or supplies under the applicable terms of the Group Health Benefit, without the Claims Fiduciary's express written consent, then the Claims Fiduciary shall have the unilateral right and discretion to wholly or partially reduce the benefits paid under the terms of the Group Health Benefit with

respect to such services in proportion to the amount of such charges, copayments, deductibles, or coinsurance amounts waived, reduced or forgiven, regardless of whether such provider represents or affirms that the Participant remains financially responsible for such amount. Furthermore, the Claims Fiduciary reserves the unilateral right and discretion to require a Participant to provide satisfactory written proof that the Participant has paid the required copayment, deductible, or coinsurance amount attributable to any covered services or supplies received, whether prior to or subsequent to the payment by the Claims Fiduciary of any benefits under the Group Health Benefit for such services or supplies; provided, however, that the Claims Fiduciary's failure to request any such proof in any one or more instance shall not constitute any waiver or limitation of this exclusion under the Group Health Benefit.

For purposes of clarification, and not limitation, the exclusion set forth in this subsection (b) would apply, for example, to an out-of-network provider's charges for services or supplies provided to a Participant based on such provider's agreement to set those charges at the in-network benefits level under the Plan or at another level not otherwise applicable to such services or supplies under the terms of the Plan.

The Claims Fiduciary shall have the sole discretion to (i) interpret, construe and apply the exclusion set out in this subsection (b), (ii) make any determinations and decisions deemed to be necessary or appropriate for such purpose, and (iii) otherwise effectuate the intent of such exclusion.

5.2 Charges by Network Providers.

To the extent that benefits under a Group Health Program are provided through a network provider organization, the Plan's reimbursement of charges by a participating network provider under the Group Health Benefit will not be subject to "usual and customary charge" limitations, but will instead be limited to the rates which have been negotiated between the Claims Administrator and the provider network. In addition, any amounts charged by network providers over the negotiated rate will not be covered and cannot be charged back to the Participant, that is, there will be no balance billing by network providers directly to Participants.

ARTICLE VI
CLAIMS PROCEDURES

6.1 General.

(a) Except as provided in subsection (b) (below), a claim for benefits under a Group Health Program will be submitted in accordance with, and to the party designated under, the terms of such Group Health Program. Notwithstanding the foregoing, unless a Group Health Program specifically provides otherwise, a claim for benefits must be submitted not later than twelve (12) months after the date that the claim arises (for example, the date a medical service is provided and the charge is incurred). If a Group Health Program does provide otherwise, then the limitation under the Group Health Program will control. In the event that a claim, as originally submitted, is not complete, the Claimant will be notified and the Claimant will then have the responsibility for providing the missing information within the timeframe stated in such notification.

(b) A Participant or Beneficiary may designate an authorized representative to act as "claimant" on his or her behalf with respect to the Group Health Benefit's claims procedures, as

permitted by ERISA. The Claims Fiduciary for the applicable Group Health Program may require that any such designation be made in writing (including electronically), using a form prescribed by the Claims Fiduciary as consistent with ERISA and in accordance with the Claims Fiduciary's procedures for such purpose, in a manner that is sufficiently clear and conspicuous to enable the Claims Fiduciary to reasonably verify the status of the authorized representative and the scope of such authorization. Whether any such designation of an authorized representation meets such requirements shall be determined by the Plan Administrator or Claims Fiduciary, as applicable, in its discretion. The Plan Administrator or the Claims Fiduciary, as applicable, may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, such entities reserve the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Plan Administrator or Claims Fiduciary, as applicable, determines that such designation is fraudulent; such as, for example, when the Plan Administrator or Claims Fiduciary, as applicable, determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.

(c) To the extent that a Group Health Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA and the regulations promulgated thereunder, as determined by the Plan Administrator, the claims procedures set out below in Sections 6.2 through 6.8 will apply to a claim for benefits under a Group Health Program. Otherwise, the claims procedures set out in such Group Health Program shall apply to such claim.

(d) The claims procedures applicable to claims made for benefits under the Group Health Benefit do not include casual or general inquiries regarding eligibility or particular Group Health Program benefits that may be provided under the Plan. In order for an "inquiry" to constitute a claim for benefits or an appeal of an Adverse Benefit Determination, a Participant must follow the claim procedures under the applicable Group Health Program, or, if such procedures are not contained in such Group Health Program, then according to the claims procedures set forth in this Article VI.

6.2 Definitions.

(a) *Adverse Benefit Determination* means any of the following: (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Group Health Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Group Health Benefit; (ii) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Group Health Benefit, resulting from the application of precertification procedures or other utilization review procedures; and (iii) a failure to cover an item or service for which benefits under the Group Health Benefit are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or because another exclusion applies under the Group Health Benefit.

(b) *Adverse Benefit Determination on Review* means the upholding or affirmation of an appealed Adverse Benefit Determination.

(c) *Benefit Determination* means a determination by the Claims Administrator on a claim for benefits under the Group Health Benefit, whether or not an Adverse Benefit Determination.

(d) *Benefit Determination on Review* means a determination by the Claims Fiduciary (or if the applicable Group Health Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

(e) *Claimant* means a Participant under the Group Health Benefit, or his authorized representative or health care provider, who is designated by the Participant to act on his behalf. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of the medical condition of the Participant to whom the Urgent Care Claim applies will be permitted to act as the authorized representative of such Participant.

(f) *Concurrent Care Decision* means, with respect to an ongoing course of treatment previously approved by the Group Health Benefit which is to be provided over a period of time or number of treatments: (i) any reduction or termination by the Group Health Benefit of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments; or (ii) any request by a Claimant to extend the ongoing course of treatment beyond the period of time or number of treatments. A Concurrent Care Decision described in clause (i) will constitute an Adverse Benefit Determination.

(g) *Health Care Professional* means a physician or other health care service provider who is licensed, accredited, or certified to perform the specified health services consistent with state law.

(h) *Pre-Service Claim* means a claim for a benefit under a group health plan that, under the terms of the applicable plan, conditions the receipt of the benefit, in whole or in part, on pre-approval of the benefit in advance of obtaining medical care.

(i) *Post-Service Claim* means a claim for a benefit under a group health plan for reimbursement or consideration of payment for the cost of medical care that has already been rendered. A Post-Service Claim is a claim that is neither a Pre-Service Claim nor an Urgent Care Claim.

(j) *Urgent Care Claim* means a claim for medical care or treatment that, if not received, (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or (ii) in the opinion of a health care provider with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. If a health care provider with knowledge of the Claimant's medical condition deems the medical care or treatment urgent, then the claim is an Urgent Care Claim.

6.3 Initial Claim Procedure and Time Limits.

(a) *Initial Claim Process.*

A claim and all required documentation will be filed in writing with the applicable Claims Administrator and decided within the applicable timeframe under federal law,

regardless of whether all information required to perfect the claim is included. The timeframe for decision begins upon receipt by the Claims Administrator of a claim submitted by the Claimant in accordance with the Group Health Benefit's claims procedures, and is contingent upon the type of claim that is submitted, whether the claim submitted is a complete claim or incomplete claim, whether additional information is required and whether an extension is required to make a decision on the claim.

(b) *Urgent Care Claim*:

(i) If an Urgent Care Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Urgent Care Claim is received, subject to subsection (b)(ii).

(ii) If an Urgent Care Claim as submitted is incomplete, the Claims Administrator will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receiving the incomplete claim. Such notice will request the additional information required to render a decision on the claim and explain why such information is necessary. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. Regardless of whether the Claimant provides the Claims Administrator with the requested information, the Claims Administrator will render a Benefit Determination on the claim and provide notice to the Claimant of such Benefit Determination as soon as possible, but not later than forty-eight (48) hours after the earlier of (A) receipt of the requested information or (B) the end of the period afforded the Claimant to provide the requested information.

(iii) In the event that the Claimant fails to follow the Group Health Benefit's procedures for filing an Urgent Care Claim, the Claimant will be notified of such failure and of the proper procedures to be followed in filing such a Claim. The notification will be provided to the Claimant as soon as possible, but not later than twenty-four (24) hours following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(b)(iii), a failure to follow the Group Health Benefit's procedures for filing will mean only such a failure that is (A) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Group Health Benefit; and (B) a communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(iv) Notification of any Adverse Benefit Determination with respect to an Urgent Care Claim will be made in accordance with Section 6.4.

(c) *Concurrent Care Decisions*.

(i) As to a Concurrent Care Decision which is an Adverse Benefit Determination, the Claims Administrator will notify the Claimant, in accordance with Section 6.4, of the Adverse Benefit Determination at a time sufficiently in advance of the

reduction or termination to allow the Claimant to appeal and obtain a Benefit Determination on Review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(ii) In the event of a Concurrent Care Decision which is a request by a Claimant to extend the course of treatment beyond the period of time or number of treatments and is an Urgent Care Claim, such Concurrent Care Decision will be decided as soon as possible, taking into account the medical exigencies. The Claims Administrator will notify the Claimant of the Benefit Determination, whether or not adverse, within twenty-four (24) hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether or not involving an Urgent Care Claim, will be made in accordance with Section 6.4, and appeal of the same will be governed by Sections 6.6(a)(i), (ii) or (iii), as appropriate.

(d) *Other Claims.* In the case of a claim that is neither an Urgent Care Claim nor a claim involving a Concurrent Care Decision as described in subsection (c), the Claims Administrator will notify the Claimant of the Plan's Benefit Determination, as follows:

(i) Pre-Service Claim:

(A) The Claims Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination (whether or not adverse) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Pre-Service Claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

(B) In the event that the Claimant fails to follow the Group Health Benefit's procedures for filing a Pre-Service Claim, the Claimant will be notified of such failure and of the proper procedures to be followed in filing such a claim. The notification will be provided to the Claimant as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(d)(i)(B), a failure to follow the Group Health Benefit's procedures for filing will mean only such a failure that is (i) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Group Health Benefit; and (ii) a communication that names a specific

Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(C) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4.

(ii) Post-Service Claim:

(A) The Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Post-Service Claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Post-Service Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

(B) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4.

6.4 Notification of Benefit Determination.

(a) Except as provided in Section 6.4(b), the Claims Administrator will provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification will set forth in a manner calculated to be understood by the Claimant:

(i) the specific reason or reasons for the Adverse Benefit Determination;

(ii) reference to the specific Plan provisions upon which the determination is based;

(iii) a description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) a description of the Group Health Benefit's appeal procedures and time limits applicable to such procedures, including, in the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims, along with a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review (or, if a Group Health Program requires two levels of appeal, following an Adverse Benefit Determination on Review with respect to the second appeal);

(v) if the Adverse Benefit Determination is based upon:

(A) an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Group Health Benefit to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(b) In the case of an Adverse Benefit Determination involving an Urgent Care Claim, the information described in Section 6.4(a) may be provided to the Claimant orally within the time frame prescribed in Section 6.3(b), provided that a written or electronic notification is furnished to the Claimant not later than three (3) days after the oral notification.

6.5 Appeal Procedures.

(a) Each Claimant will have a reasonable opportunity to appeal an Adverse Benefit Determination to the Claims Fiduciary (or, if the applicable Group Health Program requires two levels of appeal, to the Claims Administrator with respect to the first level appeal) as set forth hereafter. The Claimant must complete all of the administrative review steps available through the Claims Administrator before an appeal to the Claims Fiduciary, if any, is permitted under the Group Health Benefit.

(b) Each Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim appealed.

(c) Each Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Group Health Benefit. Whether a document, record, or other information is "relevant" to a claim for benefits under the Group Health Benefit will be determined by reference to Section 6.8.

(d) The appeal will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

(e) The Claimant will have one-hundred eighty (180) days following receipt of notification of an Adverse Benefit Determination within which to appeal said Determination. If the applicable Group Health Program requires two levels of appeal, the Claimant will have sixty (60) days following receipt of notification of an Adverse Benefit Determination on review of the first appeal within which to file a second appeal of the Adverse Benefit Determination.

(f) The appeal will not afford deference to the initial Adverse Benefit Determination and will be conducted by a decision maker who is neither the individual who made the Adverse Benefit Determination that is on appeal, nor the subordinate of such decision maker.

(g) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, the decision maker will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involving the medical judgment.

(h) All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on appeal will be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

(i) All Health Care Professionals engaged for purposes of consultation under Section 6.5(g) will be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.

(j) In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's Benefit Determination on Review, will be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

(k) A Claimant will not be required to file more than two appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA. To the extent that the claims procedures set forth in any Group Health Program provide for more than two levels of appeal of an Adverse Benefit Determination, any level of appeal beyond the second level of appeal will be "voluntary".

(l) To the extent that any Group Health Program offers a voluntary level of appeal ("**Voluntary Appeal**") (except to the extent the Plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, and notwithstanding anything in such Group Health Program to the contrary:

(i) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to a Voluntary Appeal;

(ii) Any statute of limitations or other defense based on timeliness is tolled during the time that a Voluntary Appeal is pending;

(iii) A Claimant may elect to submit a benefit dispute to a Voluntary Appeal only after exhaustion of the appeals permitted by the Group Health Program under which the benefit dispute arose, subject to Section 6.5(k);

(iv) A Claimant will be provided, upon request, sufficient information relating to the Voluntary Appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to Voluntary Appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to Voluntary Appeal will have no effect on the Claimant's rights to any other benefits under the Group Health Benefit, and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs will be imposed on the Claimant as part of the Voluntary Appeal.

(m) Notwithstanding anything in a Group Health Program to the contrary, a Claimant will not be subject to mandatory arbitration of an Adverse Benefit Determination, except to the extent that:

(i) The arbitration is counted as one of the two appeals described in Section 6.5(k) and is conducted in accordance with the requirements applicable to such appeals; and

(ii) The Claimant is not precluded from challenging the decision resulting from such arbitration under section 502(a) of ERISA or other applicable law.

6.6 Benefit Determination on Review.

(a) *Timing of Notification.*

(i) Urgent Care Claim. In the case of an Urgent Care Claim, the Claims Fiduciary (or, if the applicable Group Health Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant in accordance with Section 6.6(b) of the Plan's Benefit Determination on Review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's appeal of an Adverse Benefit Determination by the Plan.

(ii) Pre-service Claims. In the case of a Pre-Service Claim, the Claims Fiduciary (or, if the applicable Group Health Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the applicable Group Health Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than fifteen (15) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iii) Post-Service Claims. In the case of a Post-Service Claim, the Claims Fiduciary (or, if the applicable Group Health Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the applicable Group Health Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iv) In the case of an Adverse Benefit Determination on Review, the Claims Fiduciary (or, if the applicable Group Health Program requires two levels of appeal, the

Claims Administrator with respect to the first level appeal) will provide access to, and copies of, documents, records, and other information described in Sections 6.6(b)(iii), (iv) and (vi) as appropriate.

(b) *Manner and Content of Notification of Benefit Determination on Review.*

The Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide a Claimant with written or electronic notification of the Plan's Benefit Determination on Review. In the case of an Adverse Benefit Determination on Review, the notification will set forth in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the Adverse Benefit Determination on Review;

(ii) Reference to the specific Plan provisions upon which the Adverse Benefit Determination on Review is based;

(iii) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Group Health Benefit. Whether a document, record, or other information is relevant to a claim for benefits will be determined by reference to Section 6.8;

(iv) A statement describing any Voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures described in Section 6.5(l)(iv);

(v) A statement of the Claimant's right to bring an action under Section 502(a) of ERISA (or, if a Group Health Program requires two levels of appeal, the Claimant's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review with respect to the second appeal);

(vi) If the Adverse Benefit Determination on Review is based upon:

(A) an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the Claimant upon request; or

(B) a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Group Health Benefit to the Claimant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon request; and

(vii) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

6.7 Calculating Time Periods.

For the purposes of Sections 6.3 and 6.6(a), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made, will begin at the time a claim or appeal, as the case may be, is filed in accordance with the procedures of the Group Health Benefit, without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing. In the event that a period of time is extended as permitted under Section 6.3(d) or 6.6(a) due to a Claimant's failure to submit information necessary to decide a claim or the appeal, the period for making the Benefit Determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

6.8 Relevance to Claim.

For the purposes of Sections 6.5(c) and 6.6(b)(iii), a document, record, or other information will be considered "relevant" to a Claimant's claim if such document, record, or other information:

(a) was relied upon in making the Benefit Determination;

(b) was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;

(c) demonstrates compliance with any administrative processes and safeguards in making the Benefit Determination; or

(d) constitutes a statement of policy or guidance with respect to the Group Health Benefit concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Benefit Determination.

6.9 Exhaustion of Administrative Remedies.

Notwithstanding anything to the contrary in a Group Health Program, no action at law or in equity may be brought to recover under the Group Health Benefit until all administrative remedies have been exhausted (including two appeals of an Adverse Benefit Determination if required by the applicable Group Health Program). If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Group Health Benefit's claim procedures outlined herein, such Claimant will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

6.10 Action for Recovery.

Unless otherwise expressly stated in a Group Health Program Document, and subject to

Section 6.9, any action at law or in equity with respect to any and all claims relating to the Group Health Benefit must be brought for recovery within one year from the earlier of (1) the date of a final internal Adverse Benefit Determination on Review, if applicable, or (2) the accrual of any claim under or relating to the Group Health Benefit that does not result in a final internal Adverse Benefit Determination on Review. If the Group Health Program Document for a particular Fully-Insured Program expressly states a limitations period for bringing an action thereunder, then such Group Health Program Document will control.

6.11 Participant's Responsibilities.

Each Participant will be responsible for providing the Claims Administrator, the Claims Fiduciary, the Plan Administrator and/or the Employer with the Participant's and each Beneficiary's current U.S. mailing address and electronic address, as specified in the Group Health Programs. Accordingly, any notices required or permitted to be given by the Claims Administrator, Claims Fiduciary, Plan Administrator or Employer hereunder will be deemed given if directed to such address furnished by the Participant and mailed by regular United States mail, delivered by messenger or other professional delivery service, or provided by electronic means as specified in Section 2520.104b-l(c) of ERISA. The Claims Administrator, Claims Fiduciary, Plan Administrator and the Employer will not have any obligation or duty to locate a Participant, Dependent or Beneficiary. In the event that a Participant, Dependent or Beneficiary becomes entitled to a payment under the Group Health Benefit and such payment is delayed or cannot be made:

(a) because the current address according to the Claims Fiduciary's records is incorrect;

(b) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Claims Fiduciary's records,

(c) because of conflicting claims to such payments; or

(d) for any other reason;

the amount of such payment, if and when made, will be determined under the provisions of the Group Health Benefit without payment of any interest or earnings.

To the extent that the entitlement of a Participant, Dependent, Beneficiary or other individual to a benefit under the Group Health Benefit is the subject of an interpleader action in a court of competent jurisdiction, the Plan Administrator, Plan Sponsor and any other Plan fiduciary may act in reliance upon any order issued by such court regarding any individual's entitlement to benefits under the Group Health Benefit, which action shall satisfy its fiduciary and other duties under the Group Health Benefit.

6.12 Unclaimed Benefits.

If, within twelve (12) months after any amount becomes payable hereunder to a Participant or Beneficiary, and the same will not have been claimed or any check issued under the Group Health Benefit remains uncashed, provided reasonable care will have been exercised in attempting to make such payments, the amount thereof will be forfeited and will cease to be a liability of the Plan.

ARTICLE VII
COORDINATION OF BENEFITS

7.1 Coordinating Benefits with Coverage from Another Source.

If a Participant has coverage under the Group Health Benefit as well as coverage from another source (or sources), benefits that are received through the Group Health Benefit will be coordinated with the benefits available under the plan(s) containing the Participant's other source of benefits. The coordination of benefits ("**COB**") provisions in this Article VII will apply to all health benefits provided under the Group Health Benefit, but only to the extent that the applicable Group Health Program does not contain its own COB provisions. In the event that the Group Health Program contains its own COB provisions, such provisions will govern and control the coordination of benefits under that Group Health Program.

7.2 Coverage from Another Source.

For purposes of this Article VII, "coverage from another source" will mean any other plan, policy or contract (individually and collectively, a "plan") providing benefits or services for medical, prescription drug or dental care, including but not limited to, one of the following:

(a) group insurance, or any other arrangement of coverage for individuals in a group health maintenance organization (HMO) or other group on an insured, self-insured or uninsured basis, or state or federal programs providing health coverage other than a state plan under Medicaid or TRICARE, the U.S. Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families;

(b) group coverage sponsored through a school or other educational institution, for a student;

(c) coverage under a service plan contract or prepayment plan or program;

(d) group coverage under franchise organizations; or

(e) no-fault insurance required under any law of a government and provided on other than a group basis, but only to the extent the benefits are required under such no-fault law.

7.3 Construction.

Coverage from another source will be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

7.4 Allowable Charge for COB Purposes.

For a charge to be allowable for COB purposes, it must be a usual and reasonable charge and at least part of it must be covered under the Group Health Benefit.

When benefits are reduced under a primary plan because a Participant does not comply with the other plan's provisions, the amount of such reduction will not be considered an allowable charge. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred or direct provider arrangements.

In the case of HMO (Health Maintenance Organization) or other in-network only plans, the Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Participant does not use an HMO or network provider, the Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Participant used the services of an HMO or network provider.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will, for purposes of this Article VII, be considered to be the allowable charge.

7.5 Automobile Limitations.

When medical payments are available under vehicle insurance, the Group Health Benefit will pay excess benefits only, without reimbursement for vehicle plan deductibles. Except as required by law, the Group Health Benefit will always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

7.6 Ordering of Benefits.

When coverage is provided by two or more sources for the same allowable charge as stated above, whether the Group Health Benefit or the other plan (either, a "plan") is primary is established in the following order:

(a) The plan that has no COB provision will be considered primary to a plan that has COB provisions;

(b) The plan covering the person as an employee will be primary to the plan covering the person as a dependent;

(c) The plan covering a person in his own capacity will be primary to the plan covering a person as a dependent; however, if the person is a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as a non-dependent, then the plan covering the person as a dependent is primary, Medicare is secondary and the plan covering the person as a non-dependent is the tertiary plan (that is, in this specific situation, the plan covering the person as a non-dependent pays only after the plan covering the person as a dependent and after Medicare);

(d) The plan covering a person as an active employee will be primary to the plan covering the person as a retired, terminated, inactive, suspended or laid-off employee, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(e) The plan covering a person as an employee will be primary to the plan covering the person as a COBRA participant or a beneficiary under any other federal or state continuation coverage, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(f) The plan covering a dependent as a dependent of an active employee is primary to the plan covering the dependent as the dependent of a former employee or as a COBRA participant or a beneficiary under any other federal or state continuation coverage;

(g) For the purposes of a dependent covered under the plans of both of his non-divorced parents (or parents who never married, but who live together) the plan covering the parent whose birthday falls first in the year will be primary to the plan covering the parent whose birthday falls later in the year. If both parents have the same birthday, then the plan covering the parent for the longest period of time will be primary, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(h) For a dependent whose parents are divorced or legally separated (or if the parents never married and do not live together), and the dependent is covered by the plans of both parents, the plan covering the parent who is responsible for the dependent's health care under the terms of a court decree or state agency order will be the primary payor for any period after the plan has actual knowledge of those terms. If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not divorced. In the absence of such court decree or state agency order, payment will be made in the order as follows:

(i) the plan of the natural parent with custody;

(ii) the plan of the step-parent with custody; and

(iii) the plan of the natural parent without custody; and

(i) If (a), (b), (c), (d), (e), (f), (g) or (h) do not apply, then the plan covering the person for the longest period of time will be primary.

(j) Notwithstanding any provision to the contrary, to the extent required by applicable law, the Group Health Benefit shall be primary with respect to items or services for which a State provides child health assistance under the State's child health plan. This provision will be interpreted in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, and the authoritative guidance thereunder.

7.7 Reduction of Benefits Payable by the Group Health Benefit.

Whenever the Group Health Benefit is considered secondary to another plan, benefits will be payable by the primary plan to the extent that the expense is an incurred charge, and the Group Health Benefit will be liable for the remainder of the eligible expenses that would be payable in the absence of dual coverage up to the amount that would otherwise be payable to the extent payable in total under the Group Health Benefit.

7.8 Coordination of Benefits for Persons Eligible for Medicare.

With respect to a Participant who is entitled to Medicare, benefits under the Group Health Benefit to which such Participant is entitled will be coordinated with Medicare in accordance with the coordination of benefits provision of the Group Health SPD and subject to the rules and regulations as specified by the Omnibus Budget Reconciliation Act of 1980, the Tax Equity and Fiscal Responsibility Act of 1982, and all subsequent legislation defining Medicare's role as the secondary payer vis à vis a group health plan, subject to the following provisions:

(a) The Group Health Benefit is a primary plan with regard to any Participant who is entitled to Medicare benefits solely on the basis of having end-stage renal disease ("**ESRD**"); provided that Medicare will be considered to be the primary payer of benefits on behalf of a Participant with ESRD after expiration of the period that begins on the date the individual first becomes entitled to Medicare Part A benefits under Social Security Act Section 226A and ends 30 months later.

(b) The Group Health Benefit is a secondary plan with regard to all other Participants eligible for Medicare to the full extent permitted by Medicare or other applicable federal law.

(c) When a Participant is eligible for, or would have been eligible for with proper request, and does not enroll in Medicare Parts A and B, and the Group Health Benefit is not required by federal law to pay as the primary plan, then the Group Health Benefit shall pay secondary benefits as if the Participant had enrolled in Medicare Parts A and B and Medicare had paid as the primary plan.

7.9 Claims Determination Period.

Benefits will be coordinated on a calendar year basis. This is called the "claims determination period." However, the claims determination period does not include any part of a year during which a person has no coverage under the Group Health Benefit, or any part of a year before the date this COB provision or a similar provision takes effect.

7.10 Reduced Benefits when the Group Health Benefit Pays Second.

When the Group Health Benefit pays first, the benefits of the Group Health Benefit are determined before those of another plan and without considering the benefits of the other plan. When the Group Health Benefit pays second, the benefits of the Group Health Benefit may be reduced or denied as herein described. The benefits of the Group Health Benefit will be reduced when the sum of:

(a) The benefits that would be payable for the allowable charges under the Group Health Benefit in the absence of this COB provision, and

(b) The benefits that would be payable for the allowable charges under the other benefit plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds those allowable charges in a claims determination period. In that case, the benefits of the

Group Health Benefit will be reduced so that the benefits under the Group Health Benefit and the benefits payable under the other benefit plans do not total more than those allowable charges that would be available under the Group Health Benefit in the absence of this COB provision.

When the benefits of the Group Health Benefit are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Group Health Benefit.

7.11 Right to Receive or Release Necessary Information.

To make the provisions of this Article VII work, the Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person; provided however, any disclosure of "protected health information", as that term is defined in Section 12.1, by the Plan will be made in accordance with Article XII herein and the requirements of HIPAA. A Participant must provide the Plan with the information it requests about other plans and their payment of allowable charges in order to be eligible for benefits (or continued benefits) under the Group Health Benefit.

7.12 Facility of Payment to Other Plan.

The Plan may repay other plans for benefits paid that the Plan Administrator determines, in its discretion, should have been paid under the Group Health Benefit. Any such repayment by the Group Health Benefit will count as a valid payment under the Group Health Benefit.

7.13 Right of Recovery.

The Group Health Benefit may pay benefits that should be paid by another benefit plan. In this case the Plan may recover the amount paid from the other benefit plan or the Participant. Such repayment will count as a valid payment under the other benefit plan. Further, the Group Health Benefit may pay benefits that are later found to be greater than the allowable charge. In this case, the Plan may recover the amount of the overpayment from the source to which it was paid.

ARTICLE VIII
RIGHT OF SUBROGATION AND REIMBURSEMENT

The provisions of this Article VIII will govern and control the Plan's rights to subrogation and reimbursement with respect to the Group Health Benefit, and will supersede any subrogation and reimbursement provisions set forth in any Group Health Program Document to the extent that such other provisions are more restrictive or limited regarding the rights of the Plan than are these provisions. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this Article VIII on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this Article VIII on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

8.1 Benefits Subject to this Provision

This Article VIII will apply to all health benefits provided under the Group Health Benefit. For purposes of this Article, certain terms are defined as follows:

(a) "**Recovery**" means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant's attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

(b) "**Reimbursement**" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.

(c) "**Subrogation**" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

(d) "**Third Party**" means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Participant's injury or illness.

The term "Third Party" will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

8.2 When this Provision Applies

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Group Health Benefit for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the

Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Group Health Benefit, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Group Health Benefit that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this Article VIII.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Group Health Benefit, the Participant agrees that acceptance of benefits, as well as participation in the Group Health Benefit, is constructive notice of the provisions of this Article VIII, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

(a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Group Health Benefit and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Article VIII apply;

(b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

(c) Must cooperate fully with the Plan in its exercise of its rights under this Article VIII, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Group Health Benefit to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section 8.5, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this Article VIII ("**S&R Agreement**").

When a right of Recovery exists, and as a condition to any payment by the Group Health Benefit (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Group Health Benefit for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Group Health Benefit's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Group Health Benefit's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Group Health Benefit's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Group Health Benefit of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Group Health Benefit precludes operation of the "made-whole" and "common-fund" doctrines. A Participant who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Group Health Benefit for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Group Health Benefit, or receiving benefits under the Group Health Benefit, the Participant automatically agrees, without further notice, to all the terms and conditions of this Article VIII and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this Article VIII and to make changes in its interpretation as it deems necessary or appropriate.

8.3 Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Group Health Benefit. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Group Health Benefit and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

8.4 When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Group Health Benefit also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this Article VIII.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under the Group Health Benefit for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

8.5 When a Participant Retains an Attorney

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Group Health Benefit and as a condition to any payment of future benefits under the Group Health Benefit for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Group Health Benefit for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

8.6 When the Participant is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent

The provisions of this Article VIII apply to the parents, trustee, guardian or other representatives of a minor Participant and to the heirs or personal representatives of the estate of a deceased Participant, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this Article VIII, the term "Participant" will also include a COBRA Qualified Beneficiary (as defined in Section 11.10) who has elected COBRA Continuation Coverage under the Group Health Benefit and a Domestic Partner or Domestic Partner's child who has elected Partner Continuation Coverage, pursuant to Section 11.13, under the Group Health Benefit. If a covered Dependent is the Participant whose benefits under the Group Health Benefit are subject to the Plan's Subrogation and Reimbursement rights, the covered Eligible Retiree who enrolled such Dependent under the Group Health Benefit will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor and, in such event, the Eligible Retiree will be liable for any breach of this Article VIII by the Eligible Retiree or by such Dependent.

8.7 When a Participant Does Not Comply

When a Participant does not comply with the provisions of this Article VIII, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Group Health Benefit by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Article VIII, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE IX
AMENDMENT OR TERMINATION

The provisions of this Article IX will govern and control amendment and termination of the Plan (including the Group Health Benefit), and will supersede any conflicting or inconsistent provisions set forth in a Group Health Program Document.

9.1 Right to Amend.

The Board of Directors (or a committee of the Board of Directors), or an officer of the Plan Sponsor who is duly authorized by the Board of Directors (or such committee) for this purpose, will each have the right, authority and power to make, at any time, any amendment to the Plan. Notwithstanding the previous sentence, (a) the CFO and the CEO acting jointly, or (b) the CFO and the General Counsel of the Plan Sponsor acting jointly, will each have the power to approve, adopt, and execute any amendment to the Plan that (i) is required to comply with changes in applicable law or (ii) does not increase the cost of the Plan by more than five percent (5%) per year as determined in good faith and with the certification of an actuary if necessary.

No amendment will retroactively prejudice any claim for benefits under the Plan that was incurred but not paid prior to the effective date of the amendment, unless the person or entity responsible for the amendment, as applicable, determines such amendment is necessary or desirable to comply with applicable law or is required under the particular Group Health Program. Moreover, if the Plan is amended, a Participant's right to receive coverage for expenses incurred for supplies or services that were actually received or actually rendered on his behalf before the effective date of such amendment will not be reduced or eliminated. However, an amendment may reduce or eliminate a Participant's right to receive coverage for expenses that are or will be incurred for supplies or services that are received or rendered on or after the effective date of the amendment, even if such supplies or services were approved or are part of a series of treatments or services that began prior to such effective date.

9.2 Right to Terminate.

The Board of Directors (or a committee of the Board of Directors) will have the right, authority, power, and discretion to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its discretion; provided, however, such termination will not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Board of Directors (or such committee) determines it is necessary or desirable to comply with applicable law.

The CFO and the CEO, acting jointly, or the CFO and the General Counsel of the Plan Sponsor, acting jointly, may, in their discretion, terminate the participation of any Employer, with respect to its Eligible Retirees only, in the Plan (or the Group Health Benefit in particular), effective as of any date such officers deem advisable. The Plan Sponsor may revise Appendix A, as needed, to reflect the termination of an Employer from participation in the Plan or the Group Health Benefit, without regard to the formal amendment provisions of the Plan.

ARTICLE X
ADMINISTRATION

10.1 Benefits Committee.

The Benefits Committee shall be the Plan Administrator. Subject to Section 10.4, the day-to-day administration of the Group Health Benefit shall be the responsibility of the Benefits Committee. The Benefits Committee shall consist of one or more members, as appointed from time to time by the Plan Sponsor by action of the Executive Vice President responsible for Human

Resources of the Plan Sponsor (the "**EVP-HR**"). The members of the Benefits Committee shall serve at the discretion of the EVP-HR without additional compensation, but may be reimbursed for proper expenditures incurred during the course of performance of duties hereunder in accordance with applicable law. The Benefits Committee shall be subject to such duties and procedures as may be designated by the Plan Sponsor pursuant to a separate instrument.

10.2 Allocation of Authority.

The Plan Administrator will control and manage the operation and administration of the Group Health Benefit, except to the extent such duties have been delegated to other persons or entities as provided in the Wrap-Plan, this Wrap-SPD or a Group Health Program Document. Any decisions made by the Plan Administrator or Claims Fiduciary (or any other person or entity delegated authority by the Plan Administrator or Claims Fiduciary, as applicable, to determine benefits in accordance with the Plan) will be final and conclusive on all Participants, and all other persons and entities, subject only to the claims appeal provisions of the Group Health Benefit. Neither the Plan Administrator nor any Employee will receive any compensation from the Plan with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

10.3 Powers and Duties of Plan Administrator.

The Plan Administrator (and the Claims Fiduciary, but only with respect to reviewing and making decisions regarding claims under a Group Health Program) will each have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have final discretionary authority to (i) administer, enforce, construe, and construct the Group Health Benefit, including this Wrap-SPD and the Group Health Program Documents, (ii) make decisions relating to all questions of eligibility to participate, and (iii) make a determination of benefits including, without limitation, reconciling any inconsistency, correcting any defect, supplying any omission, and making all findings of fact;

(b) to prescribe procedures to be followed by Participants filing application for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Group Health Benefit and benefits thereunder;

(d) to receive from the Employer and from Participants such information as necessary for the proper administration of the Group Health Benefit;

(e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as necessary;

(f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;

(g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of Participants, including an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors or other agents as it may select, in its discretion, for that purpose; and

(h) to appoint persons or entities to assist in the administration as it deems advisable; and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator (or the Claims Fiduciary) in a fashion consistent with its intent, as determined by the Plan Administrator (or the Claims Fiduciary). The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The Plan Administrator (or Claims Fiduciary) may rely upon the direction or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under the Plan, and will not be responsible for any act or failure to act. Neither the Plan Administrator nor the Employer makes any guarantee to any Eligible Retiree in any manner for any loss that may result because of the Eligible Retiree's participation in the Group Health Benefit.

All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal procedures of the Group Health Benefit. Benefits under the Group Health Benefit will be paid only if the Plan Administrator (or Claims Fiduciary) determines in its discretion that the Participant is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination or action by any court. Any review of any such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

10.4 Delegation by the Plan Administrator.

The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Group Health Benefit, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder, including, without limitation, delegation to the Claims Administrator, the Claims Fiduciary and the Disclosure Administrator. The Plan Administrator may employ such counsel, accountants, Claims Administrators, Claims Fiduciaries, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Group Health Benefit is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator or such delegate who is also an Employee will be fully protected in respect to any action taken or permitted in good faith in reliance

on such information.

10.5 Disclosure Responsibility.

(a) *General.* The Disclosure Administrator shall, in response to a written request by a Participant or Beneficiary, furnish a copy of the documents and instruments specified in Section 104(b)(4) of ERISA ("**Plan Disclosures**") as required by ERISA. A Participant's or Beneficiary's request for Plan Disclosures must be submitted to the Disclosure Administrator in writing, at the address listed in Article XIV, and must identify the particular Plan Disclosures that are being requested. The Disclosure Administrator may, in its discretion, impose a reasonable charge to cover the cost of copying and furnishing the requested Plan Disclosures to the extent permitted by ERISA.

(b) *Requests by an Authorized Representative.* A request for Plan Disclosures may be submitted to the Disclosure Administrator by an authorized representative of the Participant or Beneficiary, provided that (i) the authorization of such representative is designated in writing by the Participant or Beneficiary in a manner that is sufficiently clear and conspicuous, as determined by the Disclosure Administrator in its discretion, to enable the Disclosure Administrator to reasonably verify the status of the authorized representative and the scope of such authorization, and (ii) a copy of the signed authorization is submitted to the Disclosure Administrator with the request for Plan Disclosures. The Disclosure Administrator will not make any Plan Disclosures to a person or entity claiming to be an authorized representative prior to receipt of an authorization that meets the criteria in clauses (i) and (ii), as determined by the Disclosure Administrator. The Disclosure Administrator may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, the Disclosure Administrator reserves the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Disclosure Administrator determines that such designation is fraudulent; such as, for example, when the Disclosure Administrator determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.

(c) *Examination of Records.* Participants and Beneficiaries shall have the right to examine such records, documents and other data as required by ERISA at reasonable times during regular business hours. Nothing contained in the Plan shall give any Participant the right to examine any data or records with respect to any other Participant except as required by applicable law which cannot be waived.

10.6 Rules and Decisions.

The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the Group Health Benefit. The Plan Administrator will be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

10.7 Facility of Payment for Incapacitated Participant.

Whenever, in the Claims Fiduciary's opinion, a Participant is entitled to receive any payment of a benefit hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Claims Fiduciary may direct payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment furnished to the Claims Fiduciary), Dependent, or relative of such person for such person's benefit, or the Claims Fiduciary may direct payment for the benefit of such person in such manner as the Claims Fiduciary considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section 10.7 will be a complete discharge of any liability for the making of such payment under the Plan.

10.8 Assignment and Payment of Benefits.

The provisions of this Section 10.8 shall supersede any provisions of a Group Health Program Document (other than the Group Health Program Document(s) of a Fully-Insured Program) regarding the subject matter hereof and shall govern and control.

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "**Plan Agreement**"), no rights, causes of action or benefits under the Group Health Benefit can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to, or on behalf of, a Participant. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Participant or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for benefits under the Group Health Benefit, (b) request the Plan document or other documents related to the Plan, the Group Health Benefit or a claim for benefits, (c) file an appeal of a denied claim for benefits under the Group Health Benefit, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Participant's benefits and/or rights under the Group Health Benefit (*i.e.*, is not merely an agreement between the Participant and the provider or its representative or agent), the Plan Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Group Health Benefit directly to the provider, the Participant, or to another designated person or entity, with or without the Participant's authorization, with each such payment being made on behalf of the Participant, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator or Claims Fiduciary of the anti-assignment provisions of this Section 10.8. In addition, any payment made under the Group Health Benefit to any such person or entity discharges the Plan's responsibility to the Participant for benefits under the Group Health Benefit to the full extent of such payment. Accordingly, if a provider is overpaid as the result of accepting a payment for the same covered service from the Participant and from the Plan, the provider, and not the Plan, shall be responsible

for reimbursing the Participant for such overpayment.

Disclosures of information about the Participant can only be made to a Participant or a Participant's authorized representative in accordance with applicable law and the terms of the Plan.

10.9 Overpayments.

If, for any reason, any benefit, premium or fee under the Group Health Benefit is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Participant or to an insurance company, a healthcare or other services provider (including an assignee of the Participant as described in Section 10.8), or other person or entity for the benefit of a Participant (collectively, a "**Third-Party Payee**"), such erroneously-paid amount shall constitute an "**Overpayment**" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Participant or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount ("**Overpayment Reimbursement**"). Without limitation, the Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA and shall be construed accordingly. By accepting a benefit, premium or fee under the Group Health Benefit, each Participant and Third-Party Payee automatically acknowledges and agrees that the Plan has the right to pursue Overpayment Reimbursement from the general assets of the Participant or Third-Party Payee to whom the Overpayment was made, to the full extent permitted by ERISA.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Participant (including, without limitation, to a covered Eligible Retiree on behalf of any of his Dependents or Beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable by the Plan on behalf of the Participant, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary, as applicable, deems to be appropriate in its discretion, to the extent permitted by applicable law. For example, the selected repayment method may include, without limitation, offsetting other payments made by the Group Health Benefit (i) to, or on behalf of, the Participant or (ii) to the same Third-Party Payee on the Participant's behalf, as permitted by applicable law (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to the ERISA claims and appeals procedures of the Group Health Benefit). For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this Section 10.9, the offset of the Overpayment hereunder is simply an adjustment to the amount payable to the Third-Party Payee to reflect the Overpayment and shall not be considered to be the denial or partial denial of any benefit claim under the Group Health Benefit.

ARTICLE XI
COBRA CONTINUATION COVERAGE

11.1 Continuation of Benefits under COBRA.

Qualified Beneficiaries will have all continuation rights required by COBRA for group health plan benefits offered under the Group Health Programs within the Plan. To the extent a Group Health Program offering health benefits does not specify COBRA rights in accordance with Code

Section 4980B, the Group Health Benefit will be administered in accordance with Code Section 4980B and as set forth in this Article XI. In addition, the Plan Administrator will adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section 11.1.

11.2 Election of COBRA Coverage.

An Eligible Retiree is not eligible to elect COBRA Continuation Coverage upon termination of his coverage under the Retiree Group Health Benefit.[1]

(a) *COBRA Continuation Coverage for Qualifying Dependent.*

Subject to Section 11.5, a Qualified Beneficiary who is a Qualifying Dependent of a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if his participation under the Group Health Benefit would terminate as a result of a Qualifying Event.

(b) *Enrollment for COBRA Continuation Coverage.*

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required enrollment materials within a maximum of sixty (60) days from the later of:

(i) loss of coverage; or

(ii) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

Failure to enroll for COBRA Continuation Coverage during this maximum sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Article XI. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee's Spouse will be deemed to be an election for that Covered Employee's Qualifying Dependents who would otherwise lose coverage under the Group Health Benefit, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on his behalf by a third party (including a third party that is not a Qualified Beneficiary).

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA Continuation Coverage. However, if a waiver is later revoked, coverage will not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the third-party administrator that performs services on behalf of the Plan Administrator as the Plan's "COBRA Administrator", at the address listed in Appendix C.

[1] A limited exception to this provision applies in the case of a Qualifying Event described in Section 11.10(h)(v).

11.3 Period of COBRA Coverage.

A Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event.

Coverage under this Section 11.3 may not continue beyond:

(a) the date on which the Employer ceases to maintain a group health plan within its controlled group;

(b) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 11.4;

(c) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes enrolled in Medicare;

(d) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes covered under another group health plan and is no longer subjected, due to changes in the law or otherwise, to a preexisting condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or

(e) in the case of a disabled Qualified Beneficiary (and his disabled or non-disabled family members) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage described in Section 11.6, and with respect to such extended coverage, the first day of the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of Similarly Situated Beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Group Health Benefit solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA Continuation Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11.4 Contribution Requirements for COBRA Coverage.

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects

COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation Coverage Contribution for the first month's premium, coverage will either terminate or will be retroactively cancelled.

The Qualified Beneficiary will have a thirty (30) day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the thirty (30) day grace period.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. The thirty (30) day grace period will not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

Except as provided in Section 11.6, the Continuation Coverage Contribution will be one hundred percent (100%) of the cost of coverage plus a two percent (2%) administrative fee for a total contribution of one hundred two percent (102%) of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (thirty (30) days) for payment of the deficiency to be made. For purposes of this Section 11.4, an amount not significantly less than the amount the Plan requires to be paid will be defined as the lesser of fifty dollars ($50) or ten percent (10%) of the required payment amount.

11.5 Limitation on Qualified Beneficiary's Rights to COBRA Coverage.

If a Qualified Beneficiary loses, or will lose, health coverage under the Group Health Benefit as a result of a Qualifying Event that is a divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary (or representative) must notify the Plan Administrator, as described in Section 11.11, within a maximum of sixty (60) days after the latest of (a) the Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA notice provided upon enrollment, of his responsibility to provide a Qualifying Event notice as described in this Section 11.5 and the Group Health Benefit's procedures for providing such notice. Failure to make timely notification will result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Article XI.

For all other Qualifying Events, the Employer must notify the Plan Administrator of the Qualifying Event. The notice must be provided within a maximum of thirty (30) days after the Qualifying Event.

11.6 Extension of COBRA Coverage Period.

A Qualified Beneficiary (or representative) must notify the Plan Administrator, as described in Section 11.11, if a second Qualifying Event occurs while the Qualified Beneficiary is receiving

COBRA Continuation Coverage. The Qualified Beneficiary must notify the Plan Administrator within a maximum of sixty (60) days after the latest of (a) the second Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the second Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of his responsibility to provide a notice of a second Qualifying Event and the Group Health Benefit's procedures for providing such notice.

If a second Qualifying Event occurs during an eighteen (18) month period of COBRA Continuation Coverage explained in Section 11.3 (or twenty-nine (29) month period, if extended due to disability), coverage may be extended to a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualifying Dependent. Coverage will be extended, however, only if the second Qualifying Event would have caused the Qualifying Dependent to lose coverage under the Group Health Benefit in the absence of the first Qualifying Event. Any such extension of COBRA Continuation Coverage applies only to Qualifying Dependents.

The maximum COBRA Continuation Coverage Period is extended up to eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

(a) the Social Security Administration ("**SSA**") determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or within the first sixty (60) days of COBRA Continuation Coverage following the Qualifying Event, and

(b) the Qualified Beneficiary (or representative) provides notice to the Plan Administrator, as described in Section 11.11, of such SSA determination:

(i) within sixty (60) days after the latest of (A) the date of the SSA determination, (B) the date on which the Qualifying Event occurred, (C) the date on which the Qualified Beneficiary loses coverage due to the Qualifying Event, or (D) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the obligation to provide the disability notice and the Group Health Benefit's procedures for providing such notice; but

(ii) not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage.

In such event, the Continuation Coverage Contribution will be one hundred fifty percent (150%) of the cost of coverage for the nineteenth (19^{th}) through twenty-ninth (29^{th}) months of COBRA Continuation Coverage.

However, if a Qualified Beneficiary who meets the above requirements receives a final determination from the SSA that he is no longer disabled, said beneficiary (or representative) must notify the Plan Administrator, as described in Section 11.11, within thirty (30) days after the later of (a) the date of that determination or (b) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the obligation to provide the end-of-

disability notice and the Group Health Benefit's procedures for providing such notice. Such a final determination by the SSA will end the disability extension of COBRA Continuation Coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following thirty days (30) from the final determination date; or (ii) the end of the COBRA Continuation Coverage period without regard to the disability extension.

11.7 Responses to Inquiry Regarding Qualified Beneficiary's Right to Coverage.

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the election period, the Plan will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

11.8 Coordination of Benefits - Medicare and COBRA.

For purposes of this Article XI, "Medicare Entitlement" means being entitled to Medicare due to either (a) enrollment (automatically or otherwise) in Medicare Parts A or B, or (b) being medically determined to have end-stage renal disease ("**ESRD**") and (i) having applied for Medicare Part A, (ii) having satisfied any waiting period requirement and (iii) being either (A) insured under Social Security, (B) entitled to retirement benefits under Social Security or (C) a spouse or dependent of a person satisfying either (A) or (B). Such Medicare Entitlement is a COBRA terminating event.

11.9 Relocation and COBRA Coverage.

If a Qualified Beneficiary moves outside the service area of a region-specific benefit package, alternative coverage, if available to active employees, will be made available to the Qualified Beneficiary no sooner than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage. A Qualified Beneficiary has thirty days from the date of the Qualified Beneficiary's relocation to request the alternative coverage.

11.10 Definitions.

For purposes of this Article XI only, the following definitions will apply:

(a) *COBRA* means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(b) *Continuation Coverage* means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage will be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of the Group Health Benefit are modified for Similarly Situated Beneficiaries, such coverage will also be modified in the same

manner for all Qualified Beneficiaries as of the same date. Annual enrollment rights extended to Participants, if any, will also be extended to similarly situated Qualified Beneficiaries.

(c) *Continuation Coverage Contribution* means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for Continuation Coverage.

(d) *Continuation Coverage Period* means the applicable time period for which Continuation Coverage may be elected.

(e) *Covered Employee* means an Eligible Retiree who is provided coverage under the Group Health Benefit due to his performance of services for the Employer.

(f) *Qualified Beneficiary* means a Covered Employee or Qualifying Dependent.

(g) *Qualifying Dependent* means:

(i) a Dependent covered under the Group Health Benefit on the day prior to the Qualifying Event (except that such term shall not include the covered Domestic Partner of a covered Eligible Retiree, or the covered child of such Domestic Partner, unless such Domestic Partner and/or child, as applicable, otherwise constitutes a "qualified beneficiary" under Code Section 4980B(g)(1)); or

(ii) a child who is covered under the Group Health Benefit on the day prior to the Qualifying Event pursuant to the terms of a qualified medical child support order.

(h) *Qualifying Event* means any of the following events which would otherwise result in a Covered Employee's or a Qualifying Dependent's loss of health coverage under the Group Health Benefit in the absence of this provision:

(i) a Covered Employee's divorce or legal separation;

(ii) a Qualified Dependent ceasing to qualify as a Dependent under the provisions of the Group Health Benefit;

(iii) a Covered Employee's entitlement to benefits under Medicare;

(iv) the death of a Covered Employee;

(v) a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a Covered Employee retired at any time.

Note: A loss of health coverage under the Group Health Benefit includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the Group Health Benefit that results from the occurrence of one of the events listed above in Subsections (i)(i) – (i)(v). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage Period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(i) *Similarly Situated Beneficiaries* means Eligible Retirees or their Dependents, as applicable, who are Participants in the Group Health Benefit.

11.11 Qualified Beneficiary Notice Procedures.

Any notice that a Qualified Beneficiary is required to provide under this Article XI must be in writing. The Plan Administrator has contracted with a third-party administrator to perform services as the Group Health Benefit's "**COBRA Administrator**." A Qualified Beneficiary must provide his written notice ("**Notice**") to the COBRA Administrator, on behalf of the Plan Administrator, at the address listed in Appendix C. Any Notice that is mailed must be postmarked no later than the last day of the applicable required notice period.

The required procedures for providing Notices under the Group Health Benefit, including the form and content of Notices, are specified in the applicable Group Health Program Document(s). To the extent that a Group Health Program does not prescribe required procedures for providing Notices under the Group Health Benefit, the procedures set out in this Section 11.11 will apply.

The information that must be provided in the Notice is based on the purpose of the Notice, as follows:

- Qualifying Event Notice.
  The Notice to inform the Plan Administrator of a Qualifying Event (including a Covered Employee's entitlement to Medicare) must contain (1) the name of the Qualified Beneficiary; (2) the name of the Plan to which the Notice applies; (3) a description of the Qualifying Event; and (4) the date on which the Qualifying Event occurred.

- Disability Determination Notice.
  The Notice to inform the Plan Administrator of a Qualified Beneficiary's disability determination by the SSA must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's disability determination letter.

- Determination of End of Disability Notice.
  The Notice to inform the Plan Administrator of the SSA's determination that a disabled Qualified Beneficiary is no longer disabled must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's determination letter that a disability no longer exists.

- Birth, Adoption or Placement Notice.
  The Notice to inform the Plan Administrator of the birth, adoption or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage must contain (1) the name of the Covered Employee, (2) the name of the Plan to which the Notice applies, (3) the reason for the Notice (*i.e.*, the birth, adoption or placement for adoption of a child, as applicable), and (4) the date of such child's birth, adoption or placement for adoption.

A separate Notice must be provided for each event set out above. In addition, evidence that the event has occurred, acceptable to the COBRA Administrator, must be provided with the Notice. The following evidence shall be deemed "acceptable":

(a) For all such events except an SSA disability (or non-disability) determination, the Qualified Beneficiary's signed certification;

(b) For an SSA disability determination, a copy of the SSA Disability Award letter; and

(c) For an SSA non-disability determination, a copy of the SSA's determination that the Qualified Beneficiary is no longer disabled.

11.12 Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Continuation Coverage.

Special COBRA rights may apply to certain Covered Employees who are eligible for trade adjustment assistance under the Trade Act of 2002 ("**TAA Employees**"). These TAA Employees may be entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not already elect COBRA Continuation Coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. It is the 60-day period beginning on the first day of the month in which the TAA Employee becomes eligible for certain benefits under the Trade Act of 2002 and during the six (6) month period immediately after the TAA Employee's coverage under the Group Health Benefit ends. A Covered Employee who qualifies or may qualify for this special election period should contact the Eligibility Administrator at the address and telephone number listed in Appendix C for additional information.

11.13 Continuation of Benefits for Covered Domestic Partners and their Covered Children.

Neither the covered Domestic Partner of a covered Eligible Retiree nor a covered child of such Domestic Partner shall be a Qualifying Dependent who is entitled to continuation of coverage rights under COBRA, except to the extent such Domestic Partner or child otherwise constitutes a "qualified beneficiary" under Code Section 4980B(g)(1).

However, if a Domestic Partner's coverage, or his child's coverage, under a Group Health Program that provides group health benefits terminates due to the occurrence an event specified in Section 11.10(h), the Domestic Partner and/or his child, as applicable, shall be entitled to elect "COBRA-like" coverage ("**Partner Continuation Coverage**") based on the same COBRA Continuation Coverage Periods, form and level of benefits, requirements for contributions by the Domestic Partner and/or his child, and other rules and administrative procedures as are applicable to COBRA Continuation Coverage provided under the Group Health Benefit.

11.14 Questions and Other Information Regarding COBRA Coverage.

The Eligible Retiree Participant will be responsible for keeping the Plan Administrator informed of any changes in his address and the addresses of his Spouse, Domestic Partner, and Dependents. Questions concerning a Participant's COBRA coverage rights should be directed to

either the COBRA Administrator or the Eligibility Administrator at the addresses and/or telephone numbers listed in Appendix C.

In the event that the Plan Administrator changes COBRA Administrators and Eligibility Administrators and the Participant is unable to reach the above-referenced COBRA Administrator and Eligibility Administrator, the Participant should direct questions to the Plan Administrator's Benefits Department at the address and telephone number listed in Article XIV.

ARTICLE XII
HIPAA PRIVACY AND SECURITY

12.1 HIPAA Privacy and Security in General.

This Article XII is intended to comply with the requirements under the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**"), the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E, as promulgated under HIPAA ("**Privacy Standards**"), the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 160 and part 164, subpart C, as promulgated under HIPAA ("**Security Standards**"), the HIPAA Enforcement Rule at 45 CFR part 160, subparts C through E ("**Enforcement Rules**") and the "**Breach Notification Rules**" issued under the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"), as each of the foregoing were amended, generally effective as of September 23, 2013, by the regulations issued on January 25, 2013 ("**HIPAA Omnibus Rules**"). References to any section of the Privacy Standards, the Security Standards, the Enforcement Rules or the Breach Notification Rules shall include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

For purposes of this Article XII, "Protected Health Information" ("**PHI**") means information, including genetic information, that is created or received by the Plan with respect to the Group Health Benefit which (i) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (ii) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (iii) is transmitted or maintained in any form or medium. "Electronic Protected Health Information" ("**ePHI**") means individually identifiable health information, including genetic information, that is created or received by the Plan with respect to the Group Health Benefit and transmitted by or maintained in electronic media.

12.2 Designation of Health Care Components and Safeguards.

To the extent the Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Standards), the provisions of this Article XII will only apply to the health care components of the Group Health Benefit (collectively referred to as the "**Health Care Components**"). All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this Article XII refer to PHI or ePHI that is created or received by or on behalf of the Health Care Components.

The Health Care Components will thus comply with the following requirements:

(a) The Health Care Components of the Plan will not disclose PHI to another component of the Plan in circumstances in which the Privacy Standards would prohibit such disclosure if the Health Care Components and the other component were separate and distinct legal entities; and

(b) If an employee of the Plan Sponsor performs duties for both the Health Care Components of the Plan and for another component of the Plan, such employee will not use or disclose PHI created or received in the course of, or incident to, the employee's work for the Health Care Component in a way prohibited by the Privacy Standards.

Note: For purposes of this Section 12.2, the portions of the Plan which provide group medical benefits, prescription drug benefits, and dental benefits under the Group Health Benefit constitute the Health Care Components.

12.3 Use and Disclosure of Protected Health Information.

The Plan Sponsor may only use and disclose PHI that it receives from a Health Care Component of the Plan, which is considered a "group health plan" as defined by the Privacy Standards, as permitted and/or required by, and consistent with, the Privacy Standards. This includes, but is not limited to, the right to use and disclose a Participant's PHI in connection with payment, treatment, and health care operations, or as otherwise permitted or required by law. The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

Payment includes activities undertaken by the Health Care Component of the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(a) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

(b) Coordination of benefits or non-duplication of benefits;

(c) Adjudication of health benefit claims (including appeals and other payment disputes);

(d) Subrogation of health benefit claims;

(e) Establishing employee contributions;

(f) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) Billing, collection activities and related health care data processing;

(h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(l) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m) Obtaining reimbursements due to the Plan.

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

(a) Quality assessment;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(d) Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

(e) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(g) Business management and general administrative activities of the Plan, including, but not limited to:

(i) Management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;

(ii) Customer service, including the provision of data analyses for policyholders,

plan sponsors or other customers;

(iii) Resolution of internal grievances; and

(iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

12.4 Certification of Amendment of Plan Documents by Plan Sponsor.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in this Article XII.

12.5 Plan Sponsor Agrees to Certain Conditions for PHI.

The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(e) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

(k) Establish separation between the Plan and the Plan Sponsor in accordance with 45 CFR § 164.504(f)(2)(iii).

With respect to ePHI, the Plan Sponsor agrees, on behalf of the Plan, to:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and

(4) Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

12.6 Adequate Separation Between the Plan and the Plan Sponsor.

In accordance with the Privacy Standards, only the employees or classes of employees designated in Appendix D may be given access to PHI.

12.7 Limitations of PHI Access and Disclosure.

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

12.8 Noncompliance Issues.

If the persons described in Appendix D do not comply with the Plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

12.9 Members of Organized Health Care Arrangement.

To the extent that any Health Care Component is fully-insured, the Plan and the health insurance issuer or HMO with respect to such Health Care Component are an organized health care arrangement (as defined in § 160.103 of the Privacy Standards), but only with respect to PHI created or received by the health insurance issuer or HMO that relates to the individuals who are

Participants or Beneficiaries in such Health Care Component.

12.10 Additional Requirements Imposed by HITECH.

The provisions of this Section 12.10 will apply to the Plan to the extent the Plan is a "covered entity" as defined in 45 CFR § 160.103. In accordance with, and to the extent required by, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

12.11 Limitation on the Use and Disclosure of Genetic Information.

Notwithstanding anything herein to the contrary, no "genetic information" (as defined by Section 105 of the Genetic Information Nondiscrimination Act of 2008) shall be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

12.12 Notification in Case of a Breach of Unsecured PHI.

In the event of the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Standards that constitutes a "Breach," as such term is defined in 45 CFR 164.402, the Plan, or its designee, shall notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed as a result of the Breach no later than sixty (60) days after the Plan, or its designee, discovers the Breach, unless notification may be delayed as permitted by 45 CFR 164.412 because such notice would impede a criminal investigation or damage national security. The Plan, or its designee, will mail individual notifications by first-class mail to the individual's last known address or by electronic mail, provided that electronic disclosure is permitted by the applicable regulations. The individual notification will include the following information:

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;

- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;

- Any steps the individual should take to protect himself from potential harm resulting from the Breach;

- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and

- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

If the Breach involves more than 500 residents of a state or jurisdiction, the Plan, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the Plan will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

12.13 Other Medical Privacy Laws.

The Plan will comply with the Privacy Standards and the Security Standards as well as with any applicable federal, state and local laws governing confidentiality of health care information, to the extent such laws are not preempted by HIPAA or ERISA.

ARTICLE XIII
MISCELLANEOUS LAW PROVISIONS

13.1 Qualified Medical Child Support Orders.

Rules relating to Qualified Medical Child Support Orders ("**QMCSO**") – The Group Health Benefit will provide benefits in accordance with the applicable requirements of any QMCSO.

(a) *Definitions.*

For purposes of Section 13.1, 13.2, 13.3 and 13.4, the following definitions apply:

(i) The term "Qualified Medical Child Support Order" will be defined for purposes of Sections 13.1, 13.2, 13.3 and 13.4 as follows: A Medical Child Support Order:

(A) which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Beneficiary is eligible under a group health plan; and

(B) with respect to which the requirements of this Section 13.1 under "Information to be Included in a QMCSO" and "Restriction on New Types or Forms of Benefits" are met.

(ii) The term "Medical Child Support Order" will be defined in Sections 13.1, 13.2 and 13.3 as follows: Any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

(A) provides for child support with respect to a child of a Participant under the Group Health Benefit or provides for health benefit coverage to such a child pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Group Health Benefit; or

(B) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget

Reconciliation Act of 1993) with respect to the Group Health Benefit.

(iii) For purposes of Sections 13.1, 13.2, 13.3 and 13.4, the term "Alternate Recipient" will be defined as follows: Any child of a Participant who is recognized under a Medical Child Support Order as having the right to enrollment under the Group Health Benefit with respect to such Participant.

(b) *Information to be Included in a QMCSO.*

A Medical Child Support Order meets the requirements of this paragraph only if such order clearly specifies:

(i) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient;

(ii) a reasonable description of the type of coverage to be provided by the Group Health Benefit to each such Alternate Recipient, or the manner in which such type of coverage is to be determined; and

(iii) the time period to which such order applies.

(c) *Restriction on New Types or Forms of Benefits.*

A Medical Child Support Order meets the requirements of this paragraph only if such order does not require a health plan to provide any type or form of benefit, or any option, not otherwise provided under the health plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

(d) *QMCSO Coverage Ends.*

A child who is covered pursuant to a QMCSO will have coverage end on the date the QMCSO expires.

13.2 Procedural Requirements.

(a) *Timely Notifications and Determinations.*

In the case of any Medical Child Support Order received by the Plan Administrator for the Group Health Benefit -

(i) the Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Group Health Benefit's procedures for determining whether a Medical Child Support Order is a QMCSO, and

(ii) within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a QMCSO and notify the Participant and each Alternate Recipient of such determination.

(b) *Establishment of Reasonable Procedures.*

The Plan Administrator will establish reasonable procedures to determine whether a Medical Child Support Order is a QMCSO and to administer the provisions of benefits under such QMCSO. Such procedures:

(i) will be in writing;

(ii) will provide for the notification of each person specified in a Medical Child Support Order who is named as eligible to receive benefits under the Group Health Benefit (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and

(iii) will permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a QMCSO.

A Participant may obtain a copy of the QMCSO procedures, without charge, upon request to the Benefits Department of the Plan Administrator at the address and/or telephone number listed in Article XIV.

13.3 Actions Taken by Fiduciaries.

(a) *General Requirement.*

If the Plan Administrator acts in accordance with Sections 13.1, 13.2 and 13.3 in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Plan's obligation to the Participant and each Alternate Recipient will be discharged.

(b) *Treatment of Alternate Recipients.*

(i) An individual who is an Alternate Recipient under a QMCSO will be considered a Beneficiary under the Group Health Benefit for purposes of any provision of ERISA.

(ii) An individual who is an Alternate Recipient under any Medical Child Support Order will be considered a Participant under the specific health plan for purposes of the reporting and disclosure requirements of Title I of ERISA.

(c) *Direct Provision of Benefits Provided to an Alternate Recipient.*

Any payment for reimbursement of expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

(d) *Payment to State Official Treated as Satisfaction of Plan's Obligation to Make Payment to Alternate Recipient.*

Payment of benefits by the Group Health Benefit to an official of a state or a political subdivision thereof, whose name and address have been substituted for the name and address of an Alternate Recipient in a QMCSO, will be treated as payment of benefits to the Alternate Recipient.

13.4 National Medical Support as Qualified Medical Child Support Order.

(a) An appropriately completed National Medical Support Notice ("**Notice**") promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 will be deemed to be a QMCSO if the Notice does not require the Plan to provide any type of form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993), and the Notice clearly specifies the following:

(i) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient (an official of a state or political subdivision may be substituted for the mailing address of any Alternate Recipient, if provided for in the Notice);

(ii) a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

(iii) the period to which the Notice applies.

(b) If a Notice which satisfies Section 13.4(a), is issued for a child of a Participant under the Group Health Benefit who is a noncustodial parent of the child, the Plan Administrator, within forty (40) business days after the date of the Notice, will:

(i) notify the state agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the Group Health Benefit and, if so, whether such child is covered under the Group Health Benefit and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a state or political subdivision thereof substituted for the name of such child pursuant to Section 13.4(a)(i) to effectuate the coverage; and

(ii) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(c) Nothing in this Section 13.4 will be construed as requiring the Plan, upon receipt of Notice, to provide benefits under the Group Health Benefit (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Group Health Benefit as of immediately before the receipt of such Notice.

13.5 Rights of States for Group Health Plans where Participants are Eligible for Medical Benefits.

(a) *Compliance by Plans with Assignment of Rights.*

A Group Health Program offered under the Group Health Benefit that provides health benefits will comply with any assignment of rights made by or on behalf of such Participant or a Beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(l)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

(b) *Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility.*

In determining or making any payments for benefits of an individual as a Participant or Beneficiary, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

(c) *Acquisition by States of Rights of Third Parties.*

If payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act offered under the Group Health Benefit in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Group Health Benefit will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services; provided, however that in no event will such a state law be applied to the extent it attempts to create rights for the state plan which are greater than those of the Participant under the Group Health Benefit, specifically including any state law which provides that a state plan can make a claim for benefits or recover benefits beyond the period permitted under the Group Health Benefit.

13.6 Health Program Coverage of Dependent Children in Adoption Cases.

(a) *Coverage Effective Upon Placement For Adoption.*

Notwithstanding anything in the Group Health Program Documents to the contrary, if a Group Health Program offered under the Group Health Benefit provides health coverage for Dependent children of Participants or Beneficiaries, such Group Health Program will provide benefits to Dependent children Placed For Adoption with Participants or Beneficiaries under the same terms and conditions as apply in case of Dependent children who are natural children of Participants or Beneficiaries under the Group Health Benefit, irrespective of whether the adoption has become final.

(b) *Definitions.*

For purposes of this Section 13.6, the following definitions apply:

(i) Child means, in connection with any adoption or Placement For Adoption of

the Child, an individual who has not attained age eighteen (18) as of the date of such adoption or Placement For Adoption.

(ii) Placement, Placement For Adoption, or being Placed For Adoption, in connection with any Placement For Adoption of a Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child's Placement with such person terminates upon the termination of such legal obligation.

13.7 Continued Coverage of Pediatric Vaccine under Group Health Plans.

A Group Health Program offered under the Group Health Benefit that is a health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under Section 1928(h)(6) of the Social Security Act as amended by Section 13830 of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

13.8 Certificate of Coverage.

(a) *Content.*

The Plan Administrator has contracted with a third-party administrator to administer certificates of Plan coverage (each a "**Certificate**") on its behalf as the Plan's "**Certificate Administrator**". The Certificate Administrator will provide the Participant with a Certificate which contains the following information: (i) the date the Certificate is issued; (ii) the name of the Plan; (iii) the name of the Eligible Retiree and other Participant(s) with respect to whom the Certificate applies and the identification number, if any, of the Eligible Retiree and Participant(s) under the Group Health Benefit; (iv) the name, address and telephone number of the Certificate Administrator providing the Certificate; (v) a statement of the number of months of coverage under the Group Health Benefit that was not interrupted by a significant break in coverage, or the dates of any waiting period and the date coverage began; and (vi) the date coverage ended, unless coverage is continuing.

The Plan will make reasonable efforts to determine any information needed for a Certificate relating to Dependent coverage.

(b) *Timing.*

The Certificate will be provided to Participants by the Certificate Administrator free of charge upon request by or, on behalf of, the Participant, at any time while the Participant has coverage under the Group Health Benefit and within 24 months after coverage under the Group Health Benefit ceases (the Certificate will be provided by the earliest date that the Plan, acting in a reasonable and prompt fashion, can provide the Certificate.

(c) *Procedures for Requesting Certificate of Creditable Coverage.*

The Plan will provide a Certificate to each individual who requests one, provided that the Certificate is requested while the individual is a Participant under the Group Health Benefit

or within 24 months after the individual's coverage under the Group Health Benefit ends. The request for a Certificate can also be made by another person or entity on behalf of such individual.

The individual may receive a Certificate upon request as provided in this subsection (c) even if the Plan has previously issued a Certificate to the individual.

The third-party administrator which is designated as the Certificate Administrator under the Group Health Benefit is listed in Appendix C. A request for a Certificate must be directed to the Certificate Administrator at the addresses and/or telephone numbers listed in Appendix C. Telephone requests will be accepted only if the Certificate is to be mailed to the last known address that the Group Health Benefit has on file for the individual to whom the request relates. All other requests must be submitted to the Certificate Administrator in writing.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- The last date that the individual was covered under the Group Health Benefit;
- The name of the Participant who enrolled the individual in the Group Health Benefit (if the individual is not the Participant); and
- A telephone number where the individual for whom the Certificate is being requested can be reached, in the event of any difficulties.

Requests that are required to be made in writing must also include:

- The name of the person making the request and evidence, acceptable to the Plan Administrator, of that person's authority to request and receive the Certificate on behalf of the individual (if the individual is not the requestor);
- The address to which the Certificate should be mailed; and
- The signature of the requestor.

Once the Certificate Administrator receives a request that meets the foregoing requirements, the Plan will act in a reasonable and prompt manner to provide the Certificate.

13.9 Newborns' and Mothers' Health Protection Act.

The Group Health Benefit will comply with the Newborns' and Mothers' Health Protection Act ("**NMHPA**") with respect to health benefits provided under a Group Health Program, except to the extent that such health benefits are "excepted benefits" or are otherwise not subject to the NMHPA provisions in Part 7 of ERISA. Under NMHPA, the Group Health Benefit and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section delivery. However, the Group Health Benefit or the issuer may pay for a shorter stay if the

attending provider, after consultation with the mother, discharges the mother or newborn earlier. The Group Health Benefit and the insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. The Group Health Benefit and the insurers may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours, as applicable.

13.10 Genetic Information Nondiscrimination Act.

The Group Health Benefit will comply with the Genetic Information Nondiscrimination Act of 2008 as provided in Section 702 of ERISA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

13.11 Other Laws.

The Group Health Benefit shall be construed to comply with ERISA and will comply with all other laws applicable to a Group Health Program to the extent not preempted by ERISA or other controlling federal law. Such laws will include, but not be limited to the Americans with Disabilities Act ("**ADA**"), the Pregnancy Discrimination Act ("**PDA**") and the Small Business Job Protection Act ("**SBJPA**").

13.12 Governing Law; Jurisdiction.

Except as otherwise required for a Fully-Insured Program, all matters or issues relating to the interpretation, construction, validity, and enforcement of the Plan with respect to the Group Health Benefit shall be governed by the laws of the State of Texas, without giving effect to any choice-of-law principle that would cause the application of the laws of any jurisdiction other than Texas, except to the extent such laws are preempted by ERISA or other controlling federal law. As the Group Health Benefit is administered in Montgomery County, Texas, mandatory venue for any claim, legal suit, action or other proceeding arising out of, or relating to, the Group Health Benefit, other than an interpleader action under the Group Health Benefit that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof, shall be the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in either Montgomery County, Texas, or Harris County, Texas, subject to removal of any such action under ERISA (under 28 U.S.C. §§ 1441 et seq. or any successor provision). Venue for an interpleader action under the Group Health Benefit that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof shall be, as decided by the Benefits Committee in its discretion, in (a) the state where the deceased Participant resided at his death (if the benefits which are the subject of the interpleader action are those of a deceased Participant), (b) the state in which at least one defendant in the interpleader action resides, or (c) the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in Montgomery County, Texas.

Each Participant, as the result of, and in consideration for, participation in the Group Health Benefit, and his designated representative, with respect to any claim or dispute relating in any way to, or arising out of, the Group Health Benefit, consents and agrees to such jurisdiction and venue as

described in this Section 13.12 and waives any objection to such jurisdiction or venue including, without limitation, that it is inconvenient. Such parties shall not commence any legal action other than before the above-named courts. Notwithstanding the previous sentence, a party may commence any legal action in a court other than the above-named courts solely for the purpose of enforcing an order or judgment issued by one of the above-named courts.

ARTICLE XIV
IMPORTANT ERISA INFORMATION

Name of Plan: Anadarko Petroleum Corporation Retiree Health Benefits Plan

Plan Sponsor's Name, Address and Telephone Number: Anadarko Petroleum Corporation, c/o Benefits Department – Human Resources, Attn: Director, Global Benefits, 1201 Lake Robbins Drive, The Woodlands, Texas 77380; (832) 636-1000.

Plan Administrator's Name, Address and Telephone Number: Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee, Attn: Director, Global Benefits, 1201 Lake Robbins Drive, The Woodlands, Texas 77380; (832) 636-1000.

Employer Identification Number: 76-0146568.

Plan Number: 504.

Type of Plan: The Plan is an "employee welfare benefit plan" subject to ERISA which provides, as the Group Health Benefit thereunder, (1) self-funded medical benefits, (2) self-funded prescription drug benefits, (3) fully-insured prescription drug benefits, and (4) self-funded dental benefits.

Type of Administration: The Group Health Benefit is administered by the Plan Administrator, with benefits being provided in accordance with the terms, limits and conditions of the Plan that are applicable to the Group Health Benefit. The Plan Administrator has engaged the Claims Administrator(s), as set forth in Appendix C, to determine eligibility for benefits, process claims and perform other administrative duties under the Group Health Benefit.

Agent for Service of Legal Process: Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee, Anadarko Petroleum Corporation Retiree Health Benefits Plan, Anadarko Petroleum Corporation, c/o CT Corporation System, 350 N. St. Paul Street, Dallas, TX 75201.

Disclosure Administrator: Director, Global Benefits, Human Resources Department, Anadarko Petroleum Corporation, 1201 Lake Robbins Drive, The Woodlands, Texas 77380.

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month period beginning each January 1st and ending on December 31st.

Sources of Contributions: The adopting Employers and Participants pay the costs for coverage. The Plan Sponsor determines the portion of costs to be paid by the adopting Employers and the Participants.

ARTICLE XV
STATEMENT OF ERISA RIGHTS

As a Participant in the Group Health Benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description, upon written request to the Disclosure Administrator (as designated in Article X). The Disclosure Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

- Continue healthcare coverage for yourself , Spouse or Dependents if there is a loss of coverage under the Group Health Benefit as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review the Group Health SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate the Group Health Benefit, called "fiduciaries" of the Group Health Benefit, have a duty to do so prudently and in the interest of Plan Participants and Beneficiaries.

No one, including the Employer, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If a claim for a benefit is denied or ignored, in whole or in part, you have a right to know

why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the Claims Procedures described in the Group Health SPD. If your appeal is denied in accordance with the Claims Procedures herein, and you have exhausted the administrative remedies provided to you under the Group Health Benefit, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or 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 who was sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan or the Group Health Benefit in particular, you should contact the Plan Administrator at (832) 636-1000 and ask for the HR-Benefits Department.

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 the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX A

As of January 1, 2018, the only Employer which has adopted and is participating in the Group Health Benefit is the Plan Sponsor.

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX B

The terms and conditions of the following Group Health Programs which apply to retiree health coverage are incorporated, in their entirety, by reference into this SPD:

1. Pre-65 Group Health Programs. Available only to Participants who have not yet attained Medicare Eligibility Due to Age:

   - UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program;
   - UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program;
   - UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program; and
   - UnitedHealthcare Dental Benefits Program (*Grandfathered Dental Dependents, as defined in Section 2(b) of Appendix F, only*).

2. Post-65 Group Health Programs. Available only to Participants who have attained Medicare Eligibility Due to Age:

   - UnitedHealthcare Dental Benefits Program; and
   - UnitedHealthcare Medicare Prescription Drug Program.

Retiree health coverage under the UnitedHealthcare POS Choice Plus Plan Medical Benefits Program, the UnitedHealthcare PPO Options (Utah) Plan Medical Benefits Program, and the UnitedHealthcare Out of Area Options Plan Medical Benefits Program terminated on December 31, 2015.

NOTICE: This Appendix has been updated by the Second Summary of Material Modification (SMM). Please see the Second SMM for more information.

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX C

As of January 1, 2018, the following third party entities serve as Claims Administrators and Claims Fiduciaries under the Group Health Benefit with respect to the following Group Health Programs:

Group Health Program	Claims Administrator / Claims Fiduciary
• UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program; • UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program; and • UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program.	UnitedHealthcare – Claims P.O. Box 740800 Atlanta, GA 30374-0800 1-888-512-4093 www.myuhc.com
• UnitedHealthcare Dental Benefits Program	UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567 1-888-512-4093 www.myuhc.com (select dental link)
• UnitedHealthcare Medicare Prescription Drug Program	***Eligibility and Benefits Verification***: UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675 1-888-556-6648 www.uhcmedicarerxforgroups.com ***Payment of Claims***: OptumRx P.O. Box 29046 Hot Springs, AR 71903

As of January 1, 2018, the following third party entities serve in the following positions under the Group Health Benefit:

Eligibility Administrator/ Certificate Administrator	**COBRA Administrator**
Towers Watson Anadarko Benefits Center 500 Akard Street, Suite 4100 Dallas, TX 75201 1-866-472-4711	Towers Watson - BenefitConnect | COBRA Services P.O. Box 919051 San Diego, CA 92191-9863 (877) 29-COBRA (26272)

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX D

As of January 1, 2018, the following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information subject to HIPAA from the Group Health Benefit:

Employee/Position	Categories of PHI under the Plan to which Access is Needed and Conditions on Access
Human Resources Manager, Global Benefits	PHI as needed to perform duties as Privacy Official and Complaint Official
All active employees of the Anadarko Benefits Department of Human Resources ("**Benefits Department**")	PHI as needed to perform administration of the Plan and assist Plan participants with questions
Systems Department employees who are responsible for maintenance of systems that may contain electronic PHI	PHI as needed to maintain and administer systems that may contain electronic PHI
Legal Department Counsel assigned to support the Benefits Department	PHI as needed to advise and counsel on any claims or other Plan administrative issues that might arise relating to PHI
Paralegals and administrative staff supporting Legal Department Counsel (above)	
Executive Vice President responsible for Human Resources	PHI as needed to perform executive functions associated with oversight of the Benefits Department and sponsorship of the Plan
Vice President, Human Resources	
Director, Global Total Rewards	
Director, Strategy, Talent Acquisition and Corporate Services	PHI as need to assist Benefits Department with claims and administrative matters under the Plan

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX E

Copies of each Group Health Program's Medicare Part D Notice of Creditable (or Non-Creditable) Coverage can be found in its respective Group Health Program Document(s) and are incorporated herein.

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX F

As of January 1, 2018, this Appendix sets forth certain terms and conditions of eligibility and participation in the Group Health Benefit. Terms and conditions of eligibility specified in the Group Health Program Documents that are not contrary to, or inconsistent with, the terms and conditions in this Appendix shall also apply.

The terms and conditions of this Appendix shall supersede any conflicting or inconsistent term or condition of a Group Health Program, and shall govern and control. However, if such conflict or inconsistency involves a term or condition required by ERISA, the Code or other controlling law, on the one hand, and a term or condition not so required on the other, the term or condition required by controlling law shall control. Further, the following terms and conditions shall be subject to all other provisions of this document (without regard to any Group Health Program Document incorporated herein) that govern eligibility for participation in the Group Health Benefit.

Section and subsection references in this Appendix shall mean the respective section or subsection of this Appendix unless stated otherwise.

1. New Eligibility and Post-65 New Participation Frozen

(a) Initial Freeze

Effective as of January 1, 2016, (i) all eligibility under the Group Health Benefit (*i.e.*, the Pre-65 Group Health Programs and the Post-65 Group Health Programs) and (ii) all participation in the Post-65 Group Health Programs was frozen on December 31, 2015, notwithstanding anything in this Wrap-SPD, the Wrap-Plan or any Group Health Program Document to the contrary.

Consequently, effective as of January 1, 2016, no Retiree, Former Employee, Dependent or any other individual could (A) become newly eligible to participate in the Group Health Benefit (*i.e.*, in either the Pre-65 Group Health Programs or the Post-65 Group Health Programs) or (B) enroll as a new Participant in a Post-65 Group Health Program on or after January 1, 2016.

(b) Elimination of Freeze in Eligibility for Pre-65 Group Health Program Coverage

Effective as of January 1, 2017, this subsection supersedes subsection (a), above, with respect to eligibility to participate in the Pre-65 Group Health Programs.

Effective as of January 1, 2017, the freeze in new eligibility under the Pre-65 Group Health Programs has been lifted. Consequently, effective as of January 1, 2017, Retirees, Former Employees, and Dependents may become newly eligible to participate in a Pre-65 Group Health Program on or after January 1, 2017 as provided herein.

2. Frozen Retiree and Former Employee Eligibility

***Post-65 Group Health Programs*:** The provisions of this Section 2 are applicable to Post-65 Group Health Program coverage only with respect to Retirees and Former Employees whose Retirement Dates or death occurred prior to January 1, 2016. In addition to the requirements for eligibility set forth in subsections (a) through (f), below, only individuals who, on December 31, 2015, had attained Medicare Eligibility Due to Age and were eligible to participate in the Plan may continue to be eligible to participate in the Post-65 Group Health Programs on or after January 1, 2016.

***Pre-65 Group Health Programs*:**

- Effective as of January 1, 2016 and ending on December 31, 2016, the provisions of this Section 2 are applicable to Pre-65 Group Health Program coverage only with respect to Retirees and Former Employees whose Retirement Dates or death occurred prior to January 1, 2016. In addition to the requirements for eligibility set forth in subsections (a) through (f), below, only individuals who, on December 31, 2015, are eligible to participate in a Pre-65 Group Health Program, and, as of January 1, 2016, have not attained Medicare Eligibility Due to Age may continue to be eligible to participate in the Pre-65 Group Health Programs on or after January 1, 2016.

- Effective as of January 1, 2017, the provisions of this Section 2 are applicable to Pre-65 Group Health Program coverage with respect to Retirees and Former Employees whose Retirement Dates or death occurred on or after January 1, 2016.

(a) Retiree and Former Employee Eligibility

Retiree and Former Employee eligibility is dependent on several factors, including the Retiree's or Former Employee's age, Years of Service, and, with respect to a Retiree, the retiree group to which he belongs. A Former Employee may also be eligible for certain benefits based on the rules of the applicable severance plan under which the Former Employee may have been terminated.

In order to be eligible to participate in the Group Health Benefit, as of the date immediately preceding the Retiree's or Former Employee's Retirement Date, the Retiree or Former Employee must have been enrolled as an active Employee in either (i) the Anadarko Petroleum Corporation Health Benefits Plan (for purposes of this Appendix, "**APC Active Plan**")(or its predecessor plan maintained by the Plan Sponsor) or (ii) a major medical, group health plan sponsored by another company on the date of such company's acquisition by an Employer.

In addition, a Retiree must be eligible to participate in the Group Health Benefit in accordance with the requirements established for the Retiree's retiree group, as listed in the tables below. A Retiree will be considered to be a member of a "legacy" retiree group in accordance with the following:

(i) if the Retiree retired on or before December 31, 2006, the Retiree is a member of the legacy retiree group for the company from which the Retiree retired;

(ii) if the Retiree retired after December 31, 2006, the Retiree is a member of the legacy retiree group for:

(A) the company that issued his 2006 Form W-2 and that included the Retiree on its payroll as of December 31, 2006; or

(B) if the Retiree was hired on or after January 1, 2007, Anadarko Petroleum Corporation (for purposes of this Appendix, "**APC**").

A Retiree will be considered to be a member of a "grandfathered" retiree group if (a) he was employed by his legacy retiree group on December 31, 2006, and (b) on December 31, 2007 (i) he was employed by APC, and (ii) his age and Years of Service totaled at least 45.

If an Employee in the Legacy Anadarko Petroleum Corporation Retiree Group terminated employment with the Employer after the age of 45 and then was rehired by the Employer, the Employee's pre-termination service that counts for purposes of determining Years of Service upon retirement (for purposes of determining eligibility for medical and dental benefits) will be the total of his Years of Service after attainment of age 45 until his first termination of employment plus his Years of Service from his date of rehire through his subsequent termination of employment.

A Former Employee and the Former Employee's Dependents (as defined by the Plan with respect to the Group Health Benefit, unless otherwise specified in the separate agreement) may also be eligible for coverage under the Group Health Benefit in accordance with the terms and conditions of a separate written agreement between the Former Employee and the Employer to the extent provided by such separate agreement.

(b) Retirements On or Before December 31, 2007

The table that follows below outlines the general eligibility rules for a Retiree who retired on or before December 31, 2007.

Notwithstanding any references in this subsection (b) to "subsidized" coverage, as applicable to Retirees, Eligible Retirees or Dependents who have not yet attained Medicare Eligibility Due to Age, effective as of January 1, 2016, the cost of coverage under the Pre-65 Group Health Programs will not be subsidized by the Plan Sponsor or any other Employer, and all such references to "subsidized" (or a similar term) shall be interpreted to mean "unsubsidized" when applied to such persons, except that a Dependent who, on December 31, 2015, was enrolled in subsidized dental coverage under the Plan through an Eligible Retiree who had attained Medicare Eligibility Due to Age (a "**Grandfathered Dental Dependent**") shall continue to receive dental coverage under the Group Health Benefit on a subsidized basis on and after January 1, 2016, whether or not such Dependent has attained Medicare Eligibility Due to Age, provided that such Eligible Retiree, prior to his death, also maintains dental coverage under a Post-65 Group Health Program. Such dental coverage for Grandfathered Dental Dependents shall terminate in accordance with Section 5(b) or Section 5(c) of this Appendix, as applicable.

Except as provided above with respect to Grandfathered Dental Dependents, effective as of January 1, 2016, dental coverage will not be provided under the Group Health Benefit as a Pre-65 Group Health Program, but only as a Post-65 Group Health Program (see also Appendix B).

Retiree Group	Pre-65 Medical	Post-65 Medical	Dental
Legacy Anadarko Petroleum Corporation Retiree Group	Subsidized medical if retired at age 55 or later with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted). Access to unsubsidized medical up to age 65 if retired at age 55 with at least 5 Years of Service (following a break in service, only Years of Service after age 45 are counted).	Part D coverage paid by the Plan Sponsor if retired at age 55 or later with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted).	Subsidized dental provided if retired at age 55 or later with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted). Access to unsubsidized dental if retired at age 55 or later with at least 5 Years of Service (following a break in service, only Years of Service after age 45 are counted).
Legacy Union Pacific Resources Group, Inc. Retiree Group	Subsidized medical if retired at age 55 or later with at least 10 Years of Service.	Part D coverage paid by the Plan Sponsor if retired at age 55 or later with at least 10 Years of Service.	Subsidized dental coverage provided until age 65, if retired at age 55 or later with at least 10 Years of Service.
Legacy Kerr-McGee Corporation Retiree Group	Subsidized medical if retired at age 52 or later with at least 10 Years of Service (or age 55 or later with at least 10 Years of Service prior to May 1, 1999). Collective bargaining unit employees were not eligible.	Part D coverage paid by the Plan Sponsor if retired at age 52 or later with at least 10 Years of Service. Collective bargaining unit employees were not eligible.	No benefit.
Legacy Oryx Energy Company Retiree Group	Subsidized medical if retired at age 52 with at least 10 years of vested service credit in the Oryx Energy Company Retirement Plan or age 55 with at least 10 years of vested service prior	Part D coverage paid by the Plan Sponsor if retired at age 52 with at least 10 years of vested service credit in the Oryx Energy Company Retirement	No benefit.

Retiree Group	Pre-65 Medical	Post-65 Medical	Dental
	to January 1, 1995 (an employee earned a vested service credit if he or she completed at least 1,000 hours of service during each 12-month period beginning on the first day of work and each anniversary); or if retired at age 65, regardless of Years of Service, and eligible for an immediate retirement benefit under the Oryx Energy Company Retirement Plan.	Plan (an employee earned a vested service credit if he or she completed at least 1,000 hours of service during each 12-month period beginning on the first day of work and each anniversary); or if retired at age 65, regardless of Years of Service, and eligible for an immediate retirement benefit under the Oryx Energy Company Retirement Plan.	
Legacy Western Gas Resources, Inc. Retiree Group	No benefit.	No benefit.	No benefit.

(c) Retirements On or After January 1, 2008 (but for Post-65 Group Health Program Coverage, prior to January 1, 2016)

The table that follows below outlines the general eligibility rules for a Retiree who retired on or after January 1, 2008 (but for Post-65 Group Health Program Coverage, prior to January 1, 2016).

Notwithstanding any references in this subsection (c) to "subsidized" coverage, as applicable to Retirees, Eligible Retirees or Dependents who have not yet attained Medicare Eligibility Due to Age, effective as of January 1, 2016, the cost of coverage under the Pre-65 Group Health Programs will not be subsidized by the Plan Sponsor or any other Employer, and all such references to "subsidized" (or a similar term) shall be interpreted to mean "unsubsidized" when applied to such persons, except that a Grandfathered Dental Dependent (as defined in Section 2(b) of this Appendix) shall continue to receive dental coverage under the Group Health Benefit on a subsidized basis on and after January 1, 2016, whether or not such Dependent has attained Medicare Eligibility Due to Age, provided that the Eligible Retiree with respect to whom such Dependent has coverage also maintains dental coverage under a Post-65 Group Health Program prior to his death. Such dental coverage for Grandfathered Dental Dependents shall terminate in accordance with Section 5(b) or Section 5(c) of this Appendix, as applicable.

Except as provided above with respect to Grandfathered Dental Dependents, effective as of January 1, 2016, dental coverage will not be provided under the Group Health Benefit as a Pre-65 Group Health Program, but only as a Post-65 Group Health Program (see also Appendix B).

Retiree Group	Pre-65 Medical	Post-65 Medical	Dental
Grandfathered Legacy Anadarko Retiree Group	Subsidized medical if retired at age 55 or later with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted). Access to unsubsidized medical up to age 65 if retired at age 55 or later with at least 5 Years of Service (following a break in service, only Years of Service after age 45 are counted).	Part D coverage paid by the Plan Sponsor if retired at age 55 or later with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted).	Subsidized dental if retired at age 55 or later with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted). Access to unsubsidized dental up to age 65 if retired at age 55 or later with at least 5 Years of Service (following a break in service, only Years of Service after age 45 are counted).
Grandfathered Legacy Kerr-McGee Corporation Retiree Group	Subsidized medical if retired at age 52 or later with at least 10 Years of Service.	Part D coverage paid by the Plan Sponsor if retirement at age 52 or later with at least 10 Years of Service.	No benefit.
Other Legacy Kerr-McGee Corporation Retiree Group	Access to unsubsidized medical up to age 65 if retired at age 52 with at least 10 Years of Service.	No benefit.	No benefit.

Retiree Group	Pre-65 Medical	Post-65 Medical	Dental
Grandfathered Legacy Western Gas Resources, Inc. Retiree Group	Subsidized medical if retired at age 55 or later with at least 10 Years of Service with the Plan Sponsor (previous service with WGR does not count toward this total, and, following a break in service, only Years of Service after age 45 are counted). Access to unsubsidized medical up to age 65 if retired at age 55 or later with at least 5 Years of Service with the Plan Sponsor (following a break in service, only Years of Service after age 45 are counted).	Part D coverage paid by the Plan Sponsor if retired at age 55 or later with at least 10 Years of Service with the Plan Sponsor (following a break in service, only Years of Service after age 45 are counted).	No benefit.
All others	Access to unsubsidized medical up to age 65 if retirement at age 55 with at least 5 years of service (following a break in service, only Years of Service after age 45 are counted).	No benefit.	No benefit.

(d) Severance Eligibility

(i) General.

In addition to the eligibility rules provided in Sections 2(b) and 2(c) of this Appendix, above, a Former Employee may be eligible to participate in the Group Health Benefit in accordance with this subsection (d).

Notwithstanding any references in this subsection (d) to "subsidized" coverage, as applicable to Retirees, Eligible Retirees or Dependents who have not yet attained Medicare Eligibility Due to Age, effective as of January 1, 2016, the cost of coverage under the Pre-65 Group Health Programs will not be subsidized by the Plan Sponsor or any other Employer, and all such references to "subsidized" (or a similar term) shall be interpreted to mean "unsubsidized" when applied to such persons, except that a Grandfathered Dental Dependent (as defined in Section 2(b) of this Appendix) shall continue to receive dental coverage under the Group Health Benefit on a subsidized basis on and after January 1, 2016, whether or not such Dependent has attained Medicare Eligibility Due to Age, provided that the Eligible Retiree with respect to whom such Dependent has coverage also maintains dental coverage under a Post-65 Group Health Program prior to his death. Such dental coverage for Grandfathered Dental Dependents shall terminate in accordance with Section 5(b) or Section 5(c) of this Appendix, as applicable.

Except as provided above with respect to Grandfathered Dental Dependents, effective as of January 1, 2016, dental coverage will not be provided under the Group Health Benefit as a Pre-65 Group Health Program, but only as a Post-65 Group Health Program (see also Appendix B).

(ii) General Anadarko Petroleum Corporation Severance Guidelines

Any Former Employee in one of the following categories who terminated employment with APC on or after February 1, 2003 and on or before December 31, 2007 is eligible to participate in the Group Health Benefit (1) at unsubsidized rates before age 55, and (2) at subsidized rates beginning the first day of the month following the Former Employee's attainment of age 55, provided that in each case he has attained the age of 50 and completed 15 or more Years of Service with APC at the time of termination of employment:

(A) any Former Employee whose employment was involuntarily terminated by the Employer without "cause" as defined below and as determined by the Plan Sponsor in its sole discretion;

(B) any Former Employee whose employment was terminated by the Employer in connection with a limited program of reductions in force as declared by the Plan Sponsor in its sole discretion; or

(C) any Former Employee whose employment was terminated by reason of a shutdown or closing of a facility or significant operation as determined by the Plan Sponsor in its sole discretion.

For purposes of the foregoing, a Former Employee's employment with the Employer shall be deemed terminated for "cause" if such termination is by reason of any of the following: (A) conviction of any felony or of a misdemeanor involving moral turpitude, (B) willful failure to perform his duties and responsibilities, (C) engagement in conduct which is materially injurious to the Employer, (D) engagement in business activities which are materially in conflict with the business interests of the Employer, (E) insubordination, (F) engagement in conduct which is in violation of the Employer's safety rules or standards or which otherwise causes injury to another Employee or any other person, or (G) engagement in conduct which is in violation of any policy or work rule of the Employer or which is otherwise inappropriate in the office or work environment.

A Former Employee whose employment ended on or after January 1, 2008 (but for Post-65 Group Health Program Coverage, prior to January 1, 2016) is eligible to participate in the Group Health Benefit (1) at unsubsidized rates before age 55, and (2) at subsidized rates beginning the first day of the month following the Former Employee's attainment of age 55, provided the Former Employee (A) is in the Legacy Anadarko Petroleum Corporation Retiree Group, (B) had attained the age of 50 and completed 15 or more Years of Service with the Plan Sponsor at the time of termination of employment, and (C) was employed by APC and the total of his age and Years of Service equaled at least 45 on December 31, 2007, and provided one of the following situations occurred:

(X) the Former Employee's employment was involuntarily terminated by the Employer without "cause" as defined below and as determined by the Plan Sponsor in its sole discretion,

(Y) the Former Employee's employment was terminated by the Employer in connection with a limited program of reductions in force as declared by the Plan Sponsor in its sole discretion, or

(Z) the Former Employee's employment was terminated by reason of a shutdown or closing of a facility or significant operation as determined by the Plan Sponsor in its sole discretion.

For purposes of the foregoing, a Former Employee's employment with the Employer shall be deemed terminated for "cause" if such termination is by reason of any of the following: (A) conviction of any felony or of a misdemeanor involving moral turpitude, (B) willful failure to perform his duties and responsibilities, (C) engagement in conduct which is materially injurious to the Employer, (D) engagement in business activities which are materially in conflict with the business interests of the Employer, (E) insubordination, (F) engagement in conduct which is in violation of the Employer's safety rules or standards or which otherwise causes injury to another Employee or any other person, or (G) engagement in conduct which is in violation of any policy or work rule of the Employer or which is otherwise inappropriate in the office or work environment.

In addition to the eligibility rules noted in the preceding section, certain groups received enhanced eligibility provisions based upon the terms of their applicable severance program prior to December 31, 2007. The following Sections 2(d)(iii) through (v) describe the enhanced eligibility provisions for certain severed groups, but is not a comprehensive description of all groups who received these eligibility provisions.

(iii) Anadarko Petroleum Corporation Employees Severed Between July 31, 2003 and December 31, 2003

If the employment of a full-time regular Employee (scheduled to work a minimum of 30 hours per week) was terminated by the Employer and (A) such termination was designated by the Plan Sponsor, in its sole discretion, as being part of a "reduction in force program", (B) the Employee's designated termination date occurred on or after July 31, 2003 and on or before December 31, 2003, and (C) as of the designated termination date, the Employee had both attained the age of 55 and completed 5 or more Years of Service with the Employer, such Employee will qualify as an Eligible Retiree such that he and his eligible Dependents will be eligible for coverage under the Group Health Benefit at the Employer subsidized rates for Eligible Retirees.

(iv) Anadarko Petroleum Corporation Employees Severed Between August 1, 2004 and July 31, 2005

If (A) the employment of an Employee was terminated by the Employer as a result

of or in connection with a "Qualified Divestiture" (as such term is defined below) or as a result of job abolishment as determined by the Employer, (B) the Employee's designated employment termination date occurred on or after August 1, 2004 and on or before July 31, 2005, and (C) as of the designated employment termination date, or within 12 months of such termination date, the Employee had or would have both attained the age of 50 and completed 15 or more Years of Service with the Employer, or within 12 months would have both attained the age of 55 and completed 10 or more Years of Service with the Employer, or the Employee's name is Sara L. McGrew, such Employee will qualify as an Eligible Retiree such that he and his Dependents will be eligible for Plan coverage (1) at unsubsidized rates before age 55, and (2) at subsidized rates beginning the first day of the month following the Eligible Retiree's attainment of age 55.

For purposes of the foregoing, the term "Qualified Divestiture" means a corporate sale transaction that closed prior to July 31, 2005 and was any of (A) a sale of any combination of assets of the Plan Sponsor if such combination of assets constitutes 10% or more of the Plan Sponsor's then value, (B) a sale of 90% or more of the assets of a subsidiary or affiliate of the Plan Sponsor, (C) a sale of all of the stock of a subsidiary or affiliate of the Plan Sponsor, or (D) any combination of the foregoing.

(v) Anadarko Petroleum Corporation Employees Severed Between August 10, 2006 and August 31, 2007

If (A) an Employee was involuntarily terminated by the Employer as a result of or in connection with (1) the Employer's reorganization resulting from the acquisitions of Kerr McGee Corporation and Western Gas Resources, or (2) a sale of Company assets, (B) such Employee was employed by APC prior to such reorganization or sale, (C) the Employee was terminated from employment on or after August 10, 2006 and on or before August 31, 2007, and (D) as of his Retirement Date, (1) the Employee had attained the age of 45 and completed 10 Years of Service with the Employer, and (2) the total of the Employee's age and his Years of Service equals at least 65, such Former Employee will be eligible to participate in the Group Health Benefit as an Eligible Retiree (1) at unsubsidized rates before age 55, and (2) at subsidized rates beginning the first day of the month following the Eligible Retiree's attainment of age 55.

Coverage under the Group Health Benefit in accordance with Sections 2(d)(iv) and (v) of this Appendix followed the six-month severance benefit coverage provided under the Anadarko Petroleum Corporation Severance Plan.

(vi) General Kerr-McGee Corporation Severance Guidelines

A Former Employee who (A) retired on or after May 1, 1999 and on or before December 31, 2007, (B) is in the Legacy Kerr-McGee Corporation Retiree Group, (C) on his Retirement Date had attained age 50, or age 49 and received special credits to reach age 50, and had at least 8 years of vesting service or received special credits to reach 8 years of vesting service, and (D) was terminated under the terms of a severance plan sponsored by the Employer, is eligible as an Eligible Retiree for subsidized retiree medical plan benefits only.

A Former Employee who (A) retired on or after January 1, 2008 (but for Post-65 Group Health Program Coverage, prior to January 1, 2016) from employment with APC, (B) is in the Legacy Kerr-McGee Corporation Retiree Group, (C) on his Retirement Date had attained age 50, or age 49 and received special credits to reach age 50, and had at least 8 years of vesting service or received special credits to reach 8 years of vesting service, (D) was terminated under the terms of a severance plan sponsored by the Employer, and (E) had a total of age and Years of Service equal to at least 45 on December 31, 2007, is eligible as an Eligible Retiree for subsidized retiree medical plan benefits only. A Former Employee who satisfies (A), (B), (C), and (D), but not (E) is eligible for unsubsidized retiree medical plan benefits only.

(vii) Western Gas Resources, Inc. Employees Severed Between August 31, 2015 and December 31, 2015

This subsection (vii) is effective as of August 31, 2015.

If the Employer involuntarily terminates the employment of an Employee who is a member of the Western Gas Resources, Inc. "legacy" retiree group (as determined under Section 2(a) of this Appendix) as a result of a divestiture of corporate assets by the Plan Sponsor (including, but not limited to, the Coal-Bed Methane (CBM) Divestiture) during the time period commencing on August 31, 2015, and ending at the end of the day on December 31, 2015 ("**WGR Severance**"), then if:

(A) such Employee was employed by Western Gas Resources, Inc. on December 31, 2006;

(B) on December 31, 2007, he was employed by Anadarko Petroleum Corporation and the total of his age and Years of Service equaled at least forty-five (45); and

(C) as of August 23, 2016, the Employee would attain at least age fifty-five (55) and would have otherwise accrued at least 10 Years of Service with the Plan Sponsor (where, for such purpose, the Employee is deemed to incur no break in employment service between the date of his WGR Severance and August, 23, 2016);

then such Employee shall be eligible to participate in the Group Health Benefit at subsidized rates established by the Plan Sponsor beginning the first day of the month next following the date of his WGR Severance.

(e) Service Credit and Benefits Accrual from Acquired Companies

(i) Anadarko Petroleum Corporation

In general, if a company acquired by APC or other Employer offered retiree medical and/or dental benefits, then a Retiree's or Former Employee's Years of Service with the

acquired company (as determined by APC) are treated as Years of Service with APC for purposes of determining eligibility for coverage under the Group Health Benefit in accordance with Section 2 of this Appendix. Accordingly, Years of Service with the following acquired companies are treated as Years of Service with APC for purposes of determining eligibility under Section 2:

(A) UPR;

(B) Norcen Energy Resources Ltd. ("**Norcen**") (which was acquired by UPR in 1998); and

(C) Occidental Petroleum Corporation ("**OXY**"), with respect to those employees who were acquired with the March 1998 sale to APC of certain Oklahoma properties owned by OXY.

(D) Employees who were acquired with the sale to APC of the Table Rock Gas Plant (acquired from Colorado Interstate Gas Company on April 7, 2003).

However, Years of Service with Howell Corporation and WGR are **not** treated as Years of Service with APC and do not count when determining eligibility for coverage under the Group Health Benefit.

Former UPR employees who retire from APC after the date UPR was acquired by APC are considered retirees of APC and must satisfy the eligibility requirements set forth in Section 2 of this Appendix. For purposes of satisfying such eligibility requirements, Years of Service with UPR and Norcen (as determined by APC) are treated as Years of Service with APC.

(ii) Kerr-McGee Corporation

In general, a Retiree's or Former Employee's Years of Service with a company acquired by Kerr-McGee Corporation ("**KMG**") (as determined by APC) are treated as Years of Service with KMG for purposes of determining eligibility for coverage under the Group Health Benefit in accordance with Section 2 of this Appendix.

Former Oryx Energy Company ("**Oryx**") employees who retire from KMG (or subsequently APC) after the date Oryx was acquired by KMG are considered part of the Legacy Kerr McGee Corporation Retiree Group or Grandfathered Legacy Kerr McGee Corporation Retiree Group, as applicable, and must satisfy the eligibility requirements set forth in Section 2 of this Appendix for such groups. For purposes of satisfying such eligibility requirements, Years of Service with Oryx (as determined by APC) are treated as Years of Service with KMG.

(iii) General Application of Prior Benefits Accrual.

If a company acquired by APC or other Employer offered a retiree medical and/or dental benefits plan, then the Plan Sponsor may, in its discretion and as permitted by applicable law, apply benefits accrued by a Retiree or Former Employee and each of his

eligible Dependents (or certain non-discriminatory classes of such individuals) under such plan(s) toward each such individual's coverage (*e.g.*, deductibles and other cost-sharing requirements) under the corresponding Group Health Programs of the Group Health Benefit. The provisions of this Section 2(e)(iii) will not apply to a Fully-Insured Program to the extent not permitted by the terms of such Fully-Insured Program.

(f) Dependent Eligibility

An individual is eligible for coverage under the Group Health Benefit as an Eligible Retiree's Dependent if such individual satisfies the following definition of "**Dependent**":

(i) An Eligible Retiree's Spouse;

(ii) An Eligible Retiree's Domestic Partner (defined below);

(iii) A Child of an Eligible Retiree or an Eligible Retiree's Spouse or Domestic Partner, but only through the end of the year of such Child's 26th birthday;

(iv) A Child of an Eligible Retiree or an Eligible Retiree's Spouse or Domestic Partner, beginning with the year of such Child's 27th birthday, but only if such Child is dependent on the Retiree or the Retiree's Spouse or Domestic Partner because of a mental or physical handicap rendering the Child medically incapacitated and unable to be self-supportive ("**Disabled**"). The Child must satisfy either of the following requirements: (A) prior to the end of the year of the Child's 26th birthday, the Child is Disabled and covered as a Dependent under the Group Health Benefit or (B) the Child is Disabled and over age 26 prior to the Child's parent first becoming eligible for coverage under the Group Health Benefit, either as a Retiree or as the Spouse or Domestic Partner of a Retiree, and the Retiree enrolls the Child in the Group Health Benefit when the Retiree first becomes eligible to enroll in such coverage (*i.e.*, such Disabled Child cannot later be added to coverage under the Group Health Benefit). In addition, the Child must reside with the Retiree in his household for more than one-half of the year, and the Child must not provide more than one-half of his own support for the year. Periodic proof of incapacity may be required by the Plan Administrator to continue coverage for the Child.

An individual who does not meet the definition of "Dependent", above, as of the Eligible Retiree's Retirement Date shall be ineligible to participate in the Group Health Benefit.

For purposes of determining eligibility for Dependent coverage, the term "Child" means a (i) biological child of a Retiree or Domestic Partner, (ii) legally adopted child or a child placed for adoption with the Retiree, Spouse or Domestic Partner, (iii) stepchild of a Retiree, or (iv) child for whom the Retiree, Spouse or Domestic Partner has a court appointed guardianship or conservatorship but only if such child primarily lives with the Retiree and is a member of the Retiree's household.

Any Child who does not meet one of the definitions in Sections 2(f)(iii) or (iv) of this Appendix (above) will be ineligible for coverage under the Group Health Benefit.

In addition, an individual who, prior to January 1, 2016, was (A) the surviving Spouse or

Domestic Partner of a deceased Employee who had accrued ten (10) or more Years of Service at the time of his death (as determined by the Plan Sponsor of the APC Active Plan) and (B) covered under the APC Active Plan as a surviving dependent of such deceased Employee on the date that such surviving dependent attained Medicare Eligibility Due to Age is eligible for coverage as a "**Surviving Dependent**" under the Group Health Benefit, but only with respect to the UnitedHealthcare Medicare Prescription Drug Program. If elected, Surviving Dependent coverage for such an individual shall terminate in accordance with Section 5(c) of this Appendix.

For purposes of Section 2(f)(ii) of this Appendix (above) in the definition of Dependent, the "**Domestic Partner**" of an Retiree means an individual who (A) is at least 18 years of age; (B) lives with the Retiree in a committed, monogamous relationship; (C) has lived in such relationship with the Retiree at the same place of residence for at least six (6) months; (D) is not legally married to the Retiree or legally married to, or in a domestic partnership with, any other person; and (E) is not related to the Retiree by blood or adoption; provided that both such individual and the Retiree intend for their relationship to be continuous and of an indefinite duration and that the Retiree is not married to, or in a domestic partnership with, any other person. The Plan Administrator may require the Retiree to provide evidence that is satisfactory to the Plan Administrator in order to verify that all the requirements set forth in this paragraph have been met. The Plan Administrator shall have the sole and absolute discretion to determine whether an individual is the Domestic Partner (as defined above) for all purposes of the Group Health Benefit, except as otherwise required under a Fully-Insured Program.

Notwithstanding the foregoing provisions of this Section, the Group Health Benefit shall treat any person as a Dependent who is required to be treated as a Dependent under the terms of any valid Qualified Medical Child Support Order only if the Retiree elects coverage under the Group Health Benefit for such person during one of the prescribed timeframes described in Section 3 of this Appendix (below), as applicable, in accordance with the Group Health Benefit's enrollment provisions.

If a Retiree does not elect coverage for an eligible Dependent during one of the prescribed timeframes described in Section 3 of this Appendix (below), as applicable, such Dependent shall never again be eligible for coverage under the Group Health Benefit.

Any Dependent who is a full-time member of the armed forces is not eligible for coverage except as may be required by the Uniformed Services Employment and Reemployment Rights Act ("**USERRA**").

An individual may not be covered as the Dependent of more than one Retiree, or covered as the Dependent of a Retiree and also covered under the APC Active Plan as a Dependent of an Employee. An individual who is eligible for coverage under the APC Active Plan as an Employee shall not be eligible for coverage as a Dependent under the Group Health Benefit. In addition, no individual may be covered twice under the Group Health Benefit. Only one of two married Retirees may cover a Child as an eligible Dependent.

At any time, the Plan Administrator may require acceptable proof that a Spouse, Domestic Partner or Child qualifies, or continues to qualify, as a Dependent under the Group Health Benefit. A Retiree will be required to reimburse the Group Health Benefit for benefits or reimbursements

provided to an individual as a Dependent with respect to any claim incurred by such individual at a time when he did not satisfy the Dependent eligibility requirements specified above. The Group Health Benefit may require a Retiree to make such reimbursement according to the provisions of Section 10.9 of this SPD.

Subject to Sections 2(b), (c), and (d)(1) of this Appendix, if a Retiree's coverage under a Pre-65 Group Health Program terminates because the Retiree attains Medicare Eligibility Due to Age, the Retiree's covered Dependent who has not yet attained Medicare Eligibility Due to Age will continue to be covered under the Pre-65 Group Health Program under the same terms until the Dependent attains Medicare Eligibility Due to Age or is no longer an eligible Dependent under the Group Health Benefit, whichever comes first. If the Retiree's Dependent attains Medicare Eligibility Due to Age prior to the Retiree attaining Medicare Eligibility Due to Age, the Dependent's coverage under the Pre-65 Group Health Program will terminate, and the Retiree will continue to be covered under the Pre-65 Group Health Program under the same terms until the Retiree attains Medicare Eligibility Due to Age.

(g) Pre-65 Surviving Dependents of Deceased Employees

(i) Initial Transfer of Coverage from APC Active Plan. An individual who (A) as of December 31, 2015, had coverage under the APC Active Plan (other than COBRA continuation coverage) as the surviving dependent of a deceased Employee who had accrued at least 10 Years of Service as of his date of death, and (B) as of January 1, 2016, had not yet attained Medicare Eligibility Due to Age, is eligible to participate, and was automatically enrolled, in a Pre-65 Group Health Program as a "Surviving Dependent" effective as of January 1, 2016.

(ii) Employee Death Occurring on or after January 1, 2016. An individual who:

(A) has not yet attained Medicare Eligibility Due to Age; and

(B) under the APC Active Plan, is the covered dependent of an Employee who (1) meets the Rule of 45 and (2) dies on or after January 1, 2016;

shall be eligible to participate in a Pre-65 Group Health Program as a "Surviving Dependent" upon the termination of her coverage under the APC Active Plan as a result of the Employee's death (or, if later, the exhaustion of the maximum 36 months of COBRA continuation coverage under the APC Active Plan which she elected, if any, with respect to the COBRA qualifying event that was the Employee's death), provided that she also meets the other requirements for an eligible Dependent hereunder and enrolls in the Pre-65 Group Health Program in accordance with Section 3(d) of this Appendix.

(iii) Surviving Dependent coverage for individuals described in this subsection (g) shall terminate in accordance with Section 5(c) of this Appendix.

3. Enrollment in Pre-65 Group Health Programs

Post-65 Group Health Programs. All participation in the Post-65 Group Health Programs was frozen on December 31, 2015, notwithstanding anything in this Wrap-SPD, the Wrap-Plan or any Group Health Program Document to the contrary. Consequently, no Eligible Retiree, Dependent or any other individual may initially enroll in a Post-65 Group Health Program on or after January 1, 2016.

Pre-65 Group Health Programs. An Eligible Retiree or eligible Dependent who has not yet attained Medicare Eligibility Due to Age may initially enroll in a Pre-65 Group Health Program in accordance with the terms and provisions of this Section 3.

(a) Initial Enrollment of New Eligible Retirees

(i) *Eligible Retirees with Retirement Dates During December of 2015*

(A) Subject to subsection (B), below, an Eligible Retiree whose Retirement Date occurred on or after December 1, 2015 and before January 1, 2016 must elect to initially enroll himself and any eligible Dependent in a Pre-65 Group Health Program within 31 days following his Retirement Date. Subject to the other applicable provisions of this Section 3 and Section 4 of this Appendix, including subsection (B), below, if such Eligible Retiree fails to do so, such Retiree and his Dependents will no longer be eligible to participate in any Pre-65 Group Health Program.

(B) An Eligible Retiree who is described in subsection (A), above, who failed to initially enroll in a Pre-65 Group Health Program during the 31-day timeframe referenced in subsection (A), above, will be offered an additional opportunity to initially enroll himself and any eligible Dependents in a Pre-65 Group Health Program during one of the following timeframes:

(1) Annual Enrollment (as defined in subsection (b), below) for the 2017 Plan Year; or

(2) if the Eligible Retiree or his eligible Dependents elected COBRA continuation coverage under the APC Active Plan with respect to the COBRA qualifying event that was the Eligible Retiree's retirement or other termination of employment with the Employer, the 31-day period that immediately follows the date that such individual exhausts his maximum 18-month, 29-month, or 36-month (as applicable) COBRA continuation coverage period.

(ii) *Eligible Retirees with Retirement Dates During 2016*

An Eligible Retiree whose Retirement Date occurs on or after January 1, 2016, and before January 1, 2017, must elect to initially enroll himself and any eligible Dependents in a Pre-65 Group Health Program within 31 days following his Retirement Date; provided, however, if such Eligible Retiree fails to do so, he will be offered an additional opportunity to elect initial enrollment for himself and any eligible Dependents in a Pre-65 Group Health Program during one of the following timeframes:

(A) Annual Enrollment (as defined in subsection (b), below) for the 2017 Plan Year; or

(B) if the Eligible Retiree or his eligible Dependents elected COBRA continuation coverage under the APC Active Plan with respect to the COBRA qualifying event that was the Eligible Retiree's retirement or other termination of employment with the Employer, the 31-day period that immediately follows the date that such individual exhausts his maximum 18-month, 29-month, or 36-month (as applicable) COBRA continuation coverage period.

(iii) *Eligible Retirees with Retirement Dates on or after January 1, 2017*

An Eligible Retiree whose Retirement Date occurs on or after January 1, 2017, must elect to initially enroll himself and any eligible Dependents in a Pre-65 Group Health Program within 31 days following his Retirement Date; provided, however, if such Eligible Retiree fails to do so, and he or his eligible Dependents elect COBRA continuation coverage under the APC Active Plan with respect to the COBRA qualifying event that was the Eligible Retiree's retirement or other termination of employment with the Employer, such Eligible Retiree will be offered an additional opportunity to elect initial enrollment for himself and any eligible Dependents in a Pre-65 Group Health Program within the 31-day period that immediately follows the date that he or any such Dependent exhausts his maximum 18-month, 29-month, or 36-month (as applicable) COBRA continuation coverage period.

(iv) Subject to the other applicable provisions of this Section 3 and Section 4 of this Appendix, if such Eligible Retiree does not initially enroll himself and any eligible Dependents during one of the timeframes specified in subsections (i), (ii) or (iii), above, such Retiree and his Dependents will no longer be eligible to participate in any Pre-65 Group Health Program.

(v) In order to be an "eligible Dependent" under this subsection (a), a Dependent must have been covered under the APC Active Plan as the dependent of the Eligible Retiree on the date that is immediately prior to the Eligible Retiree's Retirement Date.

(vi) If an Eligible Retiree referenced in subsections (i), (ii) or (iii), above, has attained Medicare Eligibility Due to Age, but his eligible Dependent has not, such Dependent may enroll herself in a Pre-65 Group Health Program in accordance with the applicable terms of subsections (i), (ii) or (iii). If, however, such Eligible Retiree has not attained Medicare Eligibility Due to Age, his eligible Dependent shall not be permitted to enroll in a Pre-65 Group Health Program unless the Eligible Retiree also enrolls in such Program.

(b) Annual Enrollment

The term "**Annual Enrollment**" means the Plan Sponsor's annual enrollment process that is held during the fourth quarter of a given year for coverage elections under the Pre-65 Group Health Programs that become effective as of January 1 of the subsequent year.

(i) *Annual Enrollment for the 2017 Plan Year - New, Changed or Waived Coverage Elections*

The Plan Sponsor will administer Annual Enrollment for the 2017 Plan Year for the purpose of making affirmative elections of new, changed or waived enrollment in coverage effective as of January 1, 2017. Such Annual Enrollment will be offered to Eligible Retirees and their eligible Dependents (including Surviving Dependents) who, as of January 1, 2017, will not have attained Medicare Eligibility Due to Age and:

(A) will not have previously initially enrolled in a Pre-65 Group Health Program in accordance with the applicable terms of the Plan;

(B) previously initially enrolled in a Pre-65 Group Health Program in accordance with the applicable terms of the Plan and will have maintained Pre-65 Group Health Program coverage, without any lapse or interruption therein; or

(C) are Legacy Special Enrollees.

New Dependents may not be added to an Eligible Retiree's existing Pre-65 Group Health Program coverage during Annual Enrollment.

An Eligible Retiree's (or Surviving Dependent's) Annual Enrollment election of new, changed or waived coverage must be (1) completed and returned to the Plan Sponsor, (2) completed telephonically, or (3) if the application is electronic, posted online, in accordance with the Plan Administrator's Annual Enrollment procedures.

If, during Annual Enrollment, an Eligible Retiree (or Surviving Dependent) affirmatively elects to waive coverage for himself and his eligible Dependents under a Pre-65 Group Health Program for the 2017 Plan Year, such Retiree (or Surviving Dependent) and Dependents will no longer be eligible to participate in that Pre-65 Group Health Program (or if that Pre-65 Group Health Program is a medical benefit program, in any other Pre-65 Group Health Program which is a medical benefit program).

If an Eligible Retiree otherwise described above in this subsection (b)(i) *will* have attained Medicare Eligibility Due to Age as of January 1, 2017, but his eligible Dependent will *not* have so attained, such Dependent may enroll herself (or remain enrolled) in a Pre-65 Group Health Program in accordance with the applicable terms of this subsection (b)(i). If, however, such Eligible Retiree will *not* have attained Medicare Eligibility Due to Age as of January 1, 2017, such Dependent will not be permitted to enroll (or remain enrolled) in a Pre-65 Group Health Program during Annual Enrollment unless the Eligible Retiree also enrolls (or remains enrolled) in such program.

(ii) *Annual Enrollment for the 2018 Plan Year – Waived Coverage Elections Only*

The Plan Sponsor will administer Annual Enrollment for the 2018 Plan Year for the sole purpose of permitting an Eligible Retiree (or Surviving Dependent) and such Retiree's eligible Dependents, each of whom (A) are covered under a Pre-65 Group Health Program

on December 31, 2017, and (B) will not have attained Medicare Eligibility Due to Age as of January 1, 2018, to affirmatively waive coverage under such Pre-65 Group Health Program for the 2018 Plan Year, effective as of January 1, 2018.

The Eligible Retiree's (or Surviving Dependent's) election to waive coverage must be (1) completed and returned to the Plan Sponsor, (2) completed telephonically, or (3) if the application is electronic, posted online, in accordance with the Plan Administrator's Annual Enrollment procedures.

If an Eligible Retiree (or Surviving Dependent) affirmatively elects to waive coverage for himself and his eligible Dependents under a Pre-65 Group Health Program for the 2018 Plan Year, such Retiree (or Surviving Dependent) and Dependents will no longer be eligible to participate in that Pre-65 Group Health Program (or if that Pre-65 Group Health Program is a medical benefit program, in any other Pre-65 Group Health Program which is a medical benefit program).

If an Eligible Retiree otherwise described in this subsection (b)(ii), above, *will* have attained Medicare Eligibility Due to Age as of January 1, 2018, but his eligible Dependent, who is covered under a Pre-65 Group Health Program on December 31, 2017, will *not* have so attained, such Dependent may remain enrolled in such Pre-65 Group Health Program effective as of January 1, 2018, by declining to affirmatively waive such coverage during Annual Enrollment. If, however, such Eligible Retiree has *not* attained Medicare Eligibility Due to Age as of January 1, 2018, his eligible Dependent will not be permitted to remain enrolled in a Pre-65 Group Health Program effective as of January 1, 2018, unless the Eligible Retiree also remains enrolled in such program effective as of January 1, 2018.

(iii) *Failure to Make an Affirmative Election during Annual Enrollment for the 2017 or 2018 Plan Years*

If, during Annual Enrollment for the 2017 or 2018 Plan Year:

(A) an Eligible Retiree who (1) is covered under a Pre-65 Group Health Program on December 31 of the year in which such Annual Enrollment is held ("**Enrollment Year**"), and (2) will not have attained Medicare Eligibility Due to Age as of January 1 of the Plan Year to which such Annual Enrollment applies ("**Coverage Year**") fails to make an affirmative election (including a waiver) of coverage under a Pre-65 Group Health Program for himself and for any of his eligible Dependents who (a) are covered under a Pre-65 Group Health Program on December 31 of the Enrollment Year, and (b) will not have attained Medicare Eligibility Due to Age as of January 1 of the Coverage Year; or

(B) a Surviving Dependent who (1) is covered under a Pre-65 Group Health Program on December 31 of the Enrollment Year, and (2) will not have attained Medicare Eligibility Due to Age as of January 1 of the Coverage Year fails to make an affirmative election (including a waiver) of coverage under a Pre-65 Group Health Program for herself;

then, in either case, such Retiree and Surviving Dependent will be deemed to have made an express election to retain the same coverage for the Coverage Year, effective as of January 1 of the Coverage Year, as in effect on December 31 of the Enrollment Year, subject to the applicable terms of eligibility under the Plan (referred to herein as "**Passive Enrollment**").

For purposes of clarification, and not limitation, in order to voluntarily drop existing Pre-65 Group Health Program coverage effective as of January 1 of a Coverage Year, the Eligible Retiree (or Surviving Dependent) must make an affirmative election during Annual Enrollment for that Coverage Year to waive such coverage for himself and his eligible Dependents, as described in subsections (b)(i) and (b)(ii), above.

If an Eligible Retiree otherwise described in subsection (b)(iii)(A), above, *will* have attained Medicare Eligibility Due to Age as of January 1 of the Coverage Year, but his eligible Dependent who is covered under a Pre-65 Group Health Program on December 31 of the Enrollment Year will *not* have so attained, such Dependent will remain enrolled in such Pre-65 Group Health Program effective as of January 1 of the Coverage Year via Passive Enrollment. If, however, such Eligible Retiree will *not* have not attained Medicare Eligibility Due to Age as of January 1 of the Coverage Year, such Dependent cannot be enrolled in a Pre-65 Group Health Program effective as of January 1 of the Coverage Year via Passive Enrollment, unless the Eligible Retiree is also enrolled in such program effective as of January 1 of the Coverage Year.

(iv) To be an "eligible Dependent" under this subsection (b), a Dependent must either (1) have been covered under the APC Active Plan as the dependent of the Eligible Retiree on the date that is immediately prior to the Eligible Retiree's Retirement Date or (2) be a Surviving Dependent.

(v) The Plan Sponsor will not administer Annual Enrollment under the Pre-65 Group Health Programs for any Plan Year after the 2018 Plan Year.

(c) Enrollment of Legacy Special Enrollees

A "Legacy Special Enrollee" (as defined below) is an Eligible Retiree; provided, however, a Legacy Special Enrollee who, as of January 1, 2017, has not previously enrolled himself and his eligible Dependents in a Pre-65 Group Health Program in accordance with the applicable terms of the Plan and maintained Pre-65 Group Health Program coverage, without any lapse or interruption therein, must affirmatively elect coverage under a Pre-65 Group Health Program for himself (and for any Dependents covered under the APC Active Plan as the dependent of the Legacy Special Enrollee on the date that is immediately prior to the Legacy Special Enrollee Retirement Date) during Annual Enrollment for the 2017 Plan Year, as provided in subsection (b), above, in order to participate in the Plan effective as of January 1, 2017.

A "**Legacy Special Enrollee**" is:

(i) a Retiree who will not have attained Medicare Eligibility Due to Age as of January 1, 2017, is a member of the Legacy Anadarko Petroleum Corporation Retiree Group, and either:

(A) retired on or before December 31, 2007, at age 55 or later, with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted); or

(B) met the Rule of 45 and retired on or after January 1, 2008 and before January 1, 2016, at age 55 or later, with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted); or

(ii) a Retiree who will not have attained Medicare Eligibility Due to Age as of January 1, 2017, is a member of the Legacy Union Pacific Resources Group, Inc. Retiree Group, and retired on or before December 31, 2007, at age 55 or later, with at least 10 Years of Service; or

(iii) a Former Employee:

(A) who will not have attained Medicare Eligibility Due to Age as of January 1, 2017, and is a member of the Legacy Anadarko Petroleum Corporation Retiree Group;

(B) whose date of termination of employment with the employer was on or after February 1, 2003 and prior to January 1, 2016; and

(C) who, as of December 31, 2016, was eligible for coverage under the Group Health Benefit based on the severance eligibility terms of the Plan as in effect on the date of his termination of employment with the employer.

If, as of January 1, 2017, a Legacy Special Enrollee and his eligible Dependents are not enrolled in a Pre-65 Group Health Program via either affirmative elections during Annual Enrollment for the 2017 Plan Year or Passive Enrollment (as described in subsection (b)(3), above) for the 2017 Plan Year, such Legacy Special Enrollee and his Dependents will no longer be eligible to participate in the Plan.

Legacy Special Enrollees cannot enroll (or reenroll) any eligible Dependents in coverage without enrolling (or reenrolling) in coverage for themselves as Eligible Retirees. The cost of any coverage under a Pre-65 Group Health Program in which a Legacy Special Enrollee enrolls shall not be subsidized by the Plan Sponsor or any other Employer (except with respect to dental coverage of Grandfathered Dental Dependents, as described in Sections 2(b), (c) and (d)(i) of this Appendix).

(d) Enrollment of Surviving Dependents

A Surviving Dependent of a deceased Employee, as described in Section 2(g) of this Appendix, must elect to enroll herself in a Pre-65 Group Health Program within 31 days following the later of (i) the date of the deceased Employee's death or (ii) the date that she exhausts her maximum 36-month period of COBRA continuation coverage which she elected, if any, under the APC Active Plan with respect to the COBRA qualifying event that was the Employee's death; provided, however, if she fails to do so, she will be offered an additional opportunity to elect

enrollment for herself in a Pre-65 Group Health Program during Annual Enrollment for the 2017 Plan Year (if later than items (i) or (ii), above), as described in subsection (b), above.

Subject to the other provisions of this Section 3 and Section 4 of this Appendix, if such Surviving Dependent does not enroll herself during one of the timeframes specified in this subsection (d), she will no longer be eligible to participate in the Plan.

(e) Compliance with Plan Administrator's Enrollment Procedures

All enrollment elections under the Group Health Benefit must be (i) completed and returned to the Plan Sponsor, (ii) completed telephonically, or (iii) if the application is electronic, posted online, in accordance with the Plan Administrator's procedures as described in this Appendix F and otherwise communicated to eligible individuals.

4. Changes in Coverage Outside of Annual Enrollment

(a) Based on Qualifying Life Event

The following changes in coverage may be made by the individuals as designated below outside of Annual Enrollment upon the occurrence of one of the following "**Qualifying Life Events**" during the Plan Year:

Eligible Retirees:

(i) Divorce, legal separation or dissolution of domestic partnership *[drop coverage only]*;

(ii) Death of Spouse, Domestic Partner or other covered Dependent *[drop coverage only]*;

Eligible Retirees and eligible Dependents (including eligible Surviving Dependents):

(iii) Change in residence that affects eligibility for coverage, for example: moving into or out of a Pre-65 Group Health Program's network area *[enroll (only through December 31, 2016), or change enrollment, in a Pre-65 Group Health Program only]*;

(iv) Change in a Dependent's eligibility for benefits *[drop coverage only]*;

(v) Loss of other health coverage outside the Plan *[enroll (only through December 31, 2016), or change enrollment, in a Pre-65 Group Health Program only]*; or

(vi) (Applicable prior to January 1, 2016 only) Attainment of age 55 *[if the Eligible Retiree was previously covered under an unsubsidized retiree medical plan, the Eligible Retiree may, at the time he attains age 55, enroll in a subsidized retiree medical plan, if eligible, even if he was not enrolled in the Pre-65 retiree health benefit]*.

An Eligible Retiree or eligible Dependent who experiences a Qualifying Life Event should notify the Anadarko Benefits Center within 30 days of the event. Any new election or election change based on a Qualifying Life Event must be (A) completed and returned to the Plan Sponsor, (B) completed telephonically, or (C) if the application is electronic, posted online, in accordance with the Plan Administrator's procedures as described in this Appendix F and otherwise communicated to eligible individuals. Depending on the type of Qualifying Life Event, the Eligible Retiree or

eligible Dependent may also need to provide proof of the event (for example, a Medicare I.D. number).

Requested terminations of coverage as the result of a Qualifying Life Event will be effective as of the last day of the month in which the request is submitted to, and accepted by, the Anadarko Benefits Center.

Requested changes to, or enrollments in, coverage as the result of a Qualifying Life Event will be effective as of the first day of the month next following the month in which the request is submitted to, and accepted by, the Anadarko Benefits Center.

(b) Voluntary Election to Drop Coverage

Effective as of January 1, 2017, an Eligible Retiree may elect to voluntarily drop his coverage (and that of his Dependents) under a Group Health Program at any time, in which case such termination will be applied as provided in Section 5(a) or 5(b), as applicable, of this Appendix F, and the Eligible Retiree and his Dependents will no longer be eligible to participate in such Group Health Program (or if such Group Health Program is a medical benefit program, in any other Group Health Program that is a medical benefit program).

Any election to drop coverage under a Group Health Program must be (i) completed and returned to the Plan Sponsor, (ii) completed telephonically, or (iii) if the application is electronic, posted online, in accordance with the Plan Administrator's procedures as described in this Appendix F and otherwise communicated to eligible individuals.

5. Termination of Coverage

(a) Eligible Retiree Coverage.

An Eligible Retiree's coverage shall terminate on the earliest to occur of the following:

(i) The date on which the Plan or the Group Health Benefit terminates, or is amended to eliminate coverage for the Eligible Retiree, for whatever reason;

(ii) The date of the Eligible Retiree's death;

(iii) The last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;

(iv) The date on which the Eligible Retiree falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person, including enrolling a person as a Spouse or other Dependent who does not qualify as a Dependent under the terms of the Group Health Benefit;

(v) With respect to a Eligible Retiree who, as of January 1, 2016, had not attained Medicare Eligibility Due to Age, the last day of the month immediately prior to the month in which such Eligible Retiree attains Medicare Eligibility Due to Age;

(vi) The date the Eligible Retiree is rehired as the Employee of an Employer or otherwise

ceases to be an Eligible Retiree; or

(vii) The date on which the Eligible Retiree elects to voluntarily drop his coverage under the Plan, in which case he will no longer be eligible to participate in the Plan.

(b) Dependent Coverage

Coverage for a Dependent shall terminate on the earliest to occur of the following:

(i) The date on which the Plan or the Group Health Benefit terminates, or is amended to eliminate coverage for the Dependent, for whatever reason;

(ii) The last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;

(iii) The date the Dependent enrolls in coverage under the APC Active Plan as an Employee;

(iv) The last day of the month in which the Dependent ceases to be an eligible Dependent under the Group Health Benefit;

(v) The date on which the Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person;

(vi) The date the Dependent's coverage ceases to be available to the Eligible Retiree;

(vii) The date on which an Eligible Retiree elects to voluntarily terminate coverage for his Dependent, in which case such Dependent will no longer be eligible to participate in the Plan;

(viii) The date on which the Dependent becomes a full-time member of the armed forces, except as provided by USERRA; or

(ix) With respect to a Dependent who, as of January 1, 2016, had not attained Medicare Eligibility Due to Age, the last day of the month immediately prior to the month in which such Dependent attains Medicare Eligibility Due to Age *[not applicable to the dental coverage of a Grandfathered Dental Dependent]*.

(c) Surviving Dependent Coverage.

If an Eligible Retiree dies while covered under the Group Health Benefit, any coverage then in effect for the deceased Eligible Retiree's surviving Spouse and other Dependents (also included in the term "**Surviving Dependents**") will be automatically continued, subject to the payment of any required contributions.

Coverage for a Surviving Dependent shall terminate on the earliest to occur of the following:

(i) The date of death of the Surviving Dependent;

(ii) The date on which the Plan or the Group Health Benefit terminates, or is amended to eliminate coverage for the Surviving Dependent, for whatever reason;

(iii) The last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;

(iv) The date the Surviving Dependent enrolls in coverage under the APC Active Plan as an Employee (if the surviving Spouse becomes such an Employee, coverage under the Group Health Benefit will terminate for all related Surviving Dependents);

(v) The last day of the month in which the Surviving Dependent ceases to be an eligible Dependent under the Group Health Benefit;

(vi) The date on which the Surviving Dependent elects to voluntarily drop her coverage under the Plan, in which case she will no longer be eligible to participate in the Plan;

(vii) The date on which the Surviving Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person;

(viii) The date on which the Surviving Dependent becomes a full-time member of the armed forces, except as provided by USERRA; or

(ix) With respect to a Surviving Dependent who, as of January 1, 2016, had not attained Medicare Eligibility Due to Age, the last day of the month prior to the month in which such Surviving Dependent attains Medicare Eligibility Due to Age *[not applicable to the dental coverage of a Grandfathered Dental Dependent who is a Surviving Dependent]*.

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX G

The following Group Health Program Documents which are operative as of January 1, 2018 are attached hereto and incorporated, in their entirety, into this SPD by reference:*

- UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program:
  - UnitedHealthcare HDHP Choice Plus Plan Booklet (2018), Group Number 755494;
- UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program:
  - UnitedHealthcare HDHP Options Plan Booklet (2018), Group Number 755494;
- UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program:
  - UnitedHealthcare HDHP Out of Area Options Plan Booklet (2018), Group Number 755494;
- UnitedHealthcare Dental Benefits Program:
  - UnitedHealthcare Dental PPO Plan (2015) (Plan Number P9568), Group Number 755494;
- UnitedHealthcare Medicare Prescription Drug Program:
  - UnitedHealthcare MedicareRx for Groups (PDP), Evidence of Coverage (2017), Group Number 00334; and
  - UnitedHealthcare RxSupplement, Certificate of Coverage (2017), Group Number 00334.

NOTICE: Appendix G was amended by the Second Summary of Material Modification (SMM). Please see the Second SMM for more information.

* The Group Health Program Documents also include any other amendments, riders or attachments to the documents listed above, or any other documents under which a Group Health Program is established and operated, as of January 1, 2018.

Program Document 1

UnitedHealthcare HDHP Choice Plus Plan Booklet (2018), Group Number 755494

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2018)

Final

Benefits Booklet

Anadarko Petroleum Corporation
HDHP Choice Plus Plan

Effective: January 1, 2018
Group Number: 755494

4814-4034-3646 v.6

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support, prior authorization and Mental Health/Substance Use Disorder Administrator: (888) 512-4093;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

Anadarko Petroleum Corporation is pleased to provide you with this Benefits Booklet, which describes the HDHP Choice Plus Plan health Benefits available to you and your covered family members under the Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan) and the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit[1] under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet.

This Benefits Booklet includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

The complete Summary Plan Description of the APC Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet) and the complete Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including

[1] The Summary Plan Description of the Group Health Benefit is one of two components of the full Summary Plan Description of the APC Retiree Health Benefits Plan. Apart from the Group Health Benefit, other group health benefits, unrelated to the HDHP Choice Plus Plan, are provided to eligible individuals under the APC Retiree Health Benefits Plan. Such benefits are described in a separate summary plan description document that constitutes the other component of the full Summary Plan Description of the APC Retiree Health Benefits Plan.

this Benefits Booklet) are each referred to in this Benefits Booklet as an "SPD." The SPDs are designed to meet the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This Benefits Booklet supersedes any previous printed or electronic Benefits Booklet for the HDHP Choice Plus Plan offered under the Plan.

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *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 Plan.

Anadarko Petroleum Corporation intends to continue the Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This Benefits Booklet is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this Benefits Booklet and the contents of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, your rights shall be determined as provided in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Anadarko Petroleum Corporation is solely responsible for paying Benefits described in this Benefits Booklet.

Please read this Benefits Booklet thoroughly to learn how the HDHP Choice Plus Plan works. If you have questions contact the Anadarko Benefits Center at (866) 472-4711 or call the number on the back of your ID card.

How To Use This Benefits Booklet

- Read the entire Benefits Booklet, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this Benefits Booklet 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 Benefits Booklet and any future amendments at **www.anadarkoadvantage.ehr.com** or request printed copies by contacting the Anadarko Benefits Center at (866) 472-4711.
- Capitalized words in the Benefits Booklet have special meanings and are defined in Section 14, *Glossary*.

- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Anadarko Petroleum Corporation is also referred to as Company.
- If there is a conflict between this Benefits Booklet and any benefit summaries (other than Summaries of Material Modifications to the SPD under ERISA) provided to you, this Benefits Booklet will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Important Note: Except as otherwise noted, the provisions of this Section 2 apply to coverage under the APC Retiree Health Benefits Plan, as applicable to the HDHP Choice Plus Plan, only to the extent that such provisions are not inconsistent with the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, which governs and controls. Please refer to the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan for additional details regarding eligibility, enrollment and other coverage terms under the APC Retiree Health Benefits Plan for eligible Retired Employees and their eligible Dependents.

Eligibility

Retiree Eligibility Frozen on December 31, 2015

Notwithstanding anything in this Benefits Booklet to the contrary, eligibility to participate in the HDHP Choice Plus Plan under the APC Retiree Health Benefits Plan was frozen on December 31, 2015, except as otherwise specifically provided in the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan. Consequently, only such Retired Employees, Dependents and other individuals as specifically provided in the Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan may become newly eligible to participate in the HDHP Choice Plus Plan under the APC Retiree Health Benefits a Plan on or after January 1, 2016.

You are eligible to participate in the Plan if you are a regular full-time or part-time Employee who is eligible to participate in the APC Health Benefits Plan in accordance with the wrap-around Summary Plan Description of the APC Health Benefits Plan or a Retired Employee who is eligible to participate in the APC Retiree Health Benefits Plan in accordance with the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse (including your Domestic Partner), as defined in Section 14, *Glossary;*
- your or your Spouse's child who is under age 26, through the end of the year in which the child turns age 26; for purposes of this and the next bullet point, "child" includes a

natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse have a court appointed guardianship or conservatorship but only if such child primarily lives with you and is a member of your household; or

- your or your Spouse's child, beginning with the year of the child's 27th birthday, who is dependent upon you or your Spouse because of a mental or physical handicap rendering the child medically incapacitated and unable to be self-supporting (Disabled). The child must satisfy either of the following requirements:
  - prior to the end of the year of the child's 26th birthday, the child is Disabled and covered as a Dependent under the Plan; or
  - the child is Disabled and over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll for coverage (i.e., the Disabled child cannot later be added to coverage under the Plan).

  In addition, the child must reside with the Employee in his household for more than one-half of the year, and the child must not provide more than one-half of his own support for the year. Periodic proof of incapacity may be required by the Plan Administrator to continue coverage for the child.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both Employees and covered under the APC Health Benefits Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. If you and your Spouse are both Retired Employees and covered under the APC Retiree Health Benefits Plan, you may each be enrolled as a Retired Employee or be covered as a Dependent of the other person, but not both. However, if you are eligible for coverage as an Employee under the APC Health Benefits Plan and your Spouse is eligible for coverage as a Retired Employee under the APC Retiree Health Benefits Plan, you are not eligible for coverage as a Dependent under the APC Retiree Health Benefits Plan, but your Spouse is eligible for coverage as a Dependent under the APC Health Benefits Plan (subject to the other applicable terms of the APC Health Benefits Plan). In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Anadarko Petroleum Corporation share in the cost of the Plan. Your contribution amount depends on the options under the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children to be *per se* dependents for federal tax purposes (unless they meet the specific requirements for qualifying as tax dependents under the Internal Revenue Code of 1986, as amended (the "Code")). Therefore, the value of Anadarko Petroleum Corporation's cost in covering a Domestic Partner and the Domestic Partner's children may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children will be paid using after-tax payroll deductions.

Your contributions are subject to review and Anadarko Petroleum Corporation reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Anadarko Benefits Center at (866) 472-4711 or logging onto **www.anadarkoadvantage.ehr.com**.

How to Enroll

To enroll, call the Anadarko Benefits Center at (866) 472-4711, or log onto **www.anadarkoadvantage.ehr.com**, within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Annual Enrollment to make your benefit elections.

Each year during Annual Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Annual Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, the birth of a child, adoption of a child, placement for adoption of a child or other family status change, you must contact the Anadarko Benefits Center at (866) 472-4711 within 31 days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

Once the Anadarko Benefits Center receives your properly completed enrollment, coverage will begin on your initial date of eligibility, as described in the SPD. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date the Anadarko Benefits Center receives notice of your marriage, provided you notify the Anadarko Benefits Center within 31 days of your marriage. 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 Anadarko Benefits Center within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health

Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status that affects eligibility for coverage or you have a special enrollment right. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.), but you can generally enroll yourself and/or your Dependents in any medical Benefit Program offered under the Plan for which you are otherwise eligible as provided in the SPD if you have a special enrollment right. The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- establishing or dissolving a Domestic Partnership;
- the birth, adoption, placement for adoption or legal guardianship of a Dependent child;
- any of the following that change your or your Dependent's employment status: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Dependent's residence;
- a change in your or your Dependent's position or work schedule that impacts eligibility for health coverage;
- your or your Dependent's gain or loss of entitlement to Medicaid or Medicare;
- significant cost or coverage changes;
- a court or administrative order; and
- any other change in status event provided under the Anadarko Petroleum Corporation Pre-Tax Premium and Benefits Plan.

The following create special enrollment rights for purposes of the Plan:

- your marriage;
- the birth, adoption, placement for adoption of a Dependent child;
- loss of eligibility for other health coverage as a result of legal separation, divorce, loss of dependent status, death of an employee, termination of employment, or reduction in hours;

- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and, with respect to the group market, no other benefit option is available to you or your eligible Dependent, resulting in a loss of eligibility for coverage;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- contributions are no longer paid by the Employer;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Anadarko Benefits Center within 60 days of termination); and
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Anadarko Benefits Center within 60 days of determination of subsidy eligibility).

Unless otherwise noted above, if you wish to change your elections, you must contact the Anadarko Benefits Center at (866) 472-4711 within 31 days of the change in family status. Otherwise, you will need to wait until the next Annual Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At Annual Enrollment, she elects not to participate in Anadarko Petroleum Corporation's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the Plan outside of Annual Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in the Plan, 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 Network level of Benefits under the Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider that is identified as a Designated Provider. Only certain Network Physicians and Network providers have been identified as Designated Providers. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

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

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** 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 Physicians available in your Plan.

Network Providers

UnitedHealthcare or its Affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

See Attachment I to this Benefits Booklet, *Health Care Reform Notices*, for additional information regarding your right under applicable law to designate a primary care provider and receive certain Covered Health Services without a referral.

Network providers are independent practitioners and are not employees of Anadarko Petroleum Corporation 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 by such providers.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services, to the extent permitted by the Affordable Care Act and other applicable law. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Eligible Expenses

Eligible Expenses are the charges for Covered Health Services that are (i) incurred by a Covered Person while the Plan is in effect and (ii) determined by UnitedHealthcare to be payable as Benefits under the Plan.

The Plan Administrator has delegated to UnitedHealthcare, in its capacity as the Claims Administrator and Claims Fiduciary, the discretion and authority to (a) decide whether a treatment or supply is a Covered Health Service, (b) formulate the methods by which Eligible Expenses will be determined, and (c) determine Eligible Expenses that are payable as Benefits under the Plan.

For Designated Network Benefits and Network Benefits, you are not responsible for any difference between the amount the provider bills and the portion of such amount that UnitedHealthcare determines constitutes Eligible Expenses. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills and the portion of such amount UnitedHealthcare determines constitutes Eligible Expenses.

Eligible Expenses are determined solely in accordance with (i) UnitedHealthcare's reimbursement policy guidelines, as described under the definition of Eligible Expenses in Section 14, *Glossary*, and (ii) the other applicable terms and conditions of coverage under the Plan.

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are based on the amount that is required by applicable law (including the Affordable Care Act), or if no amount is required by applicable law, then an amount negotiated or authorized by UnitedHealthcare, as permitted by applicable law.

For Non-Network Benefits, (*i.e.*, Benefits that are payable when Covered Health Services are received from a non-Network provider, except as the result of an Emergency or as arranged by UnitedHealthcare, as provided in the paragraph above), Eligible Expenses are based on one of the following amounts:

- Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's authorized vendors, Affiliates or subcontractors, at UnitedHealthcare's discretion, including, without limitation, pursuant to the Shared Savings Program.
- If rates have not been negotiated, then one of the following amounts, as applicable:
  - 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, with the exception of the following:
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or CMS competitive bid rates.
  - When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health*

Systems, Thomson Reuters (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

- When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented in UnitedHealthcare's systems within 30 to 90 days after *CMS* updates its data. The *CMS* published rate that is applicable to a participant's claim is the *CMS* published rate as reflected in UnitedHealthcare's systems on the date that such claim is incurred.

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

Annual Deductible

The Annual Deductible 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 Network and non-Network Annual Deductibles for the Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person transfers from another Benefit Program under the Plan, as described in the SPD, to this HDHP Choice Plus Plan, any amount already applied to the annual deductible provision under that prior Benefit Program for the year will apply to the Annual Deductible provision under this HDHP Choice Plus Plan.

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.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the maximum amount you will be required to pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for the Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual Out-of-Pocket Maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products.*

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays for Covered Health Services available in Section 15, *Prescription Drug Products*	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance payments, including those for Covered Health Services available in Section 15, *Prescription Drug Products*	Yes	Yes
Charges for non-Covered Health Services	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program; and
- Covered Health Services which require prior authorization.

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefits Booklet, the Personal Health Support Nurse 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. Covered Persons 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 toll-free number on your ID card.

Prior Authorization

The Plan requires that you obtain prior authorization from the Claims Administrator for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 6, *Additional Coverage Details* within each Covered Health Service category.

IMPORTANT: Prior authorization is not a guarantee of any payment of Benefits. In addition to any prior authorization requirement, Benefits are also subject to all other applicable requirements of the Plan, including, but not limited to, any limitations and exclusions regarding coverage, timely payment of required contributions toward your coverage, and your eligibility at the time care and services are provided.

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

When you choose to receive certain Covered Health Services from non-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 a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization from the Claims Administrator, please review it carefully so that you understand what services are subject to the authorization 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.

Note: Any request made by a person or entity other than a Covered Person (including, but not limited to, a health care provider) for prior authorization of Covered Health Services to be rendered to the Covered Person will be deemed to be a request *on behalf of the Covered*

Person by his or her authorized representative for such purpose, and not a request by such other person or entity on his or its own behalf.

Covered Health Services which Require Prior Authorization

The Plan requires prior authorization from the Claims Administrator for certain Covered Health Services. Any request for prior authorization that is required under the terms of the Plan as a condition for obtaining Benefits for Covered Health Services constitutes a "Pre-Service Claim" under the Plan, as described in Section 9, *Claims Procedures*, and ERISA.

When you choose to receive any of those Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Your obligation to obtain prior authorization is also applicable whenever a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services are subject to the authorization and what providers are authorized to deliver the services that are subject to the authorization.

If you choose to receive a service that has been determined to not be a Medically Necessary Covered Health Service or has otherwise not received prior authorization if and as required, you will be responsible for paying all charges and no Benefits will be paid for that service.

Services for which you are required to obtain prior authorization are identified in Section 6, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Covered Health Service Benefit description in Section 6, *Additional Coverage Details*, to determine how far in advance you must obtain prior authorization.

You are also required to obtain prior authorization whenever a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

Contacting the Claims Administrator for prior authorization is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Designated and Network	Non-Network
Annual Deductible[1]		
■ Individual	$1,500	$2,500
■ Family (cumulative Annual Deductible[2])	$3,000	$5,000
Annual Out-of-Pocket Maximum[3]		
■ Individual	$3,500	$8,000
■ Family (cumulative Out-of-Pocket Maximum[4])	$6,850	$15,500
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in the Plan.	Unlimited	

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

[2]The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

[3]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

[4]The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Acupuncture Services	Depending upon where the Covered Health Service is provided, Benefits for acupuncture services will be the same as those stated under each Covered Health Service category in this section.	
Ambulance Services ■ Emergency Ambulance ■ Non-Emergency Ambulance	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible 60% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay *Cancer treatment provided at any other facility is covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Applicable*	Not Applicable*
Clinical Trials	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 ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-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 Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drug Products*.	
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services - Outpatient		
■ True Emergency	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible
■ Non-Emergency	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hearing Aids ■ Examinations and Testing	*Primary Physician Designated Provider* 90% after you meet the Annual Deductible *Network Provider* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
■ Devices Up to $2,000 per hearing impaired ear every 36 months	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care Up to 120 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Infertility Services and Fertility Solutions (FS) Program For Network Benefits, infertility services must be received from a Designated Provider. See Section 6, *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.	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.
Kidney Resource Services (KRS)[3] *Kidney disease treatment provided at any other facility is covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Applicable*	Not Applicable
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Mental Health Services ■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Neonatal Resource Services (NRS)[4] *Neonatal intensive care services provided at any other facility are covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Applicable*	Not Applicable
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Nutritional Counseling ***Note:*** Nutritional or diet counseling billed as a preventive care will be paid as described under *Preventive Care Services*.	*Designated Provider* 90% after you meet the Annual Deductible *Network Provider* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Obesity Treatment		
■ Non-Surgical Treatment	Depending upon where the Covered Health Service is provided, Benefits for non-surgical obesity treatment will be the same as those stated under *Physician's Office Services* in this section and in Section 15, *Prescription Drug Products*.	
■ Surgical Treatment		
- Physician's Office Services	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered
- Physician Fees for Surgical and Medical Services	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered
- Hospital - Inpatient Stay	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered
- Lab and X-ray	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Orthognathic Surgery	Depending upon where the Covered Health Services is provided, Benefits for orthognathic surgery will be the same as those stated under each Covered Health Services category in this section.	
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	*Designated Provider* 90% after you meet the Annual Deductible *Network Provider* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services A separate Deductible will not apply for a well newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits for Pregnancy – Maternity Services will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Preventive Care Services		
■ Physician Office Services	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
■ Breast Pumps	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient Up to 70 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits for Reconstructive Procedures will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Substance-Related and Addictive Disorders Services		
■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services		
■ Cornea Transplants	Depending upon where the Covered Health Services is provided, Benefits for cornea transplants will be the same as those stated under each Covered Health Services category in this section.	
■ Other Covered Transplants	*Designated Provider* 100% Annual Deductible does not apply *Network facility* Not Covered	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Travel and Lodging (If services rendered by a Designated Provider) See Section 6, *Additional Coverage Details*, for limits	For patient and companion(s) of patient undergoing cancer treatment, obesity surgery services, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Non-Network Benefits are not available.
Wigs	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 4, *Personal Health Support and Prior Authorization* before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from UnitedHealthcare before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Provider facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

[3]These Benefits are for Covered Health Services provided through KRS at a Designated Provider facility. For kidney disease treatment not provided through KRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

[4]These Benefits are for Covered Health Services provided through NRS at a Designated Provider facility. For neonatal intensive care services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from UnitedHealthcare before you receive them.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call UnitedHealthcare. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy given by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

Covered Health Services also include acupuncture when provided in lieu of anesthesia.

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as possible prior to transport.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. "Designated Provider" is defined in Section 14, *Glossary*.

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

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (855) 583-3161; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;

- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Clinical Trials

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

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as 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; and
- 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 eligible for participation in the qualifying Clinical Trial according to the Clinical Trial protocol and such participation would be appropriate based on 1) medical and scientific information provided by the Covered Person or 2) the conclusion of a referring health care professional that is participating in the Clinical Trial.

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with 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; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - ♦ comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    - ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of participation in a Clinical Trial arises. This requirement does **not** apply to Clinical Trials for cancer or other life-threatening diseases or conditions.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a Designated Provider facility. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks (which is an Affiliate of UnitedHealthcare) or UnitedHealthcare to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or UnitedHealthcare at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;

- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Designated Provider facility.

Prior Authorization Requirement
For Covered Health Services required to be received by a Designated Provider, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of a CHD surgery arises.

Dental Services - Accident Only

Important note: Additional dental care services are covered under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The Plan 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 immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Except with respect to any accidental Injury that occurred prior to the Covered Person's effective date of coverage under the Plan, dental services for final treatment to repair the damage caused by accidental Injury must be (a) started within three months following the accident (unless extenuating circumstances exist, such as prolonged hospitalization or the presence of fixation wires from fracture care) and (b) completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic X-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies in this Section 6. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, Outpatient Prescription Drug Products.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) 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)

The Plan pays for Durable Medical Equipment (DME) that is:

- 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 Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the 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;
- orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, braces to treat curvature of the spine, cranial orthotics (helmets), shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period and are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the repair/replacement of a type 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, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as UnitedHealthcare is notified within two business days after the admission or otherwise as soon as reasonably possible if you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within two business days following admission or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided for the continued stay; however, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Hearing Aids

The Plan 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 a Physician. Benefits under this section are provided for services performed by an audiologist or specialist for a diagnosis, the hearing aid and for charges for associated fitting and testing. ***Note:*** Benefits for routine hearing screenings are provided under *Preventive Care Services*.

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.

Any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits is limited to $2,000 per hearing impaired ear every 36 months.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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.

Any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before receiving services including nutritional foods and Private Duty Nursing or otherwise as soon as is reasonably possible.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission for an Inpatient Stay in a hospice facility or otherwise as soon as is reasonably possible.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

Infertility Services and Fertility Solutions (FS) Program

Infertility services must be ordered by a Network provider and received at an FS Designated Provider facility and coordinated through FS.

The Plan has specific guidelines regarding Benefits for Infertility Services. Contact Fertility Solutions at 1-866-774-4626 for information about these guidelines.

Infertility Services

Covered Health Services for infertility services and associated expenses include:

- Physician's office visits and consultations.
- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI).
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI).
- Embryo transportation related network disruption.
- Ovulation induction and controlled ovarian stimulation.
- Pre-implantation genetic diagnosis (PGD) for diagnosis of genetic disorders only.
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Cryopreservation - embryo's (storage is limited to 3 months).

To be eligible for Benefits, the Covered Person must:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Have failed to achieve Pregnancy following six months of unsuccessful donor insemination.
- Have failed to achieve Pregnancy due to impotence/sexual dysfunction.

- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
- Be under age 44, if female.

In addition, the male related procedures described above are only available to males covered under the Plan.

Infertility Services for Same Sex Couples

The Plan will also pay for certain services for same sex couples. A female Covered Person without a male partner may be considered infertile if she is unable to conceive or maintain a pregnancy after six cycles of donor insemination (a non-covered benefit under this definition); proof of insemination must be provided. If conception is not achieved with insemination, the female Covered Person would then become eligible for advanced reproductive treatment including IVF as defined above. Any resulting embryos would be transferred only to the individual from whom the oocytes were derived.

A male Covered Person without a female partner is not covered for artificial insemination of a female surrogate. However, he is covered for the diagnosis and treatment of the male factor causing infertility (e.g., treatment of sperm abnormalities including the surgical recovery of sperm).

Infertility Services for eSET

Elective SET is defined as the transfer of a single embryo, in which more than one high-quality embryo exists but it is decided to transfer only one embryo that is selected from a larger number of available embryos, at either the cleavage or blastocyst stage of embryo development. An increased benefit under the infertility benefit applies when you meet the clinical criteria. Please contact FS for further details.

Infertility Services for Donor Insemination

The Plan will cover donor insemination for a female without a male partner. Any resulting embryos could be transferred either to the individual from whom the oocytes were derived or to her legally married partner. However, the cost of the donor sperm itself and any storage thereof is excluded from coverage.

Pre-implantation Genetic Screening (PGS)

The Plan also covers pre-implantation genetic screening (PGS) when used in conjunction with elective single embryo transfer. These technologies include, but are not limited to, array comparative genomic hybridization, quantitative polymerase chain reaction and single nucleotide polymorphism array testing.

Donor Coverage

The Plan will also cover the use of donor ovum and donor sperm and related costs, including collection and preparation. The Plan will not pay for the cost of the donor sperm

or egg or any related donor fees.

Planning Cancer Treatment

Covered Persons with a diagnosis of cancer who are planning cancer treatment, or medical treatment for any condition that is demonstrated to result in infertility are considered to meet the definition of infertility. Planned cancer treatments include bilateral orchiectomy bilateral oophorectomy, hysterectomy, chemotherapy or radiation therapy that is established in the medical literature to result in infertility. In order to use infertility benefits covered under the Plan, you must notify FS and meet the following eligibility criteria:

- Covered Persons or their partners must not have undergone a previous elective sterilization procedure, (e.g. hysterectomy, tubal ligation, vasectomy), with or without surgical reversal, regardless of post reversal results.

- Covered Person must have had a day 3 FSH test in the prior 12 months if age less than 35 or the prior six months if age 35 or greater.

- Day 3 FSH level of the female Covered Person must not have been greater than 15 mIU/mL in any (past or current) menstrual cycle regardless of the type of infertility services planned (Including donor egg, donor embryo or frozen embryo cycle).

- Only those infertility services that have a reasonable likelihood of success are covered.

Coverage is limited to:

- Collection of sperm.
- Cryopreservation of sperm.
- Ovulation induction and retrieval of eggs.
- In vitro fertilization.
- Embryo cryopreservation.

Long-term cryopreservation costs (anything longer than three months) are not covered under the Plan.

Any combination of Network Benefits and Non-Network Benefits for infertility services received through the FS program is limited to $20,000 per Covered Person during the entire period you are covered under the Plan.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of the need for infertility services arises.

What is Coinsurance?
Coinsurance is the amount you pay for a Covered Health Service, not including the Deductible.

For example, if the Plan pays 80% of Eligible Expenses for care received from a Network provider, your Coinsurance is 20%.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Providers participating in the Kidney Resource Services (KRS) program. "Designated Provider" is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

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

- lab and radiology/X-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

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

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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;
- Residential Treatment;
- Partial Hospitalization/Day Treatment;

- Intensive Outpatient Treatment;
- outpatient treatment; and

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Providers participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. "Designated Provider" is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, the Network provider must notify NRS or UnitedHealthcare if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- call UnitedHealthcare; or
- call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

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; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the 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.

Benefits include the following levels of care:

- inpatient treatment;
- Residential Treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment; and
- 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; and
- crisis intervention.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and an admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, if you are going to obtain Neurobiological Disorders – Autism Spectrum Disorder Services from a non-Network provider, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- coronary artery disease;

- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

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 Treatment

Non-Surgical Treatment

The Plan covers structured weight loss programs provided by or under the direction of a Physician. Covered Health Services include:

- examination and diagnostic testing provided in a Physician's office;
- program costs, including monitoring of weight loss; and
- Pharmaceutical Products provided as part of the program.

Covered Health Services also include Prescription Drug products for appetite suppression or weight loss provided under Section 15, *Prescription Drug Products*.

Surgical Treatment

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- the Covered Person has a minimum Body Mass Index (BMI) of 40; or
- the Covered Person has a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria, the following must also be true:

- the Covered Person is 18 years of age or older, or for adolescents, has achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4;
- there is documentation of a motivated attempt at weight loss for a minimum of six months, prior to bariatric surgery and within the last two years, through a structured diet program that includes Physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program;
- the Covered Person completes a pre-surgical psychological evaluation within 12 months of surgery;

- the surgery is performed at a Bariatric Resource Service (BRS) Designated Provider facility by a Network surgeon even if there are no BRS Designated Providers near you.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

You will have access to a certain Network of Designated Providers and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in Section 14, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling toll-free at (888) 936-7246.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider facility.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of obesity surgery arises.

It is important that you provide notification regarding your intention to have surgery by calling either the toll-free telephone number on the back of your ID card or Bariatric Resources Services at (888) 936-7246. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Orthognathic Surgery

The Plan covers orthognathic surgery in the following situations:

- a jaw deformity resulting from facial trauma or cancer; or
- a skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
  - inability to incise solid foods;
  - choking on incompletely masticated solid foods;
  - damage to soft tissue during mastication;
  - speech impediment determined to be due to the jaw deformity; or
  - malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Prior Authorization Requirement
Please remember that, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before orthognathic surgery is performed during an Inpatient Hospital Stay in a Hospital.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan 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 Physician house calls, allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by the Claims Administrator.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as is reasonably possible before Genetic Testing – BRCA is performed.

Please Note
Your Physician does not have a copy of your Benefits Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - 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. Benefits for Pregnancy and maternity services that constitute required preventive health services under the Affordable Care Act are covered as *Preventive Care Services*.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 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 the 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.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as reasonably possible with respect to any Inpatient Stay for the mother and/or the newborn that will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

It is important that you call the toll-free number on the back of your ID card with notification regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital, and as otherwise required by the Affordable Care Act. 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 the Affordable Care Act and any other applicable law:

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

Note: Screening for hearing loss in newborns is a preventive care service.

In addition to the above guidelines, the Plan covers the following as preventive care services regardless of the Covered Person's age:

- For men and women:
  - abdominal aortic aneurysm screening;
  - cholesterol screening;
  - colorectal cancer screening; and
  - shingles vaccine.
- For women:
  - BRCA testing;
  - cervical cancer screening; and
  - HPV DNA testing.

- For men: prostate screening.
- For children: autism screening.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consultations to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. 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; and
- timing of an acquisition.

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

Benefits for preventive care services will be administered and provided hereunder in accordance with any applicable requirements of the Affordable Care Act.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits is limited to 70 visits per calendar year. One visit equals up to eight hours of Skilled Care services.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type 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.

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before obtaining prosthetic devices that exceed $1,000 in cost per device.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. 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 a changed or improved physical appearance.

Improving or restoring physiologic function means that the 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.

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 the Plan if the initial breast implant followed mastectomy. Other services required 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 other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. The Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before a scheduled Reconstructive Procedures is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification to the Claims Administrator within one business day following such procedure or as soon as is reasonably possible thereafter.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- vision therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), 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. 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 can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary 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, vocational training and Residential Treatment 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.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan 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 Plan 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.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or

Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available 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.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is 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;
- it is ordered by a Physician;
- 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; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification to the Claim Administrator as soon as is reasonably possible.

Substance-Related and Addictive Disorders Services

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

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

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Prior Authorization Requirement
For Non-Network Benefits for blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgeries, cochlear implant and orthognathic surgeries you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received or, for non-scheduled services, within one business day following receipt of such services or as soon as is reasonably possible thereafter.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

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.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For Non-Network Benefits for the following outpatient therapeutic services, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received or, for non-scheduled services, within one business day following receipt of such services or as soon as is reasonably possible thereafter: Dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Provider facility (subject to the exception below for cornea transplants). Benefits are available to the donor and the recipient when the recipient is covered under the Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;

- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (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.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or UnitedHealthcare for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or UnitedHealthcare at the telephone number on your ID card for information about these guidelines.

Prior Authorization Requirement
For Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed by a Designated Provider, Benefits will not be paid.

Travel and Lodging

The Plan may provide you with travel and lodging assistance Benefits. Travel and lodging Benefits are only available for you or your eligible family member if you meet the qualifications for the Benefit, including receiving care at a Designated Provider facility that is beyond a specified distance from your home address, as further described below. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Claims Administrator's 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 Benefits 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 Plan's per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation and lodging Eligible 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 $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.

- Phone calls, newspapers, or movie rentals.

Transportation

Benefits are payable for:

- 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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

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

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

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

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis for:

- loss of hair resulting from treatment of a malignancy or any medical condition with a medical diagnosis; or
- permanent loss of hair due to an accidental Injury.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Anadarko Petroleum Corporation believes in giving you the tools you need to be an educated health care consumer. To that end, Anadarko Petroleum Corporation has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Anadarko Petroleum Corporation are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You, your Spouse and your Dependent children over age 18 are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – the Plan's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Anadarko Petroleum Corporation has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drug Products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, call (855) 583-3161.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Call NurseLine℠ toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

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

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;

- coronary disease and
- bariatric surgery.

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

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium℠ Tier 1 Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk survey to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (855) 583-3161.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

Disease Management Services

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

These programs offer:

- educational materials mailed to your home that provide guidance on managing your

specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;

- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

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

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Medication Management

UnitedHealthcare provides a service called the Medication Therapy Management Report especially for individuals who use multiple medications. This service looks to identify and prevent potential problems which can occur in individuals who use more than one

medication. In order to help you make the most of your medications, a copy of this report is sent to your Physician for review.

Your specific Medication Therapy Management Report includes a list of medications dispensed for you under your pharmacy benefit plan within the past six months. Your Physician is asked to review this report:

- to identify potential drug interactions with the prescription medications that have been prescribed to you;
- to note if more than one medication is serving the same purpose; and
- to determine if a needed medication is missing.

If your Physician identifies any concerns after reviewing the report, he or she may contact you if appropriate.

If you have any questions about any of the information presented in the Medication Therapy Management Report after you receive it please call the number provided on the report.

Wellness Programs

Healthy Back Program

UnitedHealthcare provides a program that identifies, assesses, and supports members with acute and chronic back conditions. By participating in this program you may receive free educational information through the mail and may even be called by a registered nurse who is a specialist in acute and chronic back conditions. This nurse will be a resource to advise and help you manage your condition.

This program offers:

- education on back-related information and self-care strategies;
- management of depression related to chronic back pain; and
- support in choosing treatment options.

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

Maternity Support Program

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

This program offers:

- enrollment by an OB nurse;

- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;
- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

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

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

Wellness Coaching

UnitedHealthcare offers a personalized Wellness Coaching program that can help you identify health risks, set goals and develop personalized strategies that empower you to make positive lifestyle changes to help improve your health and well-being. The one-on-one coaching integrates phone- and mail-based communications with an online interactive health coach on **www.myuhc.com**.

The Wellness Coaching program gives you access to specially trained personal wellness coaches to get you started and provides support that can keep you on track. These certified wellness coaches are cross-trained in multiple wellness concentrations for a more complete coaching experience. You will be assigned one wellness coach at the onset of your program and will be guided by the same coach throughout the program. Through information sharing, the wellness coach will work with you to create a personalized action plan that evolves throughout the program.

Wellness Coaching supports individuals with the following lifestyle issues:

- diabetes;
- exercise;
- heart health;
- nutrition;
- stress management;
- exercise programs;

- tobacco cessation; and
- weight management.

This program is offered at no cost to you or your Dependents. To enroll in the program, call Wellness Coaching toll-free at (800) 478-1057.

Anadarko Advantage – Rally Coins and Thanks! Points Incentive Programs

As part of the "Anadarko Advantage" wellness program, eligible individuals may earn two types of rewards for completing certain designated health-related activities through the Rally Coins and Thanks! Points Incentive Programs.

Eligibility

The following individuals are eligible to sign up and participate in the Rally Coins and Thanks! Points Incentive Programs:

- Any Employee, whether or not enrolled in medical coverage under a Benefit Program of the Plan that is administered by UnitedHealthcare (a "UHC Medical Program"); and
- Any Spouse or Domestic Partner who is enrolled in a UHC Medical Program (Rally Coins incentive only).

Rally Coins Incentive

Rally is an online wellness incentive program administered by UnitedHealthcare.

If you are eligible to participate, you must go to www.myuhc.com (or www.anadarko.werally.com, if you are an Employee who is not enrolled in a UHC Medical Program) and click on the "Rally Health Survey" link to enroll. When using Rally for the first time, you must create a profile online, set up a Rally account and complete a Rally Health Survey. Through the Rally Health Survey, a measure of your overall health (your "Rally age") will be calculated and UnitedHealthcare will identify and recommend particular activities for you (known as "missions") which are designed to help improve your diet, fitness or mood.

You may earn points and "coins" for completing any of the activities for your coverage class listed in the "Thanks! Points Incentive" section below. In addition, you may earn Rally "coins" for performing other activities as described on the Rally website. Please refer to the Rally website to identify the number of Rally "coins" that can be earned per activity. Please note, however, that "private challenges" (as may be described on the Rally website) are not provided for through the Anadarko Advantage – Rally Coins incentive program.

The Rally "coins" that you earn will be reflected on your Rally dashboard on the Rally website. You may spend your Rally "coins" only by entering sweepstakes for prizes, as offered on the Rally website.

Rally "coins" are not taxable. However, if you enter a sweepstakes with Rally coins and win a prize, your prize is taxable. You are solely responsible for any federal, state or local taxes that you owe with respect to any prize that you win.

Thanks! Points Incentive

Thanks! Points is an incentive program administered by Optum. If you are eligible to participate in Thanks! Points, you will automatically be enrolled when you enroll in Rally, as discussed above.

Once you are enrolled, you may earn Thanks! Points when you complete the following (based on whether or not you are enrolled in a UHC Medical Program):

Employee with coverage under a UHC Medical Program:

- Annual physical exam [1] = 1,000 points
- Mammography screening [1] = 1,000 points
- Cervical screening [1] = 1,000 points
- Colorectal cancer screening [1] = 1,000 points
- Rally Health Survey (see above) = 500 points
- Three Rally missions = 500 points
- Biometric screening [2] = 500 points

[1] You will receive your reward for these activities once your provider or an Anadarko Health Center files a medical claim for your annual physical exam or preventive screening.

[2] In order to complete this activity and earn your reward, your health care provider must complete and sign a "Health Provider Screening Form" for you. The form is prepopulated and personalized for each participant to ensure accuracy. You can access the form by clicking "Sign Up" on the "Get Screened" tile on your Rally dashboard and following the prompts. Once downloaded, the form should be taken to your appointment at an Anadarko Health Center or your health care provider's office. Either you or your health care provider may fax the completed form to the number at the bottom of the form.

Employee without coverage under a UHC Medical Program:

- Rally Health Survey (see above) = 500 points
- Rally Health Survey attestation question [3] = 1,000 points
- Three Rally missions = 500 points
- Biometric screening [4] = 500 points

[3] In order to earn points for this activity, when you take the Rally Health Survey, you must answer "yes" when asked whether you have plans to visit your primary care doctor for an annual checkup (or preventive care screening) during the current calendar year. If you do not answer "yes", you will not earn points for this activity, even if you change your answer later.

[4] In order to complete this activity and earn your reward, your health care provider must complete and sign a "Health Provider Screening Form" for you. The form is prepopulated and personalized for each participant to ensure accuracy. You can access the form by clicking "Sign Up" on the "Get Screened" tile on your Rally dashboard and following the prompts. Once downloaded, the form should be taken to your appointment at an Anadarko Health Center or your health care provider's office. Either you or your health care provider may fax the completed form to the number at the bottom of the form.

A maximum of 2,000 Thanks! Points may be earned each calendar year. You may use your Thanks! Points to purchase items, such as electronics, camping gear, gift cards and jewelry, through Anadarko's designated vendor for the Thanks! Points incentive program. Note: Thanks! Points are accumulated in the same account that may be established for you under Anadarko's service award, safety award and/or Employee Excellence award programs.

Four to six weeks following your receipt of any Thanks! Points that you earn, the value of those points will be reported on your paycheck as imputed income, and regular payroll taxes will be withheld.

Participation is Voluntary

Participation in the Rally Coins and Thanks! Points incentive programs is voluntary. If an eligible Employee (or eligible Spouse or Domestic Partner, as applicable) signs up to participate in the Rally Health Survey, he or she will be automatically enrolled in the Rally Coins and Thanks! Points incentive programs. If you do not wish to participate in these program, you should not sign up to participate in the Rally Health Survey. Additional details regarding the terms and conditions of the Rally Coins and Thanks! Points incentive programs are available by contacting Optum at 1-888-512-4093 or visit www.myuhc.com for incentives through Rally.

Applicable Laws

The Wellness Programs are intended to comply with the requirements of applicable law and regulation (which may include, but are not limited to, the Americans with Disabilities Act and the non-discrimination, privacy and security regulations under HIPAA, to the extent each is applicable) and shall be construed and administered accordingly.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN 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 6, *Additional Coverage Details*.

The Plan 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 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. 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 5, *Plan Highlights*. Please review all limits carefully, as the Plan 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 Benefits Booklet says "this includes," or "including but not limited to," it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefits Booklet specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*. **Important note: Additional dental care services are covered under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.**

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded;

2. preventive care, diagnosis or treatment of (or related to) the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided as required by applicable law under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement described under *Preventive Care Services* in Section 6, *Additional Coverage Details*. 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 6, *Additional Coverage Details*;

3. dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*;

Important note: Exclusion #3 does not apply under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*, and

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Important note: Exclusion #6 does not apply under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease;

3. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses; and
   - ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; and

7. oral appliances for snoring.

Drugs

The exclusions listed below apply only with respect to the medical benefits coverage component of the Plan. Coverage of Prescription Drug Products (as defined in Section 15, *Prescription Drug Products*) is provided as a separate component of the Plan, and thus coverage of any of the services or supplies listed below, which are excluded from the medical benefits coverage component of the Plan, may be available under the Prescription Drug Products coverage component of the Plan. See Section 15, *Prescription Drug Products*, for coverage details and exclusions.

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.

5. Growth hormone therapy.

6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up by the Plan Sponsor or its designee to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *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 for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes;

3. treatment of flat feet;

4. treatment of subluxation of the foot; and

5. shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to, compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - urinary catheters;
   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in Section 6, *Additional Coverage Details*.

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

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* in effect on the date that the services were performed.

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 edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* in effect on the date that the services were performed.

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 focused on primarily 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* in effect on the date that the services were performed.

7. Transitional Living services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to lower cholesterol or control diabetes;

- foods to control weight or treat obesity (including liquid diets) even if such foods are part of a structured weight loss program otherwise covered under the Plan;
- oral vitamins and minerals. This exclusion does not apply to vitamins and minerals included under the requirements shown under *Preventive Care Services* in Section 6, *Additional Coverage Details*;
- meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- other dietary and electrolyte supplements; and

3. health education classes unless offered by UnitedHealthcare or its Affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service; and

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

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs except as described under *Obesity Treatment* in Section 6, *Additional Coverage Details*;

4. wigs except as described in Section 6, *Additional Coverage Details*; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations and related services;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity, other than weight loss programs described under *Obesity Treatment* in Section 6, *Additional Coverage Details*; and
    - surgical treatment of obesity except as described under *Obesity Treatment* in Section 6, *Additional Coverage Details*;

15. 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 and dental restorations; and

16. 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 Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. the following infertility treatment-related services:

   - cryo-preservation and other forms of preservation of reproductive materials;
   - long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue; and
   - donor services;

2. in vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility;

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. services provided by a doula (labor aide); and

7. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Provider facility. This exclusion does not apply to cornea transplants; and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, except when required due to an Emergency or Urgent Care need; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses necessary to obtain treatment for Covered Health Services received from a Designated Provider may be reimbursed. In such cases, expenses would be reimbursed as described under *Travel and Lodging* in Section 6, *Additional Coverage Details*. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. 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; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for 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 in the Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

Note: Screening for hearing loss in newborns is covered under *Preventive Care Services* in Section 6, *Additional Coverage Details*.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force 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;
   - that are received after the date your coverage under the Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
   - that exceed Eligible Expenses or any specified limitation in this Benefits Booklet; or
   - for which a non-Network provider waives the Annual Deductible or Coinsurance amounts or with respect to which a non-Network provider does not bill the Covered Person;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. health services and supplies that do not meet the definition of a Covered Health Service (see the definition in Section 14, *Glossary*). "Covered Health Services" are those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be (a) Medically Necessary; (b) included in Section 5 and 6, *Plan Highlight*s and *Additional Coverage Details* described as a Covered Health Service; (c) provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and (d) not identified in Section 8, *Exclusions*.

9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - required solely for purposes of education, sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - 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 6, *Additional Coverage Details*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or 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 Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-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.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a Post-service Claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a Pre-service Claim as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the number on your ID card or visiting **www.anadarkoadvantage.ehr.com**. 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 Employee.

- 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 carrier or provider of the other coverage (for example, your Spouse's employer).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card within 12 months after the date of your service(s) (unless you are legally incapacitated). When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

Important – Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan 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.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay your non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Non-Network Benefits

Subject to the Assignment and Payment of Benefits section, below, UnitedHealthcare will pay any Non-Network Benefits to you, unless you make a written request to UnitedHealthcare at the time you submit your claim for such payment to be made directly to your non-Network provider, in which case, each such payment shall be made on your behalf, and not to such provider in its, his or her own right. Moreover, if any such direct payment is made, it shall not constitute a waiver by the Plan Administrator, the Claims Administrator or the Claims Fiduciary of the anti-assignment provisions of the Assignment and Payment of Benefits section, below. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to you for Benefits under the Plan to the full extent of such payment.

You may not direct UnitedHealthcare to pay your non-Network Benefits to any third party other than your non-Network Provider, as described above.

Form of Payment of Benefits

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

Assignment and Payment of Benefits

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "Plan Agreement"), no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, a non-Network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to or on behalf of a Covered Person. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Covered Person or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan Benefits, (b) request the Plan document or other documents related to the Plan or a claim for benefits, (c) file an appeal of a denied claim for Plan benefits, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Covered Person's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Covered Person and the provider or its representative or agent), the Plan Administrator, Claims Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Covered Person, or to another designated person or entity, with or without the Covered Person's authorization, with each such payment being made on behalf of the Covered Person, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator, Claims Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator, Claims Administrator or Claims Fiduciary of the anti-assignment provisions of this section. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Covered Person for benefits under the Plan to the full extent of such payment. Accordingly, if a provider is overpaid as the result of accepting a payment for the same Covered Health Services from you and from the Plan, then the provider, and not the Plan, shall be responsible for reimbursing you for such overpayment. Disclosures of information about the Covered Person can only be made to a Covered Person or a Covered Person's authorized representative and in accordance with applicable law and the terms of the Plan.

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.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

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 14, *Glossary* for the definition of Explanation of Benefits.

Claim Denials and Appeals

Types of Claims

There are four different types of claims under the Plan: Urgent Care Claims, Pre-service Claims, Post-service Claims and Concurrent Care Claims.

- an "Urgent Care Claim" is a claim for medical care or treatment with respect to which the time frames for making non-urgent care determinations either: i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or ii) in the opinion of a Physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The person acting on behalf of the Plan shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine to determine if a claim is an Urgent Care Claim. Notwithstanding the above, any claim that a Physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim, as defined above, shall be treated as an Urgent Care Claim.
- a "Concurrent Care Claim" is any claim after the Plan has approved an ongoing course of treatment to be provided over a period of time that involves a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period or course or number of treatments or any request by or on behalf of the claimant to extend such treatment or expand the number of treatments.
- a "Pre-Service Claim" is any claim for Benefits under the Plan for which the Benefit is conditioned on obtaining approval or authorization prior to obtaining the medical care.
- a "Post-Service Claim" is any claim for Benefits under the Plan that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you will receive a written notice of the denial that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

If your claim for Benefits is denied, you may call UnitedHealthcare at the number on your ID card to try to resolve the issue before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, in order to preserve your rights under federal law you must file a formal appeal as described below.

To the extent required by applicable law, the Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-service Claim, 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 do not need to submit Urgent Care Claim appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

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

For Urgent Care Claims that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care Claim;
- Pre-service Claim;
- Post-service Claim; or
- Concurrent Care Claim.

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; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

The appeal will not give deference to the initial denial.

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 that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, in order to preserve your rights under federal law, you must 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, documents and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the denial of your appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

Before the Plan can deny your appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the denial of your

appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

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 that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Federal External Review Program

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:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- 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 toll-free 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; and
- 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; and

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

Expedited External Review

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

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; or
- 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 Plan at the time the health care service or procedure that is at issue in the request was provided; and
- 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 anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at 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.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The types of claims are described above under the heading *Types of Claims*.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

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.

The tables below describe the time frames which you and UnitedHealthcare are required to follow. The timeframes applicable to Concurrent Care Claims are described in a separate section below, under the heading *Concurrent Care Claims*.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving the request for additional information

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If UnitedHealthcare denies your initial claim, they must notify you of the denial within: ■ if the initial claim is complete: ■ after receiving the completed claim (if the initial claim is incomplete):	**72 hours** **72 hours** **48 hours**
If UnitedHealthcare denies your claim, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care Claim.

Pre-Service Claims*	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, UnitedHealthcare must notify you within:	**5 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving the request for additional information
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within: ■ after receiving the completed claim (if the initial claim is incomplete), within:	**15 days*** **15 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

Pre-Service Claims*	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days for its initial claim determination if more time is needed due to circumstances beyond control of the Plan. In that case, UnitedHealthcare will notify you prior to the initial 15-day decision timeframe of the circumstances which require the extension of time and the date by which UnitedHealthcare expects to render its decision on your claim.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice
If UnitedHealthcare denies you initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days***
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control, provided that within the initial 15 days, they notify the claimant of the circumstances requiring the extension and the date by which they expect to render a decision.

Concurrent Care Claims

In the event UnitedHealthcare determines to reduce or terminate a course of treatment or a series of treatments, the affected individual will be notified in writing of the intended termination or reduction (the adverse benefit determination) sufficiently in advance of the reduction or termination so that the affected individual may appeal the adverse benefit determination. Any decision on the appeal of the adverse benefit determination on the reduction or termination must be rendered before the reduction or termination of the care or course of treatment.

If UnitedHealthcare receives a request to extend care that is an Urgent Care claim, UnitedHealthcare must render a decision within 24 hours of receipt of the claim, provided the claim is received at least 24 hours before care is scheduled to expire. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

UnitedHealthcare shall render a decision on the appeal of a Concurrent Care Claim to extend care within the time period applicable to an appeal of an Urgent Care Claim, Pre-Service Claim or Post-Service Claim described above, respectively, depending upon whether the claim is also defined as an Urgent Care Claim, a Pre-Service Claim or a Post-Service Claim.

Limitation of Action

You cannot for any reason bring any action at law or in equity to recover benefits under the Plan unless you first complete all the steps in the appeals process described in this section. Any action at law or in equity with respect to any and all claims relating to the Plan (including against Anadarko Petroleum Corporation, the Plan Administrator or the Claims Administrator) must be brought for recovery within one year from the earlier of (1) the date of a final internal adverse benefit determination, if applicable, or (2) the accrual of any claim under or relating to the Plan that does not result in a final internal adverse benefit determination. Otherwise, you lose any rights to bring such an action.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:
- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one 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 (subject to the "Note" in the section entitled *Determining Which Plan is Primary*, below).
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided 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 paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans (including this Plan), the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. 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; or
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- 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 not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

Note: The Plan does not automatically coordinate with auto liability or no-fault insurance coverage; however, the subrogation and recovery provisions of Section 11, Subrogation and Reimbursement, may apply to a Covered Person's right to Benefits under the Plan.

The following examples illustrate how the Plan 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 employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

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. This Plan 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

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

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

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

Determining the Allowable Expense If 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 a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.

- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts assignment of your Medicare benefits with respect to his, her or its services. If the provider accepts such assignment, 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 with respect to his, her or its services, the Medicare limiting charge (the most that such providers can charge you if they don't accept Medicare assignments – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

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

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

Medicare Crossover Program

The Plan 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 Plan 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 this Plan 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 this Plan.

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 go on 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 this Plan and other plans. UnitedHealthcare 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 this Plan and other plans covering the person claiming Benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this; provided, however, that any such use or disclosure of your information will be only as permitted by applicable privacy and security laws, including the privacy and security regulations issued under HIPAA. Each person claiming Benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine Benefits payable. If you do not provide UnitedHealthcare 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 a Covered Person is covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Covered Person or to (i) a health care or other services provider (including a Covered Person's assignee as described under *Assignment and Payment of Benefits* in Section 9, *Claims Procedures*), (ii) an insurance company or (iii) any other person or entity, for the benefit of a Covered Person (collectively, a "Third-Party Payee"), such erroneously-paid amount shall constitute an "Overpayment" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Covered Person or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount (Overpayment Reimbursement). Without limitation, the Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA and shall be construed accordingly. By accepting a benefit, premium or fee under the Plan, each Covered Person and Third-Party Payee automatically acknowledges and agrees that the Plan has the right to pursue Overpayment Reimbursement from the general assets of the Covered Person or Third-Party Payee to whom the Overpayment was made, to the full extent permitted by ERISA.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Covered Person (including, without limitation, to a covered Employee on behalf of any of his or her Dependents or beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable on behalf of the Covered Person, or (b) recouped by any other method which the Plan Administrator or

Claims Fiduciary, as applicable, deems to be appropriate in its discretion, to the extent permitted by law.

The Plan or the Company may obtain Overpayment Reimbursement in the form of an offset against salary or wages (if the Covered Person is an Employee) or against benefits payable to or on behalf of the Covered Person under any Company-sponsored benefit plans, including, but not limited to the Plan (but not a qualified pension plan as defined by ERISA and the Internal Revenue Code), to the extent permissible under applicable law and the terms of the applicable benefit plan. For example, the selected recovery method may include, without limitation, payroll deduction in the case of an Employee or his/her Dependent or beneficiary (in which case the Employee must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his or her participation, or continued participation, in the Plan). Furthermore, the Plan Sponsor and the Plan each reserve the right to obtain Overpayment Reimbursement by legal action.

If the Plan overpays a Third-Party Payee that is a Covered Person's health care provider (for purposes of this *Overpayment and Underpayment of Benefits* section only, a "**Provider**"), then, in addition to the recovery actions permitted under the preceding paragraphs of this section, the Company and the Plan reserve the right to obtain Overpayment Reimbursement from the Provider pursuant to *Refund of Provider Overpayments*, below.

Refund of Provider Overpayments

If the Plan pays Benefits to a Provider for expenses incurred by or on account of a Covered Person, that Covered Person or Provider must make a refund to the Plan if:

- the Plan's obligation to pay the Benefits was contingent on the Covered Person's actual payment of the expenses or legal obligation to pay the expenses, and either some or all or some of the expenses were not paid by the Covered Person or the Covered Person had no legal obligation to pay the expenses;
- all or some of the payment made by the Plan exceeded the Benefits payable under the terms of the Plan; or
- all or some of the payment made by the Plan was made in error, according to the terms of the Plan.

The Overpayment amount that must be refunded to the Plan equals the amount the Plan paid in excess of the amount that was properly payable under the terms of the Plan. If such Overpayment refund is due from the Provider, the Covered Person agrees to reasonably assist the Plan in obtaining Overpayment Reimbursement when requested. If the Covered Person or Provider does not promptly refund the full amount of the Overpayment within a reasonable time period as determined by the Plan Administrator, the Plan may obtain Overpayment Reimbursement by (i) reallocating the Overpayment as an offset, in whole or in part, against future Benefits that are payable to or on behalf of the Covered Person under the Plan; or (ii) recouping the Overpayment by any other method which the Plan Administrator or Claims Fiduciary deems appropriate in its discretion, to the extent permitted by law, with the understanding that the reallocated or otherwise recouped payment will be reimbursed to the Plan. The amount of such payment will equal the amount

of the Overpayment required to be refunded or, if less than the full amount of the required refund, will be deducted from the full amount of the refund owed to the Plan.

In the event of a Provider Overpayment, the Plan and the Company may have other legal rights to obtain Overpayment Reimbursement, in addition to the right to reallocate or otherwise recoup Overpayment amounts as enumerated above, including the right to commence a legal action to obtain Overpayment Reimbursement.

In the case of any Overpayment reallocation or other recoupment action described in this *Overpayment and Underpayment of Benefits* section, any such reallocation or recoupment against a payment to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to the ERISA claims and appeals procedures of the Plan. For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this section, the offset or other recoupment of the Overpayment hereunder is simply an adjustment to the amount owed to the Third-Party Payee to reflect the Overpayment to the Third-Party Payee and shall not be considered to be the denial or partial denial of any Benefit claim under the Plan.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The provisions of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable, will govern and control the Plan's rights to subrogation and reimbursement. These provisions are summarized in this section. Should there be any conflict between these subrogation and reimbursement provisions and those of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, the provisions in the applicable wrap-around Summary Plan Description will govern. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent permitted by applicable law as determined by the Plan Administrator.

Right of Subrogation and Reimbursement

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this section on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this section on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

Benefits Subject to this Provision

The provisions set forth in this section will apply to all benefits provided under the Plan. For purposes of this section, certain terms are defined as follows:

- **"Recovery"** means any and all monies and property paid by a Third Party to (i) the Covered Person, (ii) the Covered Person's attorney, assign, legal representative, or beneficiary, (iii) a trust of which the Covered Person is a beneficiary, or (iv) any other person or entity on behalf of the Covered Person, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the Injury or illness.
- **"Reimbursement"** means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Covered Person toward care and treatment of the Injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.
- **"Subrogation"** means the Plan's right to pursue the Covered Person's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.
- **"Third Party"** means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Covered Person's Injury or illness. The term "Third Party" will include the party or parties who caused the Injury or illness; the insurer, guarantor or

other indemnifier or indemnitor of the party or parties who caused the Injury or illness; a Covered Person's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the Injury or illness.

When this Provision Applies

A Covered Person may incur medical or other charges related to any Injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the Injury or illness. If so, the Covered Person may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Covered Person has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Covered Person receives the Recovery or (b) the Covered Person's attorney, a trust of which the Covered Person is a beneficiary, or other person or entity receives the Recovery on behalf of the Covered Person. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Covered Person hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any Injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this section.

The Plan's equitable lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures, or may be entitled to procure, regardless of whether the Covered Person has received compensation for any or all of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Covered Person's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this section, and the Covered Person hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Covered Person:

- authorizes the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Covered Person's rights to Recovery when the provisions of this section apply;
- must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- must cooperate fully with the Plan in its exercise of its rights under this section, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Covered Person who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to the subsection *When a Covered Person Retains an Attorney* below, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this section (**S&R Agreement**).

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injury or illness. The Plan may file a copy of an S&R Agreement signed by the Covered Person and his or her attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Covered Person (and his or her attorney, as applicable), a Covered Person's claim for any medical or other benefits for any Injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Covered Person, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Covered Person's claim for benefits for the Injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injury or illness before an S&R Agreement

and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Covered Person who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Covered Person is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Covered Person automatically agrees, without further notice, to all the terms and conditions of this section and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this section and to make changes in its interpretation as it deems necessary or appropriate.

Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Covered Person receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Covered Person may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his or her charges and expenses.

When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or Injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this section.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses incurred are related to an illness or Injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Covered Person has already received a

Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, the Plan will not pay any portion of the Covered Person's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Covered Person's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Covered Person's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his or her pursuit of Recovery.

Any Recovery paid to the Covered Person's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Covered Person nor his or her attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

When the Covered Person is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent

The provisions of this section will apply to the parents, trustee, guardian or other representatives of a minor Dependent child and to the heirs or personal representatives of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this section, the term "Covered Person" will also include a COBRA qualified beneficiary who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Covered Person whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor (e.g., a full-time post-secondary student) and, in such event, the Employee will be liable for any breach of this section by the Employee or by such Dependent.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Covered Person and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce the provisions of this section, the Covered Person will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan 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.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Company ends;
- the date the Plan ends or is amended to eliminate your coverage;
- the date of your death;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the last day of the month you are no longer eligible to participate in the Plan (except that coverage may be continued until the last day of the month through which you are receiving disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan or have been certified as disabled by the Company's long-term disability insurance carrier for purposes of being eligible to receive income replacement payments under such disability insurance policy, unless such coverage is terminated earlier);
- the date, if any, on which you falsify information provided to the Plan, fraudulently or deceptively use Plan services or knowingly permit such fraud or deception by another person, including enrolling a person as a Spouse or other Dependent who does not qualify as a Dependent under the terms of the Plan;
- the last day of the month in which you complete six months of unpaid leave of absence; or
- if you are receiving long term disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan, the last day of the month in which you elect to receive your full distribution from the Anadarko Retirement Plan or the Kerr-McGee Corporation Retirement Plan.

See the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan for a complete description of when a Retired Employee's coverage ends under the Group Health Benefit of the APC Retiree Health Benefits Plan.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date on which the Plan is amended to eliminate coverage for the Dependent, for whatever reason;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the date the Dependent becomes covered under the Plan as an Employee;
- the date, if any, on which the Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person;
- the date Dependents' coverage ceases to be available to the Employee;
- the date on which an Employee elects to terminate coverage for his or her Dependent, provided that you notify Anadarko Petroleum Corporation of the intention to terminate coverage within 30 days prior to the date; or
- the last day of the calendar year in which a Dependent child ceases to be an eligible Dependent under the Plan; or the last day of the month in which any other Dependent ceases to be an eligible Dependent under the Plan.

Other Events Ending Your Coverage

If a Covered Person commits an act, practice, or omission that constitutes fraud, or makes 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, such Covered Person's coverage may be subject to rescission as permitted under the Affordable Care Act. In that case, the Plan will provide the Covered Person with a written notice as required by the Affordable Care Act which informs him or her of the date that his or her coverage will end; provided, however, the Covered Person will have the right to appeal any such rescission pursuant to the Plan's claim and appeal procedures, and his or her Plan coverage will remain in effect pending the outcome of any internal appeal under such procedures.

For purposes of the above, if the Covered Person is a Dependent, a failure by the covered Employee to provide timely notice to the Plan Administrator (or its designee) in accordance with the required notification procedures in this Benefits Booklet or the wrap-around Summary Plan Description of the APC Health Benefits Plan of an event that causes such Dependent to lose eligibility for coverage under the Plan shall be deemed to constitute an intentional misrepresentation of a material fact, in which case such Dependent's coverage may be subject to rescission as permitted under the Affordable Care Act.

Note: If a Covered Person's coverage is rescinded, the Plan Sponsor reserves the right to demand the repayment by such Covered Person of any Benefits paid to him or her (or paid in his or her name, or on his or her behalf) under the Plan following the effective date of his or her coverage rescission, as provided in Overpayment and Underpayment of Benefits in Section 10, Coordination of Benefits (COB).

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 Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability rendering the child medically incapacitated and unable to be self-supporting;
- the child depends mainly on you for support and resides with you for more than one-half of the year;
- either 1) you provide to Anadarko Petroleum Corporation proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age or 2) the child has such handicap or disability and is over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll in such coverage (i.e., the child cannot later be added to coverage under the Plan); and
- you provide proof, upon Anadarko Petroleum Corporation's request, that the child continues to meet these conditions.

The proof might include medical examinations at Anadarko Petroleum Corporation's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 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 Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available if the Plan is subject to the terms of COBRA. You can contact your Plan Administrator to determine if the Plan is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator 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 Plan on the day before a qualifying event:

- an Employee;

- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's enrolled Spouse (or former Spouse).

A Domestic Partner, or the children of a Domestic Partner, who are covered under the Plan on the day prior to the qualifying event shall be treated as Qualifying Beneficiaries under the Plan, although such treatment is not a right required by COBRA.

A Retired Employee is not eligible to elect COBRA continuation coverage upon termination of his or her coverage under the Plan. However, for purposes of this section and a Spouse's or Dependent's eligibility to elect COBRA continuation coverage, a Retired Employee is considered a covered Employee.

Qualifying Events for Continuation Coverage under COBRA

The following table 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	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage because your employment terminates or your hours are reduced[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate) or dissolve a 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

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You become entitled to Medicare	N/A	See table below	See table below
Anadarko Petroleum Corporation files for bankruptcy under Title 11, United States Code[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within 60 days after the latest of a) the determination of the disability, b) the date of the qualifying event, or c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2] This is a qualifying event for any Retired Employee 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.

[3] From the date of the Employee's death if the Employee dies during the continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your Spouse and/or Dependent children in your family can get additional months of COBRA continuation coverage, up to the maximum of 36 months. This extension is available to your Spouse and/or Dependent children if you die, enroll in Medicare (Part A, Part B, or both), or get divorced or legally separated, or dissolve a Domestic Partnership. The extension is also available to a dependent child when that child stops being eligible under the Plan as a Dependent. In all of these cases you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

*Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, dissolution of Domestic Partnership or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation, dissolution of Domestic Partnership or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- 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 Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Anadarko Benefits Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage

elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

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 a Qualified Beneficiary first becomes entitled to Medicare (for this purpose, "entitled to Medicare" means enrolled in either Part A or Part B of Medicare);
- the last day of the month for which the required premium payments have been made, if such payments are not made timely;
- the later of the date the entire Plan ends or Anadarko Petroleum Corporation ceases to maintain a group health plan within its controlled group;
- in the case of a disabled Qualified Beneficiary (and his or her disabled or non-disabled family members) receiving COBRA coverage under the 11-month disability extension described in the chart above, and with respect to such extension, the first day of the month that begins more than 30 days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include

the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Anadarko Petroleum Corporation;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator 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 Plan as your Dependent, and the Plan 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 Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Anadarko Petroleum Corporation

In order to make choices about your health care coverage and treatment, Anadarko Petroleum Corporation believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan 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 Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefits Booklet); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Anadarko Petroleum Corporation and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Anadarko Petroleum Corporation and UnitedHealthcare may use individually identifiable information about you as permitted or required by law, including in operations and in research. Anadarko Petroleum Corporation and UnitedHealthcare may use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Anadarko Petroleum Corporation, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Anadarko Petroleum Corporation's agents or employees, nor are they agents or employees of UnitedHealthcare. Anadarko Petroleum Corporation 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.

Anadarko Petroleum Corporation and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Anadarko Petroleum Corporation and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare'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 Anadarko Petroleum Corporation's employees nor are they employees of UnitedHealthcare. Anadarko Petroleum Corporation and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Anadarko Petroleum Corporation and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Anadarko Petroleum Corporation is solely responsible for funding the payment of Benefits on a timely basis through its general assets. The Plan Administrator is solely responsible for (a) determining and administering enrollment (and disenrollment) in the Plan, and (b) notifying you of the termination of, or modifications to, the Plan as required by ERISA.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a Covered Person's responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.

- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- 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).
- Must decide with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

Interpretation of Benefits

The Plan Administrator has delegated to UnitedHealthcare, in its capacity as the Claims Administrator and Claims Fiduciary, the sole discretion and authority to (a) interpret the terms, conditions, limitations and exclusions of the Plan, including this Benefits Booklet and any amendments thereto, and (b) make factual determinations under the Plan, for the purpose of making final decisions regarding Benefits payable under the Plan. All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal procedures of the Plan. Benefits under the Plan will be paid only if UnitedHealthcare determines in its discretion that the Covered Person is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination or action by any court. Any review of any such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

Information and Records

All uses and disclosures of your protected health information (as defined by the HIPAA privacy regulations, *i.e.*, "**PHI**") or any other individually identifiable information about you, as discussed in this Benefits Booklet, including this Section, shall be as permitted by, and in accordance with, applicable law, including the HIPAA privacy regulations.

Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare may use your PHI to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. In addition, UnitedHealthcare may request additional information from you to decide your claim for Benefits. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare will keep this information confidential. Anadarko Petroleum Corporation and UnitedHealthcare may also use your de-identified data for commercial purposes, including research.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you, to the extent permitted by applicable law. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time for any permitted purpose under applicable law. This

applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Anadarko Petroleum Corporation is required to do by law or regulation. During and after the term of the Plan, Anadarko Petroleum Corporation and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Anadarko Petroleum Corporation recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.
In some cases, Anadarko Petroleum Corporation and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designated persons or entities will be required to use or disclose your information only as permitted by applicable law, including the HIPAA privacy regulations.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Anadarko Petroleum Corporation recommends that you discuss participating in such programs with your Physician. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Anadarko Petroleum Corporation and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Anadarko Petroleum Corporation and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend the Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Code or ERISA, or any other reason. A Plan amendment may transfer coverage to another plan or split a plan into two or more parts. If the Company does amend or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

If the Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on the terms of the Plan and may also depend on any contract provisions affecting the Plan and Company decisions.

Plan Document

This Benefits Booklet describes certain terms of your Benefits under the Plan. When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet, or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including

this Benefits Booklet. If there should be an inconsistency between the contents of this Benefits Booklet and the contents of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, your rights shall be determined as provided in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. A copy of the documents that constitute the Plan is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your authorized representative) may obtain a copy of these documents by written request to the Plan Administrator or its designee, for a nominal charge.

UnitedHealthcare Reimbursement Policies

UnitedHealthcare, as Claims Administrator and Claims Fiduciary, determines Eligible Expenses under the Plan in accordance with the applicable terms and conditions of coverage under the Plan, which include UnitedHealthcare's applicable reimbursement policies. To the extent required by ERISA, such policies are incorporated into the SPD and the Plan by reference. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies and the other applicable terms of the Plan are applied to provider billings. Network Physicians and providers are not permitted to bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because the Plan, including one of UnitedHealthcare's reimbursement policies, does not provide for reimbursement or payment (in whole or in part) for the amount that the provider billed for the service(s) rendered to you.

UnitedHealthcare shares its reimbursement policy guidelines with Network Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. You (or your authorized representative on your behalf) may also obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefits Booklet.

Many of the terms used throughout this Benefits Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefits Booklet, but it does not describe the Benefits provided by the Plan.

Affiliates – those entities (including, but not limited to, United Resource Networks) which are affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare's ultimate corporate parent, including direct and indirect subsidiaries.

Affordable Care Act – the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

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; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

Annual Enrollment – the period of time, determined by Anadarko Petroleum Corporation, during which eligible Employees may enroll themselves and their Dependents under the Plan. Anadarko Petroleum Corporation determines the period of time that is the Annual Enrollment period.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- in vitro fertilization (IVF);

- gamete intrafallopian transfer (GIFT);
- pronuclear stage tubal transfer (PROST);
- tubal embryo transfer (TET); and
- zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorders – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The BRS program provides:

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

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any amendments thereto.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its Affiliates, as designated by the Plan Administrator to provide certain claim and other administration services for the Plan.

Claims Fiduciary – UnitedHealthcare (also known as United HealthCare Services, Inc.), as designated by the Plan Administrator to make appeal determinations on all first and second levels of appeal (i.e., all internal appeals) regarding claims under the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Anadarko Petroleum Corporation.

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.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

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

- Medically Necessary;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefits Booklet are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- 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; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Network Benefits – if the Plan has a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that the Claims Administrator has identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not the Plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a 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 specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not related by blood or adoption;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- not be legally married to each other (in other words, the other person is not the Spouse of the Employee);
- be at least 18 years old;
- live together in a committed, monogamous relationship at the same place of residence for at least six months; and
- intend for their relationship to be continuous and of an indefinite duration.

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:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are (i) incurred by a Covered Person while the Plan is in effect and (ii) determined by UnitedHealthcare to be payable as Benefits under the Plan, in accordance with the provisions below and the "Eligible Expenses" provisions of Section 3, *How the Plan Works*.

The Plan Administrator has delegated to UnitedHealthcare in its capacity as the Claims Administrator and Claims Fiduciary, the discretion and authority to (a) decide whether a

treatment or supply is a Covered Health Service, (b) formulate the methods by which Eligible Expenses will be determined in accordance with the terms of the Plan, and (c) determine Eligible Expenses that are payable as Benefits under the Plan.

Eligible Expenses are determined solely in accordance with the applicable terms and conditions of coverage under the Plan, which include UnitedHealthcare's applicable reimbursement policies (as described in Section 13, *Other Important Information*). UnitedHealthcare develops the reimbursement policy guidelines, in its discretion, in accordance with one or more of the following methodologies:

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

Emergency – a medical condition manifesting 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 to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- a medical screening examination (as required under section *1867 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; and
- 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 *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee – a regular employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Anadarko Petroleum Corporation.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

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

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, Phase II or Phase 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 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described in Section 6, *Additional Coverage Details*, 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) – a statement provided by UnitedHealthcare 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 Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Fertility Solutions (FS) – a program administered by UnitedHealthcare or its affiliates made available to you under the Plan as provided in this Benefits Booklet. The FS program provides:

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

FS – see Fertility Solutions (FS).

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(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which 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 Disorder, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- 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 Skilled Nursing Facility, convalescent home or similar institution.

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 Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment – a structured outpatient Mental Health or Substance-related and Addictive Disorder treatment program that may be free-standing 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; or
- 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.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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 – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-related and Addictive Disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, Substance-related and Addictive Disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- 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 society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator – the organization or individual designated by Anadarko Petroleum Corporation who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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 or with its Affiliate to participate in the 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 Shared Savings Program.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care 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 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.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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 Plan.

To the extent an item or service is otherwise a Covered Health Service under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment or setting for an item or service, the Plan shall not discriminate based on a health care provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require the Plan to accept all types of providers into a Network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

Plan – The Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan or the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet, or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet.

Plan Administrator – Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee.

Plan Sponsor – Anadarko Petroleum Corporation.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Private Duty Nursing – shift or continuous nursing care that encompasses nursing services for Covered Persons who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Private Duty Nursing services are provided where longer durations of skilled nursing care are required and may include shift care or 24/7 continuous care in certain settings. Private Duty Nursing care is not care provided primarily for the convenience of the Covered Person.

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 Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an individual who, as of the date immediately preceding the individual's date of retirement, was enrolled as an active Employee in either the Anadarko Petroleum Corporation Health Benefits Plan (or its predecessor plan maintained by the Plan Sponsor) or a major medical, group health plan sponsored by another company on the date of such company's acquisition by the Company.

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 – UnitedHealthcare program under which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a scheduled rate previously agreed to by the non-Network provider with UnitedHealthcare (Scheduled Rate). When a discount is obtained based on the Scheduled Rate you may experience a lower amount of out-of-pocket expenses. The Plan's Coinsurance and Deductible would still apply to the reduced charge. Notwithstanding the foregoing, sometimes other Plan provisions regarding the basis for determining Eligible Expenses with respect to a non-Network provider's charges conflict with the Scheduled Rate, in which case a rate other than the Scheduled Rate may be applied by UnitedHealthcare as contractually permitted and in accordance with the "Eligible Expenses" subsection of Section 3, *How the Plan Works*, in order to determine Eligible Expenses. In that case, the non-Network provider may bill you for the difference between his or its billed amount and the amount of Eligible Expenses so determined by UnitedHealthcare. If this happens, you should call the number

on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this Benefits Booklet does not include Mental Illness or Substance-related and Addictive Disorders, regardless of the cause or origin of the Mental Illness or Substance-related and Addictive Disorder.

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 dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a 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 Plan.

SPD – the complete Summary Plan Description of the APC Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the APC Health Benefits Plan and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet), or the complete Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan and any appendices attached thereto, as they relate to the HDHP Choice Plus Plan, including this Benefits Booklet), as applicable.

Spouse – a person to whom you are lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, without limitation, the Code, ERISA, and Affordable Care Act), and any regulations promulgated under such applicable federal law, but will not include an individual divorced from you under a court-approved divorce decree. The term "Spouse" will also include a common law spouse if you and your spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. You must provide proof of a ceremonial or common law marriage if requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state. For purposes of this Benefits Booklet, the term "Spouse" will also include a Domestic Partner, as defined in this section, unless the context indicates otherwise.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of Substance-related and Addictive Disorders that are listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded pursuant to Section 8, *Exclusions*. 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.

Substance-related and Addictive Disorder - a maladaptive pattern of substance use, including alcoholism, leading to clinically significant impairment or distress, as defined in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program℠ – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

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 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 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 at an Urgent Care Center. This definition of "Urgent Care" is not applicable for purposes of classifying an "Urgent Care Claim" under the Plan's claims and appeals procedures; see instead *Claim Denials and Appeals, Types of Claims* under Section 9, *Claims Procedures* for the applicable definition of "Urgent Care Claim".

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.

SECTION 15 - PRESCRIPTION DRUG PRODUCTS

What this section includes:

- Benefits available for Prescription Drug Products;
- How to utilize the retail and mail order service for obtaining Prescription Drug Products;
- Any benefit limitations and exclusions that exist for Prescription Drug Products; and
- Definitions of terms used throughout this section related to the Prescription Drug Products portion of the Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Products benefits. It includes Copay amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

Covered Health Services[1,2]	**Your Copayment Amount**[3]	
	Network	**Non-Network**
Retail - up to a 30-day supply[4,5]	After you meet the Annual Deductible:	After you meet the Annual Deductible:
■ Tier 1	$3 Copay	$3 Copay
■ Tier 2	20% of the Prescription Drug Charge but not less than $20 and not more than $200	20% of the Out-of-Network Reimbursement Rate but not less than $20 and not more than $200
■ Tier 3	30% of the Prescription Drug Charge but not less than $20 and not more than $200	30% of the Out-of-Network Reimbursement Rate but not less than $20 and not more than $200
■ Tier 4 (includes all Specialty Prescription Drugs)	$67 Copay	$67 Copay

Covered Health Services[1,2]	Your Copayment Amount[3]	
	Network	**Non-Network**
Mail order - up to a 90-day supply[4]	After you meet the Annual Deductible:	
■ Tier 1	$6 Copay	Not Covered
■ Tier 2	20% of the Prescription Drug Charge but not less than $40 and not more than $200	Not Covered
■ Tier 3	30% of the Prescription Drug Charge but not less than $40 and not more than $200	Not Covered
■ Tier 4 (includes all Specialty Prescription Drugs)	$67 Copay	Not Covered

[1]You must obtain prior authorization from UnitedHealthcare to receive full Benefits for certain Prescription Drug Products. Otherwise, you may pay more out-of-pocket. See *Prior Authorization Requirements* in this section for details.

[2]You are not responsible for paying a Copayment or Coinsurance for Preventive Care Medications.

[3]If you choose not to substitute a lower-tiered drug for a chemically equivalent higher-tiered drug, you will pay the cost difference between the two drugs, in addition to the higher-tiered drug's Copayment or Coinsurance. This difference in cost is called an Ancillary Charge. See *Prescription Drug Products that are Chemically Equivalent* and the definition under *Glossary – Prescription Drug Products* in this section for details.

[4]Specialty Prescription Drugs are limited to a 30-day supply.

[5]Up to a 90-day supply of a retail-purchased Prescription Drug Product is available. For a 31-60-day supply, the Copay shown above will be doubled. For a 61-90-day supply, the Copay shown above will be tripled.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this Benefits Booklet.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy and then submit a manual claim for Benefits to:

Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier 1, tier 2, tier 3 and tier 4 Prescription Drug Products. All Prescription Drug Products covered by the Plan are categorized into these four tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier 1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier 1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier 2 is your middle Copay/Coinsurance option. Consider a tier 2 drug if no tier 1 drug is available to treat your condition.
- Tier 3 and Tier 4 are your highest Copay/Coinsurance options. The drugs in tier 3 and tier 4 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

Note: Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:

- The applicable Copayment and/or Coinsurance; or
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay or Coinsurance; or
- the Prescription Drug Charge for that particular Prescription Drug Product.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail Pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drug Products:

- as written by a Physician;
- up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. (***Note:*** You may obtain up to a 90-day supply if you pay a Copay for each 30-day supply);
- when a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drug Products :

- as written by a Physician; and

- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Products portion of the Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Assigning Prescription Drug Products to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug Product placement in tiers. In its evaluation of each Prescription Drug Product, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug Product; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Product benefit.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

The Plan may also require you to obtain prior authorization from UnitedHealthcare so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

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

Non-Network Pharmacy Prior Authorization

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

If UnitedHealthcare has not provided prior authorization before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug Product order or refill. You will be required to pay for the Prescription Drug Product at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Product Charge) will not be available to you at a non-Network Pharmacy. If UnitedHealthcare has not provided prior authorization before you purchase the Prescription Drug Product, you can request reimbursement after you receive the Prescription Drug Product - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge

(for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge and any Deductible that applies.

To determine if a Prescription Drug Product requires prior authorization, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drug Products requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the toll-free number on your ID card.

Prescription Drug Product Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drug Products are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug Product has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change and an Ancillary Charge may apply. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug Product is assigned.

Prescription Drug Products that are Chemically Equivalent

If two drugs are chemically equivalent (they contain the same active ingredient) and you choose not to substitute a lower-tiered drug for the higher-tiered drug, you will pay the difference between the higher-tiered drug and the lower-tiered drug, in addition to the higher-tiered drug's Copayment or Coinsurance. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is chemically the same available at a lower tier. An Ancillary Charge will not apply when a covered Prescription Drug Product is dispensed at your Physician's request if the prescription indicates to "dispense as written" (DAW).

Special Programs

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

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced benefit, or no benefit, based on whether the Prescription Drug Product was prescribed by a specialist physician. You may access information on which Prescription Drug Products are subject to benefit enhancement, reduction or no benefit through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Rebates and Other Discounts

UnitedHealthcare and Anadarko Petroleum Corporation may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays and Coinsurance.

The Claims Administrator and a number of its Affiliates, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Product section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Product section. The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician or your pharmacy that communicate a variety of messages, including information about Prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drug Products are excluded.

Medications that are:

1. for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

2. any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drug Products*) portion of the Plan;

   This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

5. compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to

Tier-3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product;

6. dispensed outside of the United States, except when required due to an Emergency or Urgent Care need;

7. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

8. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition;

9. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;

10. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;

11. certain Prescription Drug Products that have not been prescribed by a specialist physician;

12. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

13. prescribed, dispensed or intended for use during an Inpatient Stay;

14. Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that UnitedHealthcare (and Anadarko Petroleum Corporation, for purposes other than claims decisions) determines do not meet the definition of a Covered Health Service;

15. a Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product, as determined by UnitedHealthcare. In its discretion, UnitedHealthcare may make such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

16. a Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product, as determined by UnitedHealthcare. In its discretion, UnitedHealthcare may make such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

17. certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, as determined by UnitedHealthcare, unless otherwise required by law or approved by UnitedHealthcare. In its discretion, UnitedHealthcare may make such determinations up to six times during a calendar year, and UnitedHealthcare may

decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

18. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

19. unit dose packaging of Prescription Drug Products;

20. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Anadarko Petroleum Corporation have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

21. used for cosmetic purposes;

22. Prescription Drug Product as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed;

23. certain Prescription Drug Products for smoking cessation;

24. dental products, including but not limited to prescription fluoride topicals;

25. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

26. any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury;

27. medications used for cosmetic purposes; and

28. a Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

Glossary - Prescription Drug Products

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request,

when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or MAC List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Out-of-Network Reimbursement Rate or MAC List price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Out-of-Network Reimbursement Rate or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier.

Brand-name - a Prescription Drug Product that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Prescription Drug Products.

Generic - a Prescription Drug Product that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drug Products to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drug Products; and
- been designated by the Claims Administrator as a Network Pharmacy.

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

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

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

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

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

- Inhalers (with spacers);
- Insulin;
- [[Certain immunizations][Immunizations] administered in a pharmacy]; and
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips – glucose;
  - Urine-testing strips – glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices; and

- Glucose meters (this does not include continuous glucose monitors; Benefits for continuous glucose monitors are provided as described in the portion of this Benefits Booklet regarding the medical benefits coverage component of the Plan).

Preventive Care Medications - the medications that are obtained at a Network Pharmacy and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- 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;
- 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; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Note: The Plan considers all Prescription Drug Products used for contraceptive purposes to be Preventive Care Medications. This includes oral contraceptives, injectable drugs and contraceptive devices.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Specialty Prescription Drug - Prescription Drug Product that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Infertility. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutically Equivalent – when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

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

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the Plan, as well as information required of all summary plan descriptions by ERISA as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Plan Administrator

Anadarko Petroleum Corporation is the Plan Sponsor of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan. The Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee is the Plan Administrator of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan and has the discretionary authority and control to interpret the Plan, control and manage the operation and administration of the Plan and make all decisions and determination incident thereto, except to the extent otherwise delegated to other persons or entities. You may contact the Plan Administrator at:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Attn: Director, Global Benefits
1201 Lake Robbins Drive
The Woodlands, TX 77380
(832) 636-1000

Claims Administrator and Claims Fiduciary

UnitedHealthcare is the Plan's Claims Administrator and Claims Fiduciary. The role of the Claims Administrator and Claims Fiduciary is to administer, review and make final determinations regarding claims for Benefits under the Plan. As Claims Administrator, UnitedHealthcare also provides other day-to-day administrative services with respect to the Plan pursuant to an administrative services agreement with the Company. UnitedHealthcare shall not be deemed, or construed as, an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. UnitedHealthcare shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator/Claims Fiduciary by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent for Service is:

With respect to the Anadarko Petroleum Corporation Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

With respect to the Anadarko Petroleum Corporation Retiree Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Retiree Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

Other Administrative Information

This section of your Benefits Booklet contains information about how the Plan is administered as required by ERISA.

Type of Administration

The HDHP Choice Plus Plan is a component of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan, with administration provided through one or more third party administrators. The HDHP Choice Plus Plan is incorporated by reference into the APC Health Benefits Plan and the APC Retiree Health Benefits Plan, each of which is a separate employee welfare benefit plan for purposes of ERISA.

Plan Names and Plan Numbers:	Anadarko Petroleum Corporation Health Benefits Plan, Number 501 Anadarko Petroleum Corporation Retiree Health Benefits Plan, Number 504
Employer ID:	76-0146568

Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee/Retiree Employee/Surviving Dependent and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan 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 Plan information, including insurance contracts and collective bargaining agreements (if applicable), and any updated SPD, by writing to the Plan Administrator or its designee. The Plan Administrator may make a reasonable charge for copies; and
- receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the SPD and the wrap-around Plan document to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan 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. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or summary annual report from the Plan, 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 disagree with that denial, you must file an appeal (and second level appeal if the appeal is denied) in accordance with the claim and appeal procedures described in Section 9, *Claims Procedures*. If your second level appeal is denied, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court after exhausting the claim and appeal procedures described in Section 9, *Claims Procedures*. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. 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 (866) 444-3272.

The Plan's Benefits are administered by the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee, which is the Plan Administrator. UnitedHealthcare is the Claims Administrator and Claims Fiduciary and processes claims for the Plan and provides appeal services; however, UnitedHealthcare, Anadarko Petroleum Corporation, and the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare, Anadarko Petroleum Corporation, and the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act (PPACA)

Patient Protection Notices

The Plan 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 and who is available to accept you or your family members. If you are required to designate a primary care provider, the Plan will designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator 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.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits for 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; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. See Section 5, *Plan Highlights* for details. Limitations on Benefits are the same as for any other Covered Health Service. If you would like more information on these Benefits, contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

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

Under federal law, group health plans, such as the Plan, and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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 mother's or newborn's attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

In addition, the Plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization from the Plan 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 the Plan Administrator (or its designee) or issuer.

ATTACHMENT III - NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꭰ ᏏᏢ ᎫCZᏢᎫ Ꭻ4ᏫᎫ ᏂAᏭᎳW ᎥᏓ GVᏢ VᎭ ᏤR ᎫJAVᎫ ACᏫVᎫ ᎢΘᏂᏫᎫT, ᎺᎼ0ᏼᏫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

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19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

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27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒီးန့ါဘဉ်တါ်မၤစၢးဒီးတါ်ဂ့ါတါ်ကျိုၤလၢနကျိုဉ်ဒဉ်နဲဝဲလၢတဖလိဉ်ဟုဉ်အ ပူၤဘဉ်နှဉ်လီၤ.လၢတါ်ကဃ့နှါ်ပှၤကတိၤကျိုးထံတါ်တကၤအစီၢ်ကီးဘဉ်လီတဲစီအကျိုၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတါ်အိဉ်ဆူဉ်အိဉ်ချအတါ်ရဲဉ်တါ်ကျဲၤ အကၢအလိၤဒီးဆီဉ်လီၤနီါ်ဂ်ါ 0 တကှ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor a□ maroñ ñan bok jipañ im me□e□e ilo kajin eo a□ ilo ejje□□k wō□āān. Ñan kajjitōk ñan juon ri-ukok, kūr□ok nō□ba eo e□ōj an jeje ilo kaat in ID in karōk in ājmour eo a□, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T’áá jíík’eh doo ba□ a□ h ‘alínígóó bee baa hane’ígíí t’áá ni nizaád bee

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	niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'ígo ninaaltsoos nit['iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveţi dreptul de a obţine gratuit ajutor şi informaţii în limba dumneavoastră. Pentru a cere un interpret, sunaţi la numărul de telefon gratuit care se găseşte pe cardul dumneavoastră de sănătate, apăsaţi pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и

Language	Translated Taglines
	информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa’asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa’amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa’atalosagaina se tagata fa’aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo”u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܝܬܠܘܟ݂ܘܢ ܐܝܬܠܗܘܢ ܙܕܩܘܬܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܥܠܘܡܘܬܐ ܒܠܫܢܐ ܕܝܠܟܘܢ ܡܓܢܐܝܬ ܠܫܘܐܠܬܐ ܕܡܬܪܓܡܢܐ ܡܚܝܘܢ ܥܠ ܡܢܝܢܐ ܕܛܠܝܦܘܢ ܕܐܝܬܠܗ ܒܟܪܛܐ ܕܗܘܝܬܟܘܢ ܘܕܘܫܘܢ 0. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย

Language	Translated Taglines
	หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ‘a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki “0”. Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

Program Document 2

UnitedHealthcare HDHP Options Plan Booklet (2018), Group Number 755494

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2018)

Final

Benefits Booklet

Anadarko Petroleum Corporation
PPO HDHP Options Plan

Effective: January 1, 2018
Group Number: 755494

4815-7456-1374 v.4

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support, prior authorization and Mental Health/Substance Use Disorder Administrator: (888) 512-4093;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

Anadarko Petroleum Corporation is pleased to provide you with this Benefits Booklet, which describes the PPO HDHP Options Plan health Benefits available to you and your covered family members under the Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan) and the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit[1] under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet.

This Benefits Booklet includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

The complete Summary Plan Description of the APC Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet) and the complete Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP Options Plan,

[1] The Summary Plan Description of the Group Health Benefit is one of two components of the full Summary Plan Description of the APC Retiree Health Benefits Plan. Apart from the Group Health Benefit, other group health benefits, unrelated to the PPO HDHP Options Plan, are provided to eligible individuals under the APC Retiree Health Benefits Plan. Such benefits are described in a separate summary plan description document that constitutes the other component of the full Summary Plan Description of the APC Retiree Health Benefits Plan.

including this Benefits Booklet) are each referred to in this Benefits Booklet as an "SPD." The SPDs are designed to meet the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This Benefits Booklet supersedes any previous printed or electronic Benefits Booklet for the PPO HDHP Options Plan offered under the Plan.

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *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 Plan.

Anadarko Petroleum Corporation intends to continue the Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This Benefits Booklet is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this Benefits Booklet and the contents of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, your rights shall be determined as provided in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Anadarko Petroleum Corporation is solely responsible for paying Benefits described in this Benefits Booklet.

Please read this Benefits Booklet thoroughly to learn how the PPO HDHP Options Plan works. If you have questions contact the Anadarko Benefits Center at (866) 472-4711 or call the number on the back of your ID card.

How To Use This Benefits Booklet

- Read the entire Benefits Booklet, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this Benefits Booklet 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 Benefits Booklet and any future amendments at **www.anadarkoadvantage.ehr.com** or request printed copies by contacting the Anadarko Benefits Center at (866) 472-4711.
- Capitalized words in the Benefits Booklet have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Anadarko Petroleum Corporation is also referred to as Company.
- If there is a conflict between this Benefits Booklet and any benefit summaries (other than Summaries of Material Modifications to the SPD under ERISA) provided to you, this Benefits Booklet will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Important Note: Except as otherwise noted, the provisions of this Section 2 apply to coverage under the APC Retiree Health Benefits Plan, as applicable to the PPO HDHP Options Plan, only to the extent that such provisions are not inconsistent with the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, which governs and controls. Please refer to the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan for additional details regarding eligibility, enrollment and other coverage terms under the APC Retiree Health Benefits Plan for eligible Retired Employees and their eligible Dependents.

Eligibility

Retiree Eligibility Frozen on December 31, 2015

Notwithstanding anything in this Benefits Booklet to the contrary, eligibility to participate in the PPO HDHP Options Plan under the APC Retiree Health Benefits Plan was frozen on December 31, 2015, except as otherwise specifically provided in the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan. Consequently, only such Retired Employees, Dependents and other individuals as specifically provided in the Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan may become newly eligible to participate in the PPO HDHP Options Plan under the APC Retiree Health Benefits a Plan on or after January 1, 2016.

You are eligible to participate in the Plan if you are a regular full-time or part-time Employee who is eligible to participate in the APC Health Benefits Plan in accordance with the wrap-around Summary Plan Description of the APC Health Benefits Plan or a Retired Employee who is eligible to participate in the APC Retiree Health Benefits Plan in accordance with the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse (including your Domestic Partner), as defined in Section 14, *Glossary;*

- your or your Spouse's child who is under age 26, through the end of the year in which the child turns age 26; for purposes of this and the next bullet point, "child" includes a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse have a court appointed guardianship or conservatorship but only if such child primarily lives with you and is a member of your household; or
- your or your Spouse's child, beginning with the year of the child's 27th birthday, who is dependent upon you or your Spouse because of a mental or physical handicap rendering the child medically incapacitated and unable to be self-supporting (Disabled). The child must satisfy either of the following requirements:
  - prior to the end of the year of the child's 26th birthday, the child is Disabled and covered as a Dependent under the Plan; or
  - the child is Disabled and over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll for coverage (i.e., the Disabled child cannot later be added to coverage under the Plan).

  In addition, the child must reside with the Employee in his household for more than one-half of the year, and the child must not provide more than one-half of his own support for the year. Periodic proof of incapacity may be required by the Plan Administrator to continue coverage for the child.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both Employees and covered under the APC Health Benefits Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. If you and your Spouse are both Retired Employees and covered under the APC Retiree Health Benefits Plan, you may each be enrolled as a Retired Employee or be covered as a Dependent of the other person, but not both. However, if you are eligible for coverage as an Employee under the APC Health Benefits Plan and your Spouse is eligible for coverage as a Retired Employee under the APC Retiree Health Benefits Plan, you are not eligible for coverage as a Dependent under the APC Retiree Health Benefits Plan, but your Spouse is eligible for coverage as a Dependent under the APC Health Benefits Plan (subject to the other applicable terms of the APC Health Benefits Plan). In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Anadarko Petroleum Corporation share in the cost of the Plan. Your contribution amount depends on the options under the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children to be *per se* dependents for federal tax purposes (unless they meet the specific requirements for qualifying as tax dependents under the Internal Revenue Code of 1986, as amended (the "Code")). Therefore, the value of Anadarko Petroleum Corporation's cost in covering a Domestic Partner and the Domestic Partner's children may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children will be paid using after-tax payroll deductions.

Your contributions are subject to review and Anadarko Petroleum Corporation reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Anadarko Benefits Center at (866) 472-4711 or logging onto **www.anadarkoadvantage.ehr.com**.

How to Enroll

To enroll, call the Anadarko Benefits Center at (866) 472-4711, or log onto **www.anadarkoadvantage.ehr.com**, within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Annual Enrollment to make your benefit elections.

Each year during Annual Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Annual Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, the birth of a child, adoption of a child, placement for adoption of a child or other family status change, you must contact the Anadarko Benefits Center at (866) 472-4711 within 31 days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

Once the Anadarko Benefits Center receives your properly completed enrollment, coverage will begin on your initial date of eligibility, as described in the SPD. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date the Anadarko Benefits Center receives notice of your marriage, provided you notify the Anadarko Benefits Center within 31 days of your marriage. 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 Anadarko Benefits Center within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

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

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status that affects eligibility for coverage or you have a special enrollment right. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.), but you can generally enroll yourself and/or your Dependents in any medical Benefit Program offered under the Plan for which you are otherwise eligible as provided in the SPD if you have a special enrollment right. The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- establishing or dissolving a Domestic Partnership;
- the birth, adoption, placement for adoption or legal guardianship of a Dependent child;
- any of the following that change your or your Dependent's employment status: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Dependent's residence;
- a change in your or your Dependent's position or work schedule that impacts eligibility for health coverage;
- your or your Dependent's gain or loss of entitlement to Medicaid or Medicare;
- significant cost or coverage changes;
- a court or administrative order; and
- any other change in status event provided under the Anadarko Petroleum Corporation Pre-Tax Premium and Benefits Plan.

The following create special enrollment rights for purposes of the Plan:

- your marriage;
- the birth, adoption, placement for adoption of a Dependent child;

- loss of eligibility for other health coverage as a result of legal separation, divorce, loss of dependent status, death of an employee, termination of employment, or reduction in hours;
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and, with respect to the group market, no other benefit option is available to you or your eligible Dependent, resulting in a loss of eligibility for coverage;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- contributions are no longer paid by the Employer;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Anadarko Benefits Center within 60 days of termination); and
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Anadarko Benefits Center within 60 days of determination of subsidy eligibility).

Unless otherwise noted above, if you wish to change your elections, you must contact the Anadarko Benefits Center at (866) 472-4711 within 31 days of the change in family status. Otherwise, you will need to wait until the next Annual Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At Annual Enrollment, she elects not to participate in Anadarko Petroleum Corporation's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the Plan outside of Annual Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in the Plan, 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 Network level of Benefits under the Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider that is identified as a Designated Provider. Only certain Network Physicians and Network providers have been identified as Designated Providers. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

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

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** 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 Physicians available in your Plan.

Network Providers

UnitedHealthcare or its Affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

See Attachment I to this Benefits Booklet, *Health Care Reform Notices*, for additional information regarding your right under applicable law to designate a primary care provider and receive certain Covered Health Services without a referral.

Network providers are independent practitioners and are not employees of Anadarko Petroleum Corporation 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 by such providers.

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30-mile radius of your home zip code.

You can check a provider's Network status by visiting **www.myuhc.com** or by calling UnitedHealthcare at the toll-free number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Eligible Expenses

Eligible Expenses are the charges for Covered Health Services that are (i) incurred by a Covered Person while the Plan is in effect and (ii) determined by UnitedHealthcare to be payable as Benefits under the Plan.

The Plan Administrator has delegated to UnitedHealthcare, in its capacity as the Claims Administrator and Claims Fiduciary, the discretion and authority to (a) decide whether a treatment or supply is a Covered Health Service, (b) formulate the methods by which Eligible Expenses will be determined, and (c) determine Eligible Expenses that are payable as Benefits under the Plan.

For Designated Network Benefits and Network Benefits, you are not responsible for any difference between the amount the provider bills and the portion of such amount that UnitedHealthcare determines constitutes Eligible Expenses. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills and the portion of such amount UnitedHealthcare determines constitutes Eligible Expenses.

Eligible Expenses are determined solely in accordance with (i) UnitedHealthcare's reimbursement policy guidelines, as described under the definition of Eligible Expenses in Section 14, *Glossary*, and (ii) the other applicable terms and conditions of coverage under the Plan.

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are based on the amount that is required by applicable law (including the Affordable Care Act), or, if no amount is required by applicable law, then an amount negotiated or authorized by UnitedHealthcare, as permitted by applicable law.

For Non-Network Benefits, (*i.e.*, Benefits that are payable when Covered Health Services are received from a non-Network provider, except as the result of an Emergency or as arranged by UnitedHealthcare, as provided in the paragraph above), Eligible Expenses are based on one of the following amounts:

- Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's authorized vendors, Affiliates or subcontractors, at UnitedHealthcare's discretion, including, without limitation, pursuant to the Shared Savings Program.
- If rates have not been negotiated, then one of the following amounts, as applicable:
  - 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, with the exception of the following:
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or CMS competitive bid rates.
  - When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
  - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented in UnitedHealthcare's systems within 30 to 90 days after *CMS* updates its data. The *CMS* published rate that is applicable to a participant's claim is the *CMS* published rate as reflected in UnitedHealthcare's systems on the date that such claim is incurred.

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

Annual Deductible

The Annual Deductible 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 Network and non-Network Annual Deductibles for the Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person transfers from another Benefit Program under the Plan, as described in the SPD, to this PPO HDHP Options Plan, any amount already applied to the annual deductible provision under that prior Benefit Program for the year will apply to the Annual Deductible provision under this PPO HDHP Options Plan.

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.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the maximum amount you will be required to pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for the Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual Out-of-Pocket Maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays for Covered Health Services available in Section 15, *Prescription Drug Products*	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance payments, including those for Covered Health Services available in Section 15, *Prescription Drug Products*	Yes	Yes
Charges for non-Covered Health Services	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program; and
- Covered Health Services which require prior authorization.

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefits Booklet, the Personal Health Support Nurse 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. Covered Persons 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 toll-free number on your ID card.

Prior Authorization

The Plan requires that you obtain prior authorization from the Claims Administrator for certain Covered Health Services. Services for which prior authorization is required are identified below and in Section 6, *Additional Coverage Details* within each Covered Health Service category.

IMPORTANT: Prior authorization is not a guarantee of any payment of Benefits. In addition to any prior authorization requirement, Benefits are also subject to all other applicable requirements of the Plan, including, but not limited to, any limitations and exclusions regarding coverage, timely payment of required contributions toward your coverage, and your eligibility at the time care and services are provided.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization from the Claims Administrator, please review it carefully so that you understand what services are subject to the authorization 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.

Note: Any request made by a person or entity other than a Covered Person (including, but not limited to, a health care provider) for prior authorization of Covered Health Services to be rendered to the Covered Person will be deemed to be a request *on behalf of the Covered Person* by his or her authorized representative for such purpose, and not a request by such other person or entity on his or its own behalf.

Covered Health Services which Require Prior Authorization

The Plan requires prior authorization from the Claims Administrator for certain Covered Health Services. Any request for prior authorization that is required under the terms of the Plan as a condition for obtaining Benefits for Covered Health Services constitutes a "Pre-Service Claim" under the Plan, as described in Section 9, *Claims Procedures*, and ERISA.

When you choose to receive any of those Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Your obligation to obtain prior authorization is also applicable whenever a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services are subject to the authorization and what providers are authorized to deliver the services that are subject to the authorization.

If you choose to receive a service that has been determined to not be a Medically Necessary Covered Health Service or has otherwise not received prior authorization if and as required, you will be responsible for paying all charges and no Benefits will be paid for that service.

Services for which you are required to obtain prior authorization are identified in Section 6, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Covered Health Service Benefit description in Section 6, *Additional Coverage Details*, to determine how far in advance you must obtain prior authorization.

You are also required to obtain prior authorization whenever a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

Contacting the Claims Administrator for prior authorization is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB).*

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Designated and Network	Non-Network
Annual Deductible[1]		
■ Individual	$1,500	$2,500
■ Family (cumulative Annual Deductible[2])	$3,000	$5,000
Annual Out-of-Pocket Maximum[3]		
■ Individual	$3,500	$8,000
■ Family (cumulative Out-of-Pocket Maximum[4])	$6,850	$15,500
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in the Plan.	Unlimited	

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

[2]The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

[3]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

[4]The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Acupuncture Services	Depending upon where the Covered Health Service is provided, Benefits for acupuncture services will be the same as those stated under each Covered Health Service category in this section.	
Ambulance Services ■ Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay *Cancer treatment provided at any other facility is covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Applicable*	Not Applicable*
Clinical Trials	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 ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-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 Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drug Products*.	
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services - Outpatient		
■ True Emergency	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible
■ Non-Emergency	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hearing Aids ■ Examinations and Testing	*Primary Physician Designated Provider* 90% after you meet the Annual Deductible *Network Provider* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
■ Devices Up to $2,000 per hearing impaired ear every 36 months	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care Up to 120 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Infertility Services and Fertility Solutions (FS) Program For Network Benefits, infertility services must be received from a Designated Provider. See Section 6, *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.	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.
Kidney Resource Services (KRS)[3] *Kidney disease treatment provided at any other facility is covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Applicable*	Not Applicable
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Mental Health Services ■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Neonatal Resource Services (NRS)[4] *Neonatal intensive care services provided at any other facility are covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Applicable*	Not Applicable
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Nutritional Counseling ***Note:*** Nutritional or diet counseling billed as a preventive care will be paid as described under *Preventive Care Services*.	*Designated Provider* 90% after you meet the Annual Deductible *Network Provider* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Obesity Treatment		
■ Non-Surgical Treatment	Depending upon where the Covered Health Service is provided, Benefits for non-surgical obesity treatment will be the same as those stated under *Physician's Office Services* in this section and in Section 15, *Prescription Drug Products*.	
■ Surgical Treatment		
- Physician's Office Services	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered
- Physician Fees for Surgical and Medical Services	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered
- Hospital - Inpatient Stay	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered
- Lab and X-ray	*Designated Provider* 80% after you meet the Annual Deductible *Network facility* Not Covered	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Orthognathic Surgery	Depending upon where the Covered Health Services is provided, Benefits for orthognathic surgery will be the same as those stated under each Covered Health Services category in this section.	
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	*Designated Provider* 90% after you meet the Annual Deductible *Network Provider* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services A separate Deductible will not apply for a well newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits for Pregnancy – Maternity Services will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Preventive Care Services		
■ Physician Office Services	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
■ Breast Pumps	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient Up to 70 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits for Reconstructive Procedures will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Substance-Related and Addictive Disorders Services		
■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	*Designated Provider* 90% after you meet the Annual Deductible *Network Provider* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Transplantation Services ■ Cornea Transplants	Depending upon where the Covered Health Services is provided, Benefits for cornea transplants will be the same as those stated under each Covered Health Services category in this section.	
■ Other Covered Transplants	*Designated Provider* 100% Annual Deductible does not apply *Network facility* Not Covered	Not Covered
Travel and Lodging (If services rendered by a Designated Provider) See Section 6, *Additional Coverage Details*, for limits	For patient and companion(s) of patient undergoing cancer treatment, obesity surgery services, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Non-Network Benefits are not available.
Wigs	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 4, *Personal Health Support and Prior Authorization* to receive full Benefits for certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Provider facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

[3]These Benefits are for Covered Health Services provided through KRS at a Designated Provider facility. For kidney disease treatment not provided through KRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

[4]These Benefits are for Covered Health Services provided through NRS at a Designated Provider facility. For neonatal intensive care services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from UnitedHealthcare before you receive them.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call UnitedHealthcare. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy given by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

Covered Health Services also include acupuncture when provided in lieu of anesthesia.

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as possible prior to transport.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. "Designated Provider" is defined in Section 14, *Glossary*.

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

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (855) 583-3161; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;

- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Clinical Trials

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

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as 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; and
- 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 eligible for participation in the qualifying Clinical Trial according to the Clinical Trial protocol and such participation would be appropriate based on 1) medical and scientific information provided by the Covered Person or 2) the conclusion of a referring health care professional that is participating in the Clinical Trial.

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with 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; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - ♦ comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    - ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of participation in a Clinical Trial arises. This requirement does **not** apply to Clinical Trials for cancer or other life-threatening diseases or conditions.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a Designated Provider facility. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks (which is an Affiliate of UnitedHealthcare) or UnitedHealthcare to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or UnitedHealthcare at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;

- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Designated Provider facility.

Prior Authorization Requirement
For Covered Health Services required to be received by a Designated Provider, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of a CHD surgery arises.

Dental Services - Accident Only

Important note: Additional dental care services are covered under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The Plan 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 immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Except with respect to any accidental Injury that occurred prior to the Covered Person's effective date of coverage under the Plan, dental services for final treatment to repair the damage caused by accidental Injury must be (a) started within three months following the accident (unless extenuating circumstances exist, such as prolonged hospitalization or the presence of fixation wires from fracture care) and (b) completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic X-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies in this Section 6. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Prescription Drug Products*.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) 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)

The Plan pays for Durable Medical Equipment (DME) that is:

- 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 Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the 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;
- orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, braces to treat curvature of the spine, cranial orthotics (helmets), shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period and are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the repair/replacement of a type 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, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted to a Hospital as a result of an Emergency, you must notify UnitedHealthcare within two business days after the admission or otherwise as soon as reasonably possible.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 48 hours following admission or on the same day of admission, if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided for the continued stay; however, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Hearing Aids

The Plan 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 a Physician. Benefits under this section are provided for services

performed by an audiologist or specialist for a diagnosis, the hearing aid and for charges for associated fitting and testing.

Note: Benefits for routine hearing screenings are provided under *Preventive Care Services*.

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.

Any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits is limited to $2,000 per hearing impaired ear every 36 months.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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.

Any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before receiving services including nutritional foods and Private Duty Nursing or otherwise as soon as is reasonably possible.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission for an Inpatient Stay in a hospice facility or otherwise as soon as is reasonably possible.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for:
- A scheduled admission, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

Infertility Services and Fertility Solutions (FS) Program

Infertility services must be ordered by a Network provider and received at an FS Designated

Provider facility and coordinated through FS.

The Plan has specific guidelines regarding Benefits for Infertility Services. Contact Fertility Solutions at 1-866-774-4626 for information about these guidelines.

Infertility Services

Covered Health Services for infertility services and associated expenses include:

- Physician's office visits and consultations.
- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI).
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI).
- Embryo transportation related network disruption.
- Ovulation induction and controlled ovarian stimulation.
- Pre-implantation genetic diagnosis (PGD) for diagnosis of genetic disorders only.
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Cryopreservation - embryo's (storage is limited to 3 months).

To be eligible for Benefits, the Covered Person must:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Have failed to achieve Pregnancy following six months of unsuccessful donor insemination.
- Have failed to achieve Pregnancy due to impotence/sexual dysfunction.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
- Be under age 44, if female.

In addition, the male related procedures described above are only available to males covered under the Plan.

Infertility Services for Same Sex Couples

The Plan will also pay for certain services for same sex couples. A female Covered Person without a male partner may be considered infertile if she is unable to conceive or maintain a pregnancy after six cycles of donor insemination (a non-covered benefit under this definition); proof of insemination must be provided. If conception is not achieved with

insemination, the female Covered Person would then become eligible for advanced reproductive treatment including IVF as defined above. Any resulting embryos would be transferred only to the individual from whom the oocytes were derived.

A male Covered Person without a female partner is not covered for artificial insemination of a female surrogate. However, he is covered for the diagnosis and treatment of the male factor causing infertility (*e.g.*, treatment of sperm abnormalities including the surgical recovery of sperm).

Infertility Services for eSET

Elective SET is defined as the transfer of a single embryo, in which more than one high-quality embryo exists but it is decided to transfer only one embryo that is selected from a larger number of available embryos, at either the cleavage or blastocyst stage of embryo development. An increased benefit under the infertility benefit applies when you meet the clinical criteria. Please contact FS for further details.

Infertility Services for Donor Insemination

The Plan will cover donor insemination for a female without a male partner. Any resulting embryos could be transferred either to the individual from whom the oocytes were derived or to her legally married partner. However, the cost of the donor sperm itself and any storage thereof is excluded from coverage.

Pre-implantation Genetic Screening (PGS)

The Plan also covers pre-implantation genetic screening (PGS) when used in conjunction with elective single embryo transfer. These technologies include, but are not limited to, array comparative genomic hybridization, quantitative polymerase chain reaction and single nucleotide polymorphism array testing.

Donor Coverage

The Plan will also cover the use of donor ovum and donor sperm and related costs, including collection and preparation. The Plan will not pay for the cost of the donor sperm or egg or any related donor fees.

Planning Cancer Treatment

Covered Persons with a diagnosis of cancer who are planning cancer treatment, or medical treatment for any condition that is demonstrated to result in infertility are considered to meet the definition of infertility. Planned cancer treatments include bilateral orchiectomy bilateral oophorectomy, hysterectomy, chemotherapy or radiation therapy that is established in the medical literature to result in infertility. In order to use infertility benefits covered under the Plan, you must notify FS and meet the following eligibility criteria:

- Covered Persons or their partners must not have undergone a previous elective sterilization procedure, (e.g. hysterectomy, tubal ligation, vasectomy), with or without surgical reversal, regardless of post reversal results.

- Covered Person must have had a day 3 FSH test in the prior 12 months if age less than 35 or the prior six months if age 35 or greater.
- Day 3 FSH level of the female Covered Person must not have been greater than 15 mIU/mL in any (past or current) menstrual cycle regardless of the type of infertility services planned (Including donor egg, donor embryo or frozen embryo cycle).
- Only those infertility services that have a reasonable likelihood of success are covered.

Coverage is limited to:

- Collection of sperm.
- Cryopreservation of sperm.
- Ovulation induction and retrieval of eggs.
- In vitro fertilization.
- Embryo cryopreservation.

Long-term cryopreservation costs (anything longer than three months) are not covered under the Plan.

Any combination of Network Benefits and Non-Network Benefits for infertility services received through the FS program is limited to $20,000 per Covered Person during the entire period you are covered under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of the need for infertility services arises.

What is Coinsurance?
Coinsurance is the amount you pay for a Covered Health Service, not including the Deductible.

For example, if the Plan pays 80% of Eligible Expenses for care received from a Network provider, your Coinsurance is 20%.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Providers participating in the Kidney Resource Services (KRS) program. "Designated Provider" is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

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

- lab and radiology/X-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

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

Prior Authorization Requirement
For sleep studies, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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;
- Residential Treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- outpatient treatment; and

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Providers participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. "Designated Provider" is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, the Network provider must notify NRS or UnitedHealthcare if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- call UnitedHealthcare; or
- call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

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; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the 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.

Benefits include the following levels of care:

- inpatient treatment;
- Residential Treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment; and
- 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; and
- crisis intervention.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and an admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, if you are going to obtain Neurobiological Disorders – Autism Spectrum Disorder Services from a non-Network provider you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

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 Treatment

Non-Surgical Treatment

The Plan covers structured weight loss programs provided by or under the direction of a Physician. Covered Health Services include:

- examination and diagnostic testing provided in a Physician's office;
- program costs, including monitoring of weight loss; and
- Pharmaceutical Products provided as part of the program.

Covered Health Services also include Prescription Drug products for appetite suppression or weight loss provided under Section 15, *Prescription Drug Products*.

Surgical Treatment

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- the Covered Person has a minimum Body Mass Index (BMI) of 40; or
- the Covered Person has a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria, the following must also be true:

- the Covered Person is 18 years of age or older, or for adolescents, has achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4;
- there is documentation of a motivated attempt at weight loss for a minimum of six months, prior to bariatric surgery and within the last two years, through a structured diet program that includes Physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program;
- the Covered Person completes a pre-surgical psychological evaluation within 12 months of surgery;
- the surgery is performed at a Bariatric Resource Service (BRS) Designated Provider facility by a Network surgeon even if there are no BRS Designated Providers near you.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

You will have access to a certain Network of Designated Providers and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in Section 14, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling toll-free at (888) 936-7246.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider facility.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of obesity surgery arises.

It is important that you provide notification regarding your intention to have surgery by calling either the toll-free telephone number on the back of your ID card or Bariatric Resource Services at (888) 936-7246. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Orthognathic Surgery

The Plan covers orthognathic surgery in the following situations:

- a jaw deformity resulting from facial trauma or cancer; or
- a skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
  - inability to incise solid foods;
  - choking on incompletely masticated solid foods;
  - damage to soft tissue during mastication;
  - speech impediment determined to be due to the jaw deformity; or
  - malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Prior Authorization Requirement
Please remember that you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before orthognathic surgery is performed during an Inpatient Hospital Stay in a Hospital.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan 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 Physician house calls, allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by the Claims Administrator.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as is reasonably possible before Genetic Testing – BRCA is performed.

Please Note
Your Physician does not have a copy of your Benefits Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - 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. Benefits for Pregnancy and maternity services that constitute required preventive health services under the Affordable Care Act are covered as *Preventive Care Services*.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 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 the 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.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as reasonably possible with respect to any Inpatient Stay for the mother and/or the newborn that will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

It is important that you call the toll-free number on the back of your ID card with notification regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital, and as otherwise required by the Affordable Care Act. 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 the Affordable Care Act and any other applicable law:

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

Note: Screening for hearing loss in newborns is a preventive care service.

In addition to the above guidelines, the Plan covers the following as preventive care services regardless of the Covered Person's age:

- For men and women:
  - abdominal aortic aneurysm screening;

- cholesterol screening;
- colorectal cancer screening; and
- shingles vaccine.

■ For women:

- BRCA testing;
- cervical cancer screening; and
- HPV DNA testing.

■ For men: prostate screening.

■ For children: autism screening.

In addition to the services listed above, this preventive care benefit includes certain:

■ routine lab tests;

■ diagnostic consultations to prevent disease and detect abnormalities;

■ diagnostic radiology and nuclear imaging procedures to screen for abnormalities;

■ breast cancer screening and genetic testing; and

■ tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. 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; and

■ timing of an acquisition.

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

Benefits for preventive care services will be administered and provided hereunder in accordance with any applicable requirements of the Affordable Care Act.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits is limited to 70 visits per calendar year. One visit equals up to eight hours of Skilled Care services.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type 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.

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

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before obtaining prosthetic devices that exceed $1,000 in cost per device.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. 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 a changed or improved physical appearance.

Improving or restoring physiologic function means that the 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.

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 the Plan if the initial breast implant followed mastectomy. Other services required 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 other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. The Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement
For:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before a scheduled Reconstructive Procedures is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification to the Claims Administrator within one business day following such procedure or as soon as is reasonably possible thereafter.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- vision therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), 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. 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 can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary 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, vocational training and Residential Treatment 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.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan 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 Plan 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.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available 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.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is 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;
- it is ordered by a Physician;
- 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; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Prior Authorization Requirement
Please remember for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification to the Claims Administrator as soon as is reasonably possible.

Substance-Related and Addictive Disorders Services

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

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

Prior Authorization Requirement
Please remember for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Prior Authorization Requirement
For blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgeries, cochlear implant and orthognathic surgeries you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received or, for non-scheduled services, within one business day following receipt of such services or as soon as is reasonably possible thereafter.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

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.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received or, for non-scheduled services, within one business day following receipt of such services or as soon as is reasonably possible thereafter: Dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Provider facility (subject to the exception below for cornea transplants). Benefits are available to the donor and the recipient when the recipient is covered under the Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (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.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or UnitedHealthcare for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or UnitedHealthcare at the telephone number on your ID card for information about these guidelines.

Prior Authorization Requirement
For Benefits you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed by a Designated Provider, Benefits will not be paid.

Travel and Lodging

The Plan may provide you with travel and lodging assistance Benefits. Travel and lodging Benefits are only available for you or your eligible family member if you meet the qualifications for the Benefit, including receiving care at a Designated Provider facility that is beyond a specified distance from your home address, as further described below. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Claims Administrator's 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 Benefits 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 Plan's per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation

and lodging Eligible 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 $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

Benefits are payable for:

- 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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

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

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

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

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis for:

- loss of hair resulting from treatment of a malignancy or any medical condition with a medical diagnosis; or
- permanent loss of hair due to an accidental Injury.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Anadarko Petroleum Corporation believes in giving you the tools you need to be an educated health care consumer. To that end, Anadarko Petroleum Corporation has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Anadarko Petroleum Corporation are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You, your Spouse and your Dependent children over age 18 are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – the Plan's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Anadarko Petroleum Corporation has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drug Products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, call (855) 583-3161.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Call NurseLine℠ toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

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

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;

- coronary disease and
- bariatric surgery.

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

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium℠ Tier 1 Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk survey to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (855) 583-3161.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

Disease Management Services

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

These programs offer:

- educational materials mailed to your home that provide guidance on managing your

specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;

- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

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

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Medication Management

UnitedHealthcare provides a service called the Medication Therapy Management Report especially for individuals who use multiple medications. This service looks to identify and prevent potential problems which can occur in individuals who use more than one

medication. In order to help you make the most of your medications, a copy of this report is sent to your Physician for review.

Your specific Medication Therapy Management Report includes a list of medications dispensed for you under your pharmacy benefit plan within the past six months. Your Physician is asked to review this report:

- to identify potential drug interactions with the prescription medications that have been prescribed to you;
- to note if more than one medication is serving the same purpose; and
- to determine if a needed medication is missing.

If your Physician identifies any concerns after reviewing the report, he or she may contact you if appropriate.

If you have any questions about any of the information presented in the Medication Therapy Management Report after you receive it please call the number provided on the report.

Wellness Programs

Healthy Back Program

UnitedHealthcare provides a program that identifies, assesses, and supports members with acute and chronic back conditions. By participating in this program you may receive free educational information through the mail and may even be called by a registered nurse who is a specialist in acute and chronic back conditions. This nurse will be a resource to advise and help you manage your condition.

This program offers:

- education on back-related information and self-care strategies;
- management of depression related to chronic back pain; and
- support in choosing treatment options.

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

Maternity Support Program

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

This program offers:

- enrollment by an OB nurse;

- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;
- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

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

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

Wellness Coaching

UnitedHealthcare offers a personalized Wellness Coaching program that can help you identify health risks, set goals and develop personalized strategies that empower you to make positive lifestyle changes to help improve your health and well-being. The one-on-one coaching integrates phone- and mail-based communications with an online interactive health coach on **www.myuhc.com**.

The Wellness Coaching program gives you access to specially trained personal wellness coaches to get you started and provides support that can keep you on track. These certified wellness coaches are cross-trained in multiple wellness concentrations for a more complete coaching experience. You will be assigned one wellness coach at the onset of your program and will be guided by the same coach throughout the program. Through information sharing, the wellness coach will work with you to create a personalized action plan that evolves throughout the program.

Wellness Coaching supports individuals with the following lifestyle issues:

- diabetes;
- exercise;
- heart health;
- nutrition;
- stress management;
- exercise programs;

- tobacco cessation; and
- weight management.

This program is offered at no cost to you or your Dependents. To enroll in the program, call Wellness Coaching toll-free at (800) 478-1057.

Anadarko Advantage – Rally Coins and Thanks! Points Incentive Programs

As part of the "Anadarko Advantage" wellness program, eligible individuals may earn two types of rewards for completing certain designated health-related activities through the Rally Coins and Thanks! Points Incentive Programs.

Eligibility

The following individuals are eligible to sign up and participate in the Rally Coins and Thanks! Points Incentive Programs:

- Any Employee, whether or not enrolled in medical coverage under a Benefit Program of the Plan that is administered by UnitedHealthcare (a "UHC Medical Program"); and
- Any Spouse or Domestic Partner who is enrolled in a UHC Medical Program (Rally Coins incentive only).

Rally Coins Incentive

Rally is an online wellness incentive program administered by UnitedHealthcare.

If you are eligible to participate, you must go to www.myuhc.com (or www.anadarko.werally.com, if you are an Employee who is not enrolled in a UHC Medical Program) and click on the "Rally Health Survey" link to enroll. When using Rally for the first time, you must create a profile online, set up a Rally account and complete a Rally Health Survey. Through the Rally Health Survey, a measure of your overall health (your "Rally age") will be calculated and UnitedHealthcare will identify and recommend particular activities for you (known as "missions") which are designed to help improve your diet, fitness or mood.

You may earn points and "coins" for completing any of the activities for your coverage class listed in the "Thanks! Points Incentive" section below. In addition, you may earn Rally "coins" for performing other activities as described on the Rally website. Please refer to the Rally website to identify the number of Rally "coins" that can be earned per activity. Please note, however, that "private challenges" (as may be described on the Rally website) are not provided for through the Anadarko Advantage – Rally Coins incentive program.

The Rally "coins" that you earn will be reflected on your Rally dashboard on the Rally website. You may spend your Rally "coins" only by entering sweepstakes for prizes, as offered on the Rally website.

Rally "coins" are not taxable. However, if you enter a sweepstakes with Rally coins and win a prize, your prize is taxable. You are solely responsible for any federal, state or local taxes that you owe with respect to any prize that you win.

Thanks! Points Incentive

Thanks! Points is an incentive program administered by Optum. If you are eligible to participate in Thanks! Points, you will automatically be enrolled when you enroll in Rally, as discussed above.

Once you are enrolled, you may earn Thanks! Points when you complete the following (based on whether or not you are enrolled in a UHC Medical Program):

Employee with coverage under a UHC Medical Program:

- Annual physical exam [1] = 1,000 points
- Mammography screening [1] = 1,000 points
- Cervical screening [1] = 1,000 points
- Colorectal cancer screening [1] = 1,000 points
- Rally Health Survey (see above) = 500 points
- Three Rally missions = 500 points
- Biometric screening [2] = 500 points

[1] You will receive your reward for these activities once your provider or an Anadarko Health Center files a medical claim for your annual physical exam or preventive screening.

[2] In order to complete this activity and earn your reward, your health care provider must complete and sign a "Health Provider Screening Form" for you. The form is prepopulated and personalized for each participant to ensure accuracy. You can access the form by clicking "Sign Up" on the "Get Screened" tile on your Rally dashboard and following the prompts. Once downloaded, the form should be taken to your appointment at an Anadarko Health Center or your health care provider's office. Either you or your health care provider may fax the completed form to the number at the bottom of the form.

Employee without coverage under a UHC Medical Program:

- Rally Health Survey (see above) = 500 points
- Rally Health Survey attestation question [3] = 1,000 points
- Three Rally missions = 500 points
- Biometric screening [4] = 500 points

[3] In order to earn points for this activity, when you take the Rally Health Survey, you must answer "yes" when asked whether you have plans to visit your primary care doctor for an annual checkup (or preventive care screening) during the current calendar year. If you do not answer "yes", you will not earn points for this activity, even if you change your answer later.

[4] In order to complete this activity and earn your reward, your health care provider must complete and sign a "Health Provider Screening Form" for you. The form is prepopulated and personalized for each participant to ensure accuracy. You can access the form by clicking "Sign Up" on the "Get Screened" tile on your Rally dashboard and following the prompts. Once downloaded, the form should be taken to your appointment at an Anadarko Health Center or your health care provider's office. Either you or your health care provider may fax the completed form to the number at the bottom of the form.

A maximum of 2,000 Thanks! Points may be earned each calendar year. You may use your Thanks! Points to purchase items, such as electronics, camping gear, gift cards and jewelry, through Anadarko's designated vendor for the Thanks! Points incentive program. Note: Thanks! Points are accumulated in the same account that may be established for you under Anadarko's service award, safety award and/or Employee Excellence award programs.

Four to six weeks following your receipt of any Thanks! Points that you earn, the value of those points will be reported on your paycheck as imputed income, and regular payroll taxes will be withheld.

Participation is Voluntary

Participation in the Rally Coins and Thanks! Points incentive programs is voluntary. If an eligible Employee (or eligible Spouse or Domestic Partner, as applicable) signs up to participate in the Rally Health Survey, he or she will be automatically enrolled in the Rally Coins and Thanks! Points incentive programs. If you do not wish to participate in these program, you should not sign up to participate in the Rally Health Survey. Additional details regarding the terms and conditions of the Rally Coins and Thanks! Points incentive programs are available by contacting Optum at 1-888-512-4093 or visit www.myuhc.com for incentives through Rally.

Applicable Laws

The Wellness Programs are intended to comply with the requirements of applicable law and regulation (which may include, but are not limited to, the Americans with Disabilities Act and the non-discrimination, privacy and security regulations under HIPAA, to the extent each is applicable) and shall be construed and administered accordingly.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN 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 6, *Additional Coverage Details*.

The Plan 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 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. 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 5, *Plan Highlights*. Please review all limits carefully, as the Plan 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 Benefits Booklet says "this includes," or "including but not limited to," it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefits Booklet specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*. **Important note: Additional dental care services are covered under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.**

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded;

2. preventive care, diagnosis or treatment of (or related to) the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided as required by applicable law under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement described under *Preventive Care Services* in Section 6, *Additional Coverage Details*. 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 6, *Additional Coverage Details*;

3. dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*;

Important note: Exclusion #3 does not apply under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*, and

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Important note: Exclusion #6 does not apply under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease;

3. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses; and
   - ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; and

7. oral appliances for snoring.

Drugs

The exclusions listed below apply only with respect to the medical benefits coverage component of the Plan. Coverage of Prescription Drug Products (as defined in Section 15, *Prescription Drug Products*) is provided as a separate component of the Plan, and thus coverage of any of the services or supplies listed below, which are excluded from the medical benefits coverage component of the Plan, may be available under the Prescription Drug Products coverage component of the Plan. See Section 15, *Prescription Drug Products*, for coverage details and exclusions.

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.

5. Growth hormone therapy.

6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up by the Plan Sponsor or its designee to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *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 for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes;

3. treatment of flat feet;

4. treatment of subluxation of the foot; and

5. shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to, compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - urinary catheters;
   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in Section 6,

Additional Coverage Details.

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

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* in effect on the date that the services were performed.

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 edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* in effect on the date that the services were performed.

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 focused on primarily 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* in effect on the date that the services were performed.

7. Transitional Living services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to lower cholesterol or control diabetes;
   - foods to control weight or treat obesity (including liquid diets) even if such foods are part of a structured weight loss program otherwise covered under the Plan;

- oral vitamins and minerals. This exclusion does not apply to vitamins and minerals included under the requirements shown under *Preventive Care Services* in Section 6, *Additional Coverage Details*;
- meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- other dietary and electrolyte supplements; and

3. health education classes unless offered by UnitedHealthcare or its Affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service; and

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

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs except as described under *Obesity Treatment* in Section 6, *Additional Coverage Details*;

4. wigs except as described in Section 6, *Additional Coverage Details*; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations and related services;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity, other than weight loss programs described under *Obesity Treatment* in Section 6, *Additional Coverage Details*; and
    - surgical treatment of obesity except as described under *Obesity Treatment* in Section 6, *Additional Coverage Details*;

15. 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 and dental restorations; and

16. 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 Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. the following infertility treatment-related services:

   - cryo-preservation and other forms of preservation of reproductive materials;
   - long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue; and
   - donor services;

2. in vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility;

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. services provided by a doula (labor aide); and

7. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Provider facility. This exclusion does not apply to cornea transplants; and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, except when required due to an Emergency or Urgent Care need; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses necessary to obtain treatment for Covered Health Services received from a Designated Provider may be reimbursed. In such cases, expenses would be reimbursed as described under *Travel and Lodging* in Section 6, *Additional Coverage Details*. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. 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; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for 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 in the Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

Note: Screening for hearing loss in newborns is covered under *Preventive Care Services* in Section 6, *Additional Coverage Details*.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force 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;
   - that are received after the date your coverage under the Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
   - that exceed Eligible Expenses or any specified limitation in this Benefits Booklet; or
   - for which a non-Network provider waives the Annual Deductible or Coinsurance amounts or with respect to which a non-Network provider does not bill the Covered Person;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. health services and supplies that do not meet the definition of a Covered Health Service (see the definition in Section 14, *Glossary*). "Covered Health Services" are those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be (a) Medically Necessary; (b) included in Section 5 and 6, *Plan Highlight*s and *Additional Coverage Details* described as a Covered Health Service; (c) provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and (d) not identified in Section 8, *Exclusions*.

9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - required solely for purposes of education, sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - 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 6, *Additional Coverage Details*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or 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 Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-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.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a Post-service Claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a Pre-service Claim as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the number on your ID card or visiting **www.anadarkoadvantage.ehr.com**. 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 Employee.

- 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 carrier or provider of the other coverage (for example, your Spouse's employer).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card within 12 months after the date of your service(s) (unless you are legally incapacitated). When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

Important – Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan 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.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay your non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Non-Network Benefits

Subject to the Assignment and Payment of Benefits section, below, UnitedHealthcare will pay any Non-Network Benefits to you, unless you make a written request to UnitedHealthcare at the time you submit your claim for such payment to be made directly to your non-Network provider, in which case, each such payment shall be made on your behalf, and not to such provider in its, his or her own right. Moreover, if any such direct payment is made, it shall not constitute a waiver by the Plan Administrator, the Claims Administrator or the Claims Fiduciary of the anti-assignment provisions of the Assignment and Payment of Benefits section, below. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to you for Benefits under the Plan to the full extent of such payment.

You may not direct UnitedHealthcare to pay your Non-Network Benefits to any third party other than your non-Network Provider, as described above.

Form of Payment of Benefits

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

Assignment and Payment of Benefits

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "Plan Agreement"), no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, a non-Network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to or on behalf of a Covered Person. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Covered Person or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan Benefits, (b) request the Plan document or other documents related to the Plan or a claim for benefits, (c) file an appeal of a denied claim for Plan benefits, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Covered Person's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Covered Person and the provider or its representative or agent), the Plan Administrator, Claims Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Covered Person, or to another designated person or entity, with or without the Covered Person's authorization, with each such payment being made on behalf of the Covered Person, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator, Claims Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator, Claims Administrator or Claims Fiduciary of the anti-assignment provisions of this section. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Covered Person for benefits under the Plan to the full extent of such payment. Accordingly, if a provider is overpaid as the result of accepting a payment for the same Covered Health Services from you and from the Plan, then the provider, and not the Plan, shall be responsible for reimbursing you for such overpayment. Disclosures of information about the Covered Person can only be made to a Covered Person or a Covered Person's authorized representative and in accordance with applicable law and the terms of the Plan.

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.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

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 14, *Glossary* for the definition of Explanation of Benefits.

Claim Denials and Appeals

Types of Claims

There are four different types of claims under the Plan: Urgent Care Claims, Pre-service Claims, Post-service Claims and Concurrent Care Claims.

- an "Urgent Care Claim" is a claim for medical care or treatment with respect to which the time frames for making non-urgent care determinations either: i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or ii) in the opinion of a Physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The person acting on behalf of the Plan shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine to determine if a claim is an Urgent Care Claim. Notwithstanding the above, any claim that a Physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim, as defined above, shall be treated as an Urgent Care Claim.
- a "Concurrent Care Claim" is any claim after the Plan has approved an ongoing course of treatment to be provided over a period of time that involves a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period or course or number of treatments or any request by or on behalf of the claimant to extend such treatment or expand the number of treatments.
- a "Pre-Service Claim" is any claim for Benefits under the Plan for which the Benefit is conditioned on obtaining approval or authorization prior to obtaining the medical care.
- a "Post-Service Claim" is any claim for Benefits under the Plan that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you will receive a written notice of the denial that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

If your claim for Benefits is denied, you may call UnitedHealthcare at the number on your ID card to try to resolve the issue before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, in order to preserve your rights under federal law you must file a formal appeal as described below.

To the extent required by applicable law, the Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-service Claim, 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 do not need to submit Urgent Care Claim appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

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

For Urgent Care Claims that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care Claim;
- Pre-service Claim;
- Post-service Claim; or
- Concurrent Care Claim.

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; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

The appeal will not give deference to the initial denial.

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 that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, in order to preserve your rights under federal law, you must 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, documents and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the denial of your appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

Before the Plan can deny your appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the denial of your

appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

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 that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Federal External Review Program

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:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- 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 toll-free 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; and
- 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; and

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

Expedited External Review

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

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; or
- 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 Plan at the time the health care service or procedure that is at issue in the request was provided; and
- 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 anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at 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.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The types of claims are described above under the heading *Types of Claims*.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

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.

The tables below describe the time frames which you and UnitedHealthcare are required to follow. The timeframes applicable to Concurrent Care Claims are described in a separate section below, under the heading *Concurrent Care Claims*.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving the request for additional information

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If UnitedHealthcare denies your initial claim, they must notify you of the denial within: ■ if the initial claim is complete: ■ after receiving the completed claim (if the initial claim is incomplete):	**72 hours** **72 hours** **48 hours**
If UnitedHealthcare denies your claim, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care Claim.

Pre-Service Claims*	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, UnitedHealthcare must notify you within:	**5 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving the request for additional information
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within: ■ after receiving the completed claim (if the initial claim is incomplete), within:	**15 days*** **15 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

Pre-Service Claims*	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days for its initial claim determination if more time is needed due to circumstances beyond control of the Plan. In that case, UnitedHealthcare will notify you prior to the initial 15-day decision timeframe of the circumstances which require the extension of time and the date by which UnitedHealthcare expects to render its decision on your claim.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice
If UnitedHealthcare denies you initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days***
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control, provided that within the initial 15 days, they notify the claimant of the circumstances requiring the extension and the date by which they expect to render a decision.

Concurrent Care Claims

In the event UnitedHealthcare determines to reduce or terminate a course of treatment or a series of treatments, the affected individual will be notified in writing of the intended termination or reduction (the adverse benefit determination) sufficiently in advance of the reduction or termination so that the affected individual may appeal the adverse benefit determination. Any decision on the appeal of the adverse benefit determination on the reduction or termination must be rendered before the reduction or termination of the care or course of treatment.

If UnitedHealthcare receives a request to extend care that is an Urgent Care claim, UnitedHealthcare must render a decision within 24 hours of receipt of the claim, provided the claim is received at least 24 hours before care is scheduled to expire. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

UnitedHealthcare shall render a decision on the appeal of a Concurrent Care Claim to extend care within the time period applicable to an appeal of an Urgent Care Claim, Pre-Service Claim or Post-Service Claim described above, respectively, depending upon whether the claim is also defined as an Urgent Care Claim, a Pre-Service Claim or a Post-Service Claim.

Limitation of Action

You cannot for any reason bring any action at law or in equity to recover benefits under the Plan unless you first complete all the steps in the appeals process described in this section. Any action at law or in equity with respect to any and all claims relating to the Plan (including against Anadarko Petroleum Corporation, the Plan Administrator or the Claims Administrator) must be brought for recovery within one year from the earlier of (1) the date of a final internal adverse benefit determination, if applicable, or (2) the accrual of any claim under or relating to the Plan that does not result in a final internal adverse benefit determination. Otherwise, you lose any rights to bring such an action.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one 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 (subject to the "Note" in the section entitled *Determining Which Plan is Primary*, below).
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided 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 paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans (including this Plan), the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. 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; or
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- 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 not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

Note: The Plan does not automatically coordinate with auto liability or no-fault insurance coverage; however, the subrogation and recovery provisions of Section 11, Subrogation and Reimbursement, may apply to a Covered Person's right to Benefits under the Plan.

The following examples illustrate how the Plan 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 employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

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. This Plan 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

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

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

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

Determining the Allowable Expense If 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 a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare*.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable

expense, as long as the provider accepts assignment of your Medicare benefits with respect to his, her or its services. If the provider accepts such assignment, 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 with respect to his, her or its services, the Medicare limiting charge (the most that such providers can charge you if they don't accept Medicare assignments – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

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

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

Medicare Crossover Program

The Plan 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 Plan 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 this Plan 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 this Plan.

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 go on 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 this Plan and other plans. UnitedHealthcare 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 this Plan and other plans covering the person claiming Benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this; provided, however, that any such use or disclosure of your information will be only as permitted by applicable privacy and security laws, including the privacy and security regulations issued under HIPAA. Each person claiming Benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine Benefits payable. If you do not provide UnitedHealthcare 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 a Covered Person is covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Covered Person or to (i) a health care or other services provider (including a Covered Person's assignee as described under *Assignment and Payment of Benefits* in Section 9, *Claims Procedures*), (ii) an insurance company or (iii) any other person or entity, for the benefit of a Covered Person (collectively, a "Third-Party Payee"), such erroneously-paid amount shall constitute an "Overpayment" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Covered Person or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount (Overpayment Reimbursement). Without limitation, the Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA and shall be construed accordingly. By accepting a benefit, premium or fee under the Plan, each Covered Person and Third-Party Payee automatically acknowledges and agrees that the Plan has the right to pursue Overpayment Reimbursement from the general assets of the Covered Person or Third-Party Payee to whom the Overpayment was made, to the full extent permitted by ERISA.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Covered Person (including, without limitation, to a covered Employee on behalf of any of his or her Dependents or beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable on behalf of the Covered Person, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary, as applicable, deems to be appropriate in its discretion, to the extent permitted by law.

The Plan or the Company may obtain Overpayment Reimbursement in the form of an offset against salary or wages (if the Covered Person is an Employee) or against benefits payable to or on behalf of the Covered Person under any Company-sponsored benefit plans, including, but not limited to the Plan (but not a qualified pension plan as defined by ERISA and the Internal Revenue Code), to the extent permissible under applicable law and the terms of the applicable benefit plan. For example, the selected recovery method may include, without limitation, payroll deduction in the case of an Employee or his/her Dependent or beneficiary (in which case the Employee must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his or her participation, or continued participation, in the Plan). Furthermore, the Plan Sponsor and the Plan each reserve the right to obtain Overpayment Reimbursement by legal action.

If the Plan overpays a Third-Party Payee that is a Covered Person's health care provider (for purposes of this *Overpayment and Underpayment of Benefits* section only, a "**Provider**"), then, in addition to the recovery actions permitted under the preceding paragraphs of this section, the Company and the Plan reserve the right to obtain Overpayment Reimbursement from the Provider pursuant to *Refund of Provider Overpayments*, below.

Refund of Provider Overpayments

If the Plan pays Benefits to a Provider for expenses incurred by or on account of a Covered Person, that Covered Person or Provider must make a refund to the Plan if:

- the Plan's obligation to pay the Benefits was contingent on the Covered Person's actual payment of the expenses or legal obligation to pay the expenses, and either some or all or some of the expenses were not paid by the Covered Person or the Covered Person had no legal obligation to pay the expenses;
- all or some of the payment made by the Plan exceeded the Benefits payable under the terms of the Plan; or
- all or some of the payment made by the Plan was made in error, according to the terms of the Plan.

The Overpayment amount that must be refunded to the Plan equals the amount the Plan paid in excess of the amount that was properly payable under the terms of the Plan. If such Overpayment refund is due from the Provider, the Covered Person agrees to reasonably assist the Plan in obtaining Overpayment Reimbursement when requested. If the Covered Person or Provider does not promptly refund the full amount of the Overpayment within a reasonable time period as determined by the Plan Administrator, the Plan may obtain Overpayment Reimbursement by (i) reallocating the Overpayment as an offset, in whole or in part, against future Benefits that are payable to or on behalf of the Covered Person under the Plan; or (ii) recouping the Overpayment by any other method which the Plan Administrator or Claims Fiduciary deems appropriate in its discretion, to the extent permitted by law, with the understanding that the reallocated or otherwise recouped payment will be reimbursed to the Plan. The amount of such payment will equal the amount of the Overpayment required to be refunded or, if less than the full amount of the required refund, will be deducted from the full amount of the refund owed to the Plan.

In the event of a Provider Overpayment, the Plan and the Company may have other legal rights to obtain Overpayment Reimbursement, in addition to the right to reallocate or otherwise recoup Overpayment amounts as enumerated above, including the right to commence a legal action to obtain Overpayment Reimbursement.

In the case of any Overpayment reallocation or other recoupment action described in this *Overpayment and Underpayment of Benefits* section, any such reallocation or recoupment against a payment to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to the ERISA claims and appeals procedures of the Plan. For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this section, the offset or other recoupment of the Overpayment hereunder is simply an adjustment to the amount owed to the Third-Party Payee to reflect the Overpayment to the Third-Party Payee and shall not be considered to be the denial or partial denial of any Benefit claim under the Plan.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The provisions of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable, will govern and control the Plan's rights to subrogation and reimbursement. These provisions are summarized in this section. Should there be any conflict between these subrogation and reimbursement provisions and those of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, the provisions in the applicable wrap-around Summary Plan Description will govern. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent permitted by applicable law as determined by the Plan Administrator.

Right of Subrogation and Reimbursement

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this section on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this section on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

Benefits Subject to this Provision

The provisions set forth in this section will apply to all benefits provided under the Plan. For purposes of this section, certain terms are defined as follows:

- **"Recovery"** means any and all monies and property paid by a Third Party to (i) the Covered Person, (ii) the Covered Person's attorney, assign, legal representative, or beneficiary, (iii) a trust of which the Covered Person is a beneficiary, or (iv) any other person or entity on behalf of the Covered Person, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the Injury or illness.
- **"Reimbursement"** means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Covered Person toward care and treatment of the Injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.
- **"Subrogation"** means the Plan's right to pursue the Covered Person's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.
- **"Third Party"** means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Covered Person's Injury or illness. The term "Third Party" will include the party or parties who caused the Injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the Injury or illness; a

Covered Person's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the Injury or illness.

When this Provision Applies

A Covered Person may incur medical or other charges related to any Injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the Injury or illness. If so, the Covered Person may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Covered Person has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Covered Person receives the Recovery or (b) the Covered Person's attorney, a trust of which the Covered Person is a beneficiary, or other person or entity receives the Recovery on behalf of the Covered Person. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Covered Person hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any Injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this section.

The Plan's equitable lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures, or may be entitled to procure, regardless of whether the Covered Person has received compensation for any or all of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Covered Person's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this section, and the Covered Person hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Covered Person:

- authorizes the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Covered Person's rights to Recovery when the provisions of this section apply;
- must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- must cooperate fully with the Plan in its exercise of its rights under this section, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Covered Person who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to the subsection *When a Covered Person Retains an Attorney* below, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this section (**S&R Agreement**).

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injury or illness. The Plan may file a copy of an S&R Agreement signed by the Covered Person and his or her attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Covered Person (and his or her attorney, as applicable), a Covered Person's claim for any medical or other benefits for any Injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Covered Person, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Covered Person's claim for benefits for the Injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injury or illness before an S&R Agreement

and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Covered Person who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Covered Person is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Covered Person automatically agrees, without further notice, to all the terms and conditions of this section and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this section and to make changes in its interpretation as it deems necessary or appropriate.

Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Covered Person receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Covered Person may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his or her charges and expenses.

When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or Injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this section.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses incurred are related to an illness or Injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Covered Person has already received a

Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, the Plan will not pay any portion of the Covered Person's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Covered Person's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Covered Person's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his or her pursuit of Recovery.

Any Recovery paid to the Covered Person's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Covered Person nor his or her attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

When the Covered Person is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent

The provisions of this section will apply to the parents, trustee, guardian or other representatives of a minor Dependent child and to the heirs or personal representatives of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this section, the term "Covered Person" will also include a COBRA qualified beneficiary who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Covered Person whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor (e.g., a full-time post-secondary student) and, in such event, the Employee will be liable for any breach of this section by the Employee or by such Dependent.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan

Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Covered Person and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce the provisions of this section, the Covered Person will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan 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.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Company ends;
- the date the Plan ends or is amended to eliminate your coverage;
- the date of your death;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the last day of the month you are no longer eligible to participate in the Plan (except that coverage may be continued until the last day of the month through which you are receiving disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan or have been certified as disabled by the Company's long-term disability insurance carrier for purposes of being eligible to receive income replacement payments under such disability insurance policy, unless such coverage is terminated earlier);
- the date, if any, on which you falsify information provided to the Plan, fraudulently or deceptively use Plan services or knowingly permit such fraud or deception by another person, including enrolling a person as a Spouse or other Dependent who does not qualify as a Dependent under the terms of the Plan;
- the last day of the month in which you complete six months of unpaid leave of absence; or
- if you are receiving long term disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan, the last day of the month in which you elect to receive your full distribution from the Anadarko Retirement Plan or the Kerr-McGee Corporation Retirement Plan.

See the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan for a complete description of when a Retired Employee's coverage ends under the Group Health Benefit of the APC Retiree Health Benefits Plan.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date on which the Plan is amended to eliminate coverage for the Dependent, for whatever reason;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the date the Dependent becomes covered under the Plan as an Employee;
- the date, if any, on which the Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person;
- the date Dependents' coverage ceases to be available to the Employee;
- the date on which an Employee elects to terminate coverage for his or her Dependent, provided that you notify Anadarko Petroleum Corporation of the intention to terminate coverage within 30 days prior to the date; or
- the last day of the calendar year in which a Dependent child ceases to be an eligible Dependent under the Plan; or the last day of the month in which any other Dependent ceases to be an eligible Dependent under the Plan.

Other Events Ending Your Coverage

If a Covered Person commits an act, practice, or omission that constitutes fraud, or makes 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, such Covered Person's coverage may be subject to rescission as permitted under the Affordable Care Act. In that case, the Plan will provide the Covered Person with a written notice as required by the Affordable Care Act which informs him or her of the date that his or her coverage will end; provided, however, the Covered Person will have the right to appeal any such rescission pursuant to the Plan's claim and appeal procedures, and his or her Plan coverage will remain in effect pending the outcome of any internal appeal under such procedures.

For purposes of the above, if the Covered Person is a Dependent, a failure by the covered Employee to provide timely notice to the Plan Administrator (or its designee) in accordance with the required notification procedures in this Benefits Booklet or the wrap-around Summary Plan Description of the APC Health Benefits Plan of an event that causes such Dependent to lose eligibility for coverage under the Plan shall be deemed to constitute an intentional misrepresentation of a material fact, in which case such Dependent's coverage may be subject to rescission as permitted under the Affordable Care Act.

Note: If a Covered Person's coverage is rescinded, the Plan Sponsor reserves the right to demand the repayment by such Covered Person of any Benefits paid to him or her (or paid in his or her name, or on his or her behalf) under the Plan following the effective date of his or her coverage rescission, as provided in Overpayment and Underpayment of Benefits in Section 10, Coordination of Benefits (COB).

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 Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability rendering the child medically incapacitated and unable to be self-supporting;
- the child depends mainly on you for support and resides with you for more than one-half of the year;
- either 1) you provide to Anadarko Petroleum Corporation proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age or 2) the child has such handicap or disability and is over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll in such coverage (i.e., the child cannot later be added to coverage under the Plan); and
- you provide proof, upon Anadarko Petroleum Corporation's request, that the child continues to meet these conditions.

The proof might include medical examinations at Anadarko Petroleum Corporation's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 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 Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available if the Plan is subject to the terms of COBRA. You can contact your Plan Administrator to determine if the Plan is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator 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 Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a

child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or

- an Employee's enrolled Spouse (or former Spouse).

A Domestic Partner, or the children of a Domestic Partner, who are covered under the Plan on the day prior to the qualifying event shall be treated as Qualifying Beneficiaries under the Plan, although such treatment is not a right required by COBRA.

A Retired Employee is not eligible to elect COBRA continuation coverage upon termination of his or her coverage under the Plan. However, for purposes of this section and a Spouse's or Dependent's eligibility to elect COBRA continuation coverage, a Retired Employee is considered a covered Employee.

Qualifying Events for Continuation Coverage under COBRA

The following table 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	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage because your employment terminates or your hours are reduced[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate) or dissolve a 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	N/A	See table below	See table below

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Anadarko Petroleum Corporation files for bankruptcy under Title 11, United States Code[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within 60 days after the latest of a) the determination of the disability, b) the date of the qualifying event, or c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2] This is a qualifying event for any Retired Employee 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.

[3] From the date of the Employee's death if the Employee dies during the continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your Spouse and/or Dependent children in your family can get additional months of COBRA continuation coverage, up to the maximum of 36 months. This extension is available to your Spouse and/or Dependent children if you die, enroll in Medicare (Part A, Part B, or both), or get divorced or legally separated, or dissolve a Domestic Partnership. The extension is also available to a dependent child when that child stops being eligible under the Plan as a Dependent. In all of these cases you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

*Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, dissolution of Domestic Partnership or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation, dissolution of Domestic Partnership or an enrolled Dependent's loss of eligibility as an enrolled Dependent;

- the date your enrolled Dependent would lose coverage under the Plan; or
- 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 Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Anadarko Benefits Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

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 a Qualified Beneficiary first becomes entitled to Medicare (for this purpose, "entitled to Medicare" means enrolled in either Part A or Part B of Medicare);
- the last day of the month for which the required premium payments have been made, if such payments are not made timely;
- the later of the date the entire Plan ends or Anadarko Petroleum Corporation ceases to maintain a group health plan within its controlled group;
- in the case of a disabled Qualified Beneficiary (and his or her disabled or non-disabled family members) receiving COBRA coverage under the 11-month disability extension described in the chart above, and with respect to such extension, the first day of the month that begins more than 30 days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not

be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Anadarko Petroleum Corporation;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator 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 Plan as your Dependent, and the Plan 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 Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Anadarko Petroleum Corporation

In order to make choices about your health care coverage and treatment, Anadarko Petroleum Corporation believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan 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 Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefits Booklet); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Anadarko Petroleum Corporation and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Anadarko Petroleum Corporation and UnitedHealthcare may use individually identifiable information about you as permitted or required by law, including in operations and in research. Anadarko Petroleum Corporation and UnitedHealthcare may use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Anadarko Petroleum Corporation, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Anadarko Petroleum Corporation's agents or employees, nor are they agents or employees of UnitedHealthcare. Anadarko Petroleum Corporation 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.

Anadarko Petroleum Corporation and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Anadarko Petroleum Corporation and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare'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 Anadarko Petroleum Corporation's employees nor are they employees of UnitedHealthcare. Anadarko Petroleum Corporation and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Anadarko Petroleum Corporation and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Anadarko Petroleum Corporation is solely responsible for funding the payment of Benefits on a timely basis through its general assets. The Plan Administrator is solely responsible for (a) determining and administering enrollment (and disenrollment) in the Plan, and (b) notifying you of the termination of, or modifications to, the Plan as required by ERISA.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a Covered Person's responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.

- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- 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).
- Must decide with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

Interpretation of Benefits

The Plan Administrator has delegated to UnitedHealthcare, in its capacity as the Claims Administrator and Claims Fiduciary, the sole discretion and authority to (a) interpret the terms, conditions, limitations and exclusions of the Plan, including this Benefits Booklet and any amendments thereto, and (b) make factual determinations under the Plan, for the purpose of making final decisions regarding Benefits payable under the Plan. All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal procedures of the Plan. Benefits under the Plan will be paid only if UnitedHealthcare determines in its discretion that the Covered Person is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination or action by any court. Any review of any such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

Information and Records

All uses and disclosures of your protected health information (as defined by the HIPAA privacy regulations, *i.e.*, "**PHI**") or any other individually identifiable information about you, as discussed in this Benefits Booklet, including this Section, shall be as permitted by, and in accordance with, applicable law, including the HIPAA privacy regulations.

Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare may use your PHI to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. In addition, UnitedHealthcare may request additional information from you to decide your claim for Benefits. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare will keep this information confidential. Anadarko Petroleum Corporation and UnitedHealthcare may also use your de-identified data for commercial purposes, including research.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you, to the extent permitted by applicable law. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time for any permitted purpose under applicable law. This

applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Anadarko Petroleum Corporation is required to do by law or regulation. During and after the term of the Plan, Anadarko Petroleum Corporation and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Anadarko Petroleum Corporation recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.
In some cases, Anadarko Petroleum Corporation and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designated persons or entities will be required to use or disclose your information only as permitted by applicable law, including the HIPAA privacy regulations.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Anadarko Petroleum Corporation recommends that you discuss participating in such programs with your Physician. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Anadarko Petroleum Corporation and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Anadarko Petroleum Corporation and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend the Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Code or ERISA, or any other reason. A Plan amendment may transfer coverage to another plan or split a plan into two or more parts. If the Company does amend or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

If the Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on the terms of the Plan and may also depend on any contract provisions affecting the Plan and Company decisions.

Plan Document

This Benefits Booklet describes certain terms of your Benefits under the Plan. When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet, or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP

Options Plan, including this Benefits Booklet. If there should be an inconsistency between the contents of this Benefits Booklet and the contents of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, your rights shall be determined as provided in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. A copy of the documents that constitute the Plan is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your authorized representative) may obtain a copy of these documents by written request to the Plan Administrator or its designee, for a nominal charge.

UnitedHealthcare Reimbursement Policies

UnitedHealthcare, as Claims Administrator and Claims Fiduciary, determines Eligible Expenses under the Plan in accordance with the applicable terms and conditions of coverage under the Plan, which include UnitedHealthcare's applicable reimbursement policies. To the extent required by ERISA, such policies are incorporated into the SPD and the Plan by reference. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies and the other applicable terms of the Plan are applied to provider billings. Network Physicians and providers are not permitted to bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because the Plan, including one of UnitedHealthcare's reimbursement policies, does not provide for reimbursement or payment (in whole or in part) for the amount that the provider billed for the service(s) rendered to you.

UnitedHealthcare shares its reimbursement policy guidelines with Network Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. You (or your authorized representative on your behalf) may also obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefits Booklet.

Many of the terms used throughout this Benefits Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefits Booklet, but it does not describe the Benefits provided by the Plan.

Affiliates – those entities (including, but not limited to, United Resource Networks) which are affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare's ultimate corporate parent, including direct and indirect subsidiaries.

Affordable Care Act – the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

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; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

Annual Enrollment – the period of time, determined by Anadarko Petroleum Corporation, during which eligible Employees may enroll themselves and their Dependents under the Plan. Anadarko Petroleum Corporation determines the period of time that is the Annual Enrollment period.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- in vitro fertilization (IVF);

- gamete intrafallopian transfer (GIFT);
- pronuclear stage tubal transfer (PROST);
- tubal embryo transfer (TET); and
- zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorders – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The BRS program provides:

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

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any amendments thereto.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its Affiliates, as designated by the Plan Administrator to provide certain claim and other administration services for the Plan.

Claims Fiduciary – UnitedHealthcare (also known as United HealthCare Services, Inc.), as designated by the Plan Administrator to make appeal determinations on all first and second levels of appeal (i.e., all internal appeals) regarding claims under the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Anadarko Petroleum Corporation.

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.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

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

- Medically Necessary;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefits Booklet are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- 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; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Network Benefits – if the Plan has a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that the Claims Administrator has identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not the Plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a 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 specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not related by blood or adoption;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- not be legally married to each other (in other words, the other person is not the Spouse of the Employee);
- be at least 18 years old;
- live together in a committed, monogamous relationship at the same place of residence for at least six months; and
- intend for their relationship to be continuous and of an indefinite duration.

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:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are (i) incurred by a Covered Person while the Plan is in effect and (ii) determined by UnitedHealthcare to be payable as Benefits under the Plan, in accordance with the provisions below and the "Eligible Expenses" provisions of Section 3, *How the Plan Works*.

The Plan Administrator has delegated to UnitedHealthcare in its capacity as the Claims Administrator and Claims Fiduciary, the discretion and authority to (a) decide whether a

treatment or supply is a Covered Health Service, (b) formulate the methods by which Eligible Expenses will be determined in accordance with the terms of the Plan, and (c) determine Eligible Expenses that are payable as Benefits under the Plan.

Eligible Expenses are determined solely in accordance with the applicable terms and conditions of coverage under the Plan, which include UnitedHealthcare's applicable reimbursement policies (as described in Section 13, *Other Important Information*). UnitedHealthcare develops the reimbursement policy guidelines, in its discretion, in accordance with one or more of the following methodologies:

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

Emergency – a medical condition manifesting 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 to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- a medical screening examination (as required under section *1867 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; and
- 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 *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee – a regular employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Anadarko Petroleum Corporation.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

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

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not 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); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, Phase II or Phase 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 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described in Section 6, *Additional Coverage Details*, 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) – a statement provided by UnitedHealthcare 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 Plan; and

- the reason(s) why the service or supply was not covered by the Plan.

Fertility Solutions (FS) – a program administered by UnitedHealthcare or its affiliates made available to you under the Plan as provided in this Benefits Booklet. The FS program provides:

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

FS – see Fertility Solutions (FS).

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(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which 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; and
- 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 Skilled Nursing Facility, convalescent home or similar institution.

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 Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples

include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment – a structured outpatient Mental Health or Substance-related and Addictive Disorders treatment program that may be free-standing 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; or
- 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.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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 – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-related and Addictive Disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, Substance-related and Addictive Disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and

- 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 society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator – the organization or individual designated by Anadarko Petroleum Corporation who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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 or with its Affiliate to participate in the 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 Shared Savings Program.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care 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 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.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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 Plan.

To the extent an item or service is otherwise a Covered Health Service under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment or setting for an item or service, the Plan shall not discriminate based on a health care provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require the Plan to accept all types of providers into a Network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

Plan – The Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan) or the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet.

Plan Administrator – Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee.

Plan Sponsor – Anadarko Petroleum Corporation.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Private Duty Nursing – shift or continuous nursing care that encompasses nursing services for Covered Persons who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Private Duty Nursing services are provided where longer durations of skilled nursing care are required and may include shift care or 24/7 continuous care in certain settings. Private Duty Nursing care is not care provided primarily for the convenience of the Covered Person.

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 Disorders Services treatment. The facility meets all of the

following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an individual who, as of the date immediately preceding the individual's date of retirement, was enrolled as an active Employee in either the Anadarko Petroleum Corporation Health Benefits Plan (or its predecessor plan maintained by the Plan Sponsor) or a major medical, group health plan sponsored by another company on the date of such company's acquisition by the Company.

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 – UnitedHealthcare program under which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a scheduled rate previously agreed to by the non-Network provider with UnitedHealthcare (Scheduled Rate). When a discount is obtained based on the Scheduled Rate you may experience a lower amount of out-of-pocket expenses. The Plan's Coinsurance and Deductible would still apply to the reduced charge. Notwithstanding the foregoing, sometimes other Plan provisions regarding the basis for determining Eligible Expenses with respect to a non-Network provider's charges conflict with the Scheduled Rate, in which case a rate other than the Scheduled Rate may be applied by UnitedHealthcare as contractually permitted and in accordance with the "Eligible Expenses" subsection of Section 3, *How the Plan Works*, in order to determine Eligible Expenses. In that case, the non-Network provider may bill you for the difference between his or its billed amount and the amount of Eligible Expenses so determined by UnitedHealthcare. If this happens, you should call the number on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this Benefits Booklet does not include Mental Illness or Substance-related and Addictive Disorders,

regardless of the cause or origin of the Mental Illness or Substance-related and Addictive Disorder.

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 dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a 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 Plan.

SPD – the complete Summary Plan Description of the APC Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the APC Health Benefits Plan and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet), or the complete Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan and any appendices attached thereto, as they relate to the PPO HDHP Options Plan, including this Benefits Booklet), as applicable.

Spouse – a person to whom you are lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, without limitation, the Code, ERISA, and Affordable Care Act), and any regulations promulgated under such applicable federal law, but will not include an individual divorced from you under a court-approved divorce decree. The term "Spouse" will also include a common law spouse if you and your spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. You must provide proof of a ceremonial or common law marriage if requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state. For purposes of this Benefits Booklet, the term "Spouse" will also include a Domestic Partner, as defined in this section, unless the context indicates otherwise.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of Substance-related and Addictive Disorders that are listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded pursuant to Section 8, *Exclusions*. 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.

Substance-related and Addictive Disorder - a maladaptive pattern of substance use, including alcoholism, leading to clinically significant impairment or distress, as defined in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program℠ – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

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 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 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, at an Urgent Care Center. This definition of "Urgent Care" is not applicable for purposes of classifying an "Urgent Care Claim" under the Plan's claims and appeals procedures; see instead *Claim Denials and Appeals, Types of Claims* under Section 9, *Claims Procedures* for the applicable definition of "Urgent Care Claim".

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.

SECTION 15 - PRESCRIPTION DRUG PRODUCTS

What this section includes:

- Benefits available for Prescription Drug Products;
- How to utilize the retail and mail order service for obtaining Prescription Drug Products;
- Any benefit limitations and exclusions that exist for Prescription Drug Products; and
- Definitions of terms used throughout this section related to the Prescription Drug Products portion of the Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Products benefits. It includes Copay amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

Covered Health Services[1,2]	**Your Copayment Amount**[3]	
	Network	**Non-Network**
Retail - up to a 30-day supply[4,5]	After you meet the Annual Deductible:	After you meet the Annual Deductible:
■ Tier 1	$3 Copay	$3 Copay
■ Tier 2	20% of the Prescription Drug Charge but not less than $20 and not more than $200	20% of the Out-of-Network Reimbursement Rate but not less than $20 and not more than $200
■ Tier 3	30% of the Prescription Drug Charge but not less than $20 and not more than $200	30% of the Out-of-Network Reimbursement Rate but not less than $20 and not more than $200
■ Tier 4 (includes all Specialty Prescription Drugs)	$67 Copay	$67 Copay

Covered Health Services[1,2]	Your Copayment Amount[3]	
	Network	**Non-Network**
Mail order - up to a 90-day supply[4]	After you meet the Annual Deductible:	
■ Tier 1	$6 Copay	Not Covered
■ Tier 2	20% of the Prescription Drug Charge but not less than $40 and not more than $200	Not Covered
■ Tier 3	30% of the Prescription Drug Charge but not less than $40 and not more than $200	Not Covered
■ Tier 4 (includes all Specialty Prescription Drugs)	$67 Copay	Not Covered

[1]You must obtain prior authorization from UnitedHealthcare to receive full Benefits for certain Prescription Drug Products. Otherwise, you may pay more out-of-pocket. See *Prior Authorization Requirements* in this section for details.

[2]You are not responsible for paying a Copayment or Coinsurance for Preventive Care Medications.

[3]If you choose not to substitute a lower-tiered drug for a chemically equivalent higher-tiered drug, you will pay the cost difference between the two drugs, in addition to the higher-tiered drug's Copayment or Coinsurance. This difference in cost is called an Ancillary Charge. See *Prescription Drug Products that are Chemically Equivalent* and the definition under *Glossary – Prescription Drug Products* in this section for details.

[4]Specialty Prescription Drugs are limited to a 30-day supply.

[5]Up to a 90-day supply of a retail-purchased Prescription Drug Product is available. For a 31-60-day supply, the Copay shown above will be doubled. For a 61-90-day supply, the Copay shown above will be tripled.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this Benefits Booklet.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy and then submit a manual claim for Benefits to:

Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier 1, tier 2, tier 3 and tier 4 Prescription Drug Products. All Prescription Drug Products covered by the Plan are categorized into these four tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier 1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier 1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier 2 is your middle Copay/Coinsurance option. Consider a tier 2 drug if no tier 1 drug is available to treat your condition.
- Tier 3 and Tier 4 are your highest Copay/Coinsurance options. The drugs in tier 3 and tier 4 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

Note: Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:

- The applicable Copayment and/or Coinsurance; or
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay or Coinsurance; or
- the Prescription Drug Charge for that particular Prescription Drug Product.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail Pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drug Products:

- as written by a Physician;
- up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. (***Note:*** You may obtain up to a 90-day supply if you pay a Copay for each 30-day supply);
- when a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drug Products :

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Products portion of the Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Assigning Prescription Drug Products to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug Product placement in tiers. In its evaluation of each Prescription Drug Product, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug Product; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general

population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Product benefit.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

The Plan may also require you to obtain prior authorization from UnitedHealthcare so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

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

Non-Network Pharmacy Prior Authorization

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

If UnitedHealthcare has not provided prior authorization before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug Product order or refill. You will be required to pay for the Prescription Drug Product at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Product Charge) will not be available to you at a non-Network Pharmacy. If UnitedHealthcare has not provided prior authorization before you purchase the Prescription Drug Product, you can request reimbursement after you receive the Prescription Drug Product - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge and any Deductible that applies.

To determine if a Prescription Drug Product requires prior authorization, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drug Products requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the toll-free number on your ID card.

Prescription Drug Product Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drug Products are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug Product has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator have developed, subject to periodic review and

modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change and an Ancillary Charge may apply. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug Product is assigned.

Prescription Drug Products that are Chemically Equivalent

If two drugs are chemically equivalent (they contain the same active ingredient) and you choose not to substitute a lower-tiered drug for the higher-tiered drug, you will pay the difference between the higher-tiered drug and the lower-tiered drug, in addition to the higher-tiered drug's Copayment or Coinsurance. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is chemically the same available at a lower tier. An Ancillary Charge will not apply when a covered Prescription Drug Product is dispensed at your Physician's request if the prescription indicates to "dispense as written" (DAW).

Special Programs

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

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced benefit, or no benefit, based on whether the Prescription Drug Product was prescribed by a specialist physician. You may access information on which Prescription Drug Products are subject to benefit enhancement, reduction or no benefit through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Rebates and Other Discounts

UnitedHealthcare and Anadarko Petroleum Corporation may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays and Coinsurance.

The Claims Administrator and a number of its Affiliates, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Product section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Product section.

The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician or your pharmacy that communicate a variety of messages, including information about Prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drug Products are excluded.

Medications that are:

1. for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

2. any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drug Products*) portion of the Plan;

   This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

5. compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product;

6. dispensed outside of the United States, except when required due to an Emergency or Urgent Care need;

7. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

8. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition;

9. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;

10. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;

11. certain Prescription Drug Products that have not been prescribed by a specialist physician;

12. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

13. prescribed, dispensed or intended for use during an Inpatient Stay;

14. Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that UnitedHealthcare (and Anadarko Petroleum Corporation, for purposes other than claims decisions) determines do not meet the definition of a Covered Health Service;

15. a Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product, as determined by UnitedHealthcare. In its discretion, UnitedHealthcare may make such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

16. a Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product, as determined by UnitedHealthcare. In its discretion, UnitedHealthcare may make such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

17. certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, as determined by UnitedHealthcare, unless otherwise required by law or approved by UnitedHealthcare. In its discretion, UnitedHealthcare may make

such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

18. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

19. unit dose packaging of Prescription Drug Products;

20. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Anadarko Petroleum Corporation have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

21. used for cosmetic purposes;

22. Prescription Drug Product as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed;

23. certain Prescription Drug Products for smoking cessation;

24. dental products, including but not limited to prescription fluoride topicals;

25. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

26. any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury;

27. medications used for cosmetic purposes; and

28. a Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

Glossary - Prescription Drug Products

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or MAC List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Out-of-Network Reimbursement Rate or MAC List price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Out-of-Network Reimbursement Rate or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier.

Brand-name - a Prescription Drug Product that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Prescription Drug Products.

Generic - a Prescription Drug Product that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drug Products to Covered Persons;

- agreed to accept specified reimbursement rates for Prescription Drug Products; and
- been designated by the Claims Administrator as a Network Pharmacy.

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

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

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

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

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

- Inhalers (with spacers);
- Insulin;
- [[Certain immunizations][Immunizations] administered in a pharmacy]; and
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips – glucose;
  - Urine-testing strips – glucose;
  - Ketone-testing strips and tablets;

- Lancets and lancet devices; and
- Glucose meters (this does not include continuous glucose monitors; Benefits for continuous glucose monitors are provided as described in the portion of this Benefits Booklet regarding the medical benefits coverage component of the Plan).

Preventive Care Medications - the medications that are obtained at a Network Pharmacy and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- 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;
- 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; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Note: The Plan considers all Prescription Drug Products used for contraceptive purposes to be Preventive Care Medications. This includes oral contraceptives, injectable drugs and contraceptive devices.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Specialty Prescription Drug - Prescription Drug Product that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Infertility. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutically Equivalent – when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

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

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the Plan, as well as information required of all summary plan descriptions by ERISA as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Plan Administrator

Anadarko Petroleum Corporation is the Plan Sponsor of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan. The Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee is the Plan Administrator of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan and has the discretionary authority and control to interpret the Plan, control and manage the operation and administration of the Plan and make all decisions and determination incident thereto, except to the extent otherwise delegated to other persons or entities. You may contact the Plan Administrator at:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Attn: Director, Global Benefits
1201 Lake Robbins Drive
The Woodlands, TX 77380
(832) 636-1000

Claims Administrator and Claims Fiduciary

UnitedHealthcare is the Plan's Claims Administrator and Claims Fiduciary. The role of the Claims Administrator and Claims Fiduciary is to administer, review and make final determinations regarding claims for Benefits under the Plan. As Claims Administrator, UnitedHealthcare also provides other day-to-day administrative services with respect to the Plan pursuant to an administrative services agreement with the Company. UnitedHealthcare shall not be deemed, or construed as, an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. UnitedHealthcare shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator/Claims Fiduciary by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent for Service is:

With respect to the Anadarko Petroleum Corporation Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

With respect to the Anadarko Petroleum Corporation Retiree Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Retiree Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

Other Administrative Information

This section of your Benefits Booklet contains information about how the Plan is administered as required by ERISA.

Type of Administration

The PPO HDHP Options Plan is a component of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan, with administration provided through one or more third party administrators. The PPO HDHP Options Plan is incorporated by reference into the APC Health Benefits Plan and the APC Retiree Health Benefits Plan, each of which is a separate employee welfare benefit plan for purposes of ERISA.

Plan Names and Plan Numbers:	Anadarko Petroleum Corporation Health Benefits Plan, Number 501 Anadarko Petroleum Corporation Retiree Health Benefits Plan, Number 504
Employer ID:	76-0146568
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee/Retiree Employee/Surviving Dependent and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan 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 Plan information, including insurance contracts and collective bargaining agreements (if applicable), and any updated SPD, by writing to the Plan Administrator or its designee. The Plan Administrator may make a reasonable charge for copies; and
- receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the SPD and the wrap-around Plan document to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan 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. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or summary annual report from the Plan, 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 disagree with that denial, you must file an appeal (and second level appeal if the appeal is denied) in accordance with the claim and appeal procedures described in Section 9, *Claims Procedures*. If your second level appeal is denied, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a

domestic relations order, you may file suit in federal court after exhausting the claim and appeal procedures described in Section 9, *Claims Procedures*. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. 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 (866) 444-3272.

The Plan's Benefits are administered by the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee, which is the Plan Administrator. UnitedHealthcare is the Claims Administrator and Claims Fiduciary and processes claims for the Plan and provides appeal services; however, UnitedHealthcare, Anadarko Petroleum Corporation, and the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare, Anadarko Petroleum Corporation, and the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act (PPACA)

Patient Protection Notices

The Plan 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 and who is available to accept you or your family members. If you are required to designate a primary care provider, the Plan will designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator 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.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits for 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; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. See Section 5, *Plan Highlights* for details. Limitations on Benefits are the same as for any other Covered Health Service. If you would like more information on these Benefits, contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

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

Under federal law, group health plans, such as the Plan, and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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 mother's or newborn's attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

In addition, the Plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization from the Plan 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 the Plan Administrator (or its designee) or issuer.

ATTACHMENT III - NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꭰ ᏏᏢ ᎫCZᏢᎫ Ꭻ4ᏫᎫ ᏂAᏭᎯW ᎥᏓ GᏙᏢ VᎯ ᏒR ᎫJAVᎫ ACᏫᎯVᎫ ᎢΘᏂᏫᎯᎫT, ᎺᏊ0ᵒᏫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒီးနွံ်ဘဉ်တါ်မၤစၢၤဒီးတါ်ဂ့ၢ်တါ်ကျိုၤလၢနကျိုဉ်ဒဉ်နဝဲလၢတလိဉ်ဟုဉ်အ ပူၤဘဉ်နွဉ်လီၤ.လၢတါ်ကဃ့နွံပှၤကတိၤကျိုးထံတါ်တက၊အဂီၢ်ကီးဘဉ်လီတဲစီအကျိုၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပှၤလၢအအိဉ်လၢနတါ်အိဉ်ဆူဉ်အိဉ်ချအတါ်ရဲဉ်တါ်ကျဲၤ အကၤအလိၤဒီးဆီဉ်လီၤနိၢ်ဂၤ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor a□ maroñ ñan bok jipañ im me□e□e ilo kajin eo a□ ilo ejje□□k wō□āān. Ñan kajjitōk ñan juon ri-ukok, kūr□ok nō□ba eo e□ōj an jeje ilo kaat in ID in karōk in ājmour eo a□, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T’áá jíík’eh doo bą́ąh ‘alínígóó bee baa hane’ígíí t’áá ni nizaád bee

Language	Translated Taglines
	niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit['iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíilchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и

Language	Translated Taglines
	информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	[illegible] [illegible] [illegible] TTY 711. 0 [illegible]
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ‘a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki “0”. Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

Program Document 3

UnitedHealthcare HDHP Out of Area Options Plan Booklet (2018), Group Number 755494

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2018)

Final

Benefits Booklet

Anadarko Petroleum Corporation
HDHP Out of Area Options Plan

Effective: January 1, 2018
Group Number: 755494

UnitedHealthcare®

4815-0745-2510 v.4

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support, prior authorization and Mental Health/Substance Use Disorder Administrator: (888) 512-4093;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

Anadarko Petroleum Corporation is pleased to provide you with this Benefits Booklet, which describes the HDHP Out of Area Options Plan health Benefits available to you and your covered family members under the Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan) and the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit[1] under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet.

This Benefits Booklet includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

The complete Summary Plan Description of the APC Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet) and the complete Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out

[1] The Summary Plan Description of the Group Health Benefit is one of two components of the full Summary Plan Description of the APC Retiree Health Benefits Plan. Apart from the Group Health Benefit, other group health benefits, unrelated to the HDHP Out of Area Options Plan, are provided to eligible individuals under the APC Retiree Health Benefits Plan. Such benefits are described in a separate summary plan description document that constitutes the other component of the full Summary Plan Description of the APC Retiree Health Benefits Plan.

of Area Options Plan, including this Benefits Booklet) are each referred to in this Benefits Booklet as an "SPD." The SPDs are designed to meet the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This Benefits Booklet supersedes any previous printed or electronic Benefits Booklet for the HDHP Out of Area Options Plan offered under the Plan.

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *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 Plan.

Anadarko Petroleum Corporation intends to continue the Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This Benefits Booklet is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this Benefits Booklet and the contents of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, your rights shall be determined as provided in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Anadarko Petroleum Corporation is solely responsible for paying Benefits described in this Benefits Booklet.

Please read this Benefits Booklet thoroughly to learn how the HDHP Out of Area Options Plan works. If you have questions contact the Anadarko Benefits Center at (866) 472-4711 or call the number on the back of your ID card.

How To Use This Benefits Booklet

- Read the entire Benefits Booklet, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this Benefits Booklet 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 Benefits Booklet and any future amendments at **www.anadarkoadvantage.ehr.com** or request printed copies by contacting the Anadarko Benefits Center at (866) 472-4711.
- Capitalized words in the Benefits Booklet have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Anadarko Petroleum Corporation is also referred to as Company.
- If there is a conflict between this Benefits Booklet and any benefit summaries (other than Summaries of Material Modifications to the SPD under ERISA) provided to you, this Benefits Booklet will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Important Note: Except as otherwise noted, the provisions of this Section 2 apply to coverage under the APC Retiree Health Benefits Plan, as applicable to the HDHP Out of Area Options Plan, only to the extent that such provisions are not inconsistent with the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, which governs and controls. Please refer to the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan for additional details regarding eligibility, enrollment and other coverage terms under the APC Retiree Health Benefits Plan for eligible Retired Employees and their eligible Dependents.

Eligibility

Retiree Eligibility Frozen on December 31, 2015

Notwithstanding anything in this Benefits Booklet to the contrary, eligibility to participate in the HDHP Out of Area Options Plan under the APC Retiree Health Benefits Plan was frozen on December 31, 2015, except as otherwise specifically provided in the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan. Consequently, only such Retired Employees, Dependents and other individuals as specifically provided in the Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan may become newly eligible to participate in the HDHP Out of Area Options Plan under the APC Retiree Health Benefits a Plan on or after January 1, 2016.

You are eligible to participate in the Plan if you are a regular full-time or part-time Employee who is eligible to participate in the APC Health Benefits Plan in accordance with the wrap-around Summary Plan Description of the APC Health Benefits Plan or a Retired Employee who is eligible to participate in the APC Retiree Health Benefits Plan in accordance with the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse (including your Domestic Partner), as defined in Section 14, *Glossary;*

- your or your Spouse's child who is under age 26, through the end of the year in which the child turns age 26; for purposes of this and the next bullet point, "child" includes a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse have a court appointed guardianship or conservatorship but only if such child primarily lives with you and is a member of your household; or
- your or your Spouse's child, beginning with the year of the child's 27th birthday, who is dependent upon you or your Spouse because of a mental or physical handicap rendering the child medically incapacitated and unable to be self-supporting (Disabled). The child must satisfy either of the following requirements:
  - prior to the end of the year of the child's 26th birthday, the child is Disabled and covered as a Dependent under the Plan; or
  - the child is Disabled and over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll for coverage (i.e., the Disabled child cannot later be added to coverage under the Plan).

  In addition, the child must reside with the Employee in his household for more than one-half of the year, and the child must not provide more than one-half of his own support for the year. Periodic proof of incapacity may be required by the Plan Administrator to continue coverage for the child.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both Employees and covered under the APC Health Benefits Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. If you and your Spouse are both Retired Employees and covered under the APC Retiree Health Benefits Plan, you may each be enrolled as a Retired Employee or be covered as a Dependent of the other person, but not both. However, if you are eligible for coverage as an Employee under the APC Health Benefits Plan and your Spouse is eligible for coverage as a Retired Employee under the APC Retiree Health Benefits Plan, you are not eligible for coverage as a Dependent under the APC Retiree Health Benefits Plan, but your Spouse is eligible for coverage as a Dependent under the APC Health Benefits Plan (subject to the other applicable terms of the APC Health Benefits Plan). In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Anadarko Petroleum Corporation share in the cost of the Plan. Your contribution amount depends on the options under the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children to be *per se* dependents for federal tax purposes (unless they meet the specific requirements for qualifying as tax dependents under the Internal Revenue Code of 1986, as amended (the "Code")). Therefore, the value of Anadarko Petroleum Corporation's cost in covering a Domestic Partner and the Domestic Partner's children may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children will be paid using after-tax payroll deductions.

Your contributions are subject to review and Anadarko Petroleum Corporation reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Anadarko Benefits Center at (866) 472-4711 or logging onto **www.anadarkoadvantage.ehr.com**.

How to Enroll

To enroll, call the Anadarko Benefits Center at (866) 472-4711, or log onto **www.anadarkoadvantage.ehr.com**, within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Annual Enrollment to make your benefit elections.

Each year during Annual Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Annual Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, the birth of a child, adoption of a child, placement for adoption of a child or other family status change, you must contact the Anadarko Benefits Center at (866) 472-4711 within 31 days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

Once the Anadarko Benefits Center receives your properly completed enrollment, coverage will begin on your initial date of eligibility, as described in the SPD. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date the Anadarko Benefits Center receives notice of your marriage, provided you notify the Anadarko Benefits Center within 31 days of your marriage. 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 Anadarko Benefits Center within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

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

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status that affects eligibility for coverage or you have a special enrollment right. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.), but you can generally enroll yourself and/or your Dependents in any medical Benefit Program offered under the Plan for which you are otherwise eligible as provided in the SPD if you have a special enrollment right. The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- establishing or dissolving a Domestic Partnership;
- the birth, adoption, placement for adoption or legal guardianship of a Dependent child;
- any of the following that change your or your Dependent's employment status: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Dependent's residence;
- a change in your or your Dependent's position or work schedule that impacts eligibility for health coverage;
- your or your Dependent's gain or loss of entitlement to Medicaid or Medicare;
- significant cost or coverage changes;
- a court or administrative order; and
- any other change in status event provided under the Anadarko Petroleum Corporation Pre-Tax Premium and Benefits Plan.

The following create special enrollment rights for purposes of the Plan:

- your marriage;
- the birth, adoption, placement for adoption of a Dependent child;

- loss of eligibility for other health coverage as a result of legal separation, divorce, loss of dependent status, death of an employee, termination of employment, or reduction in hours;
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and, with respect to the group market, no other benefit option is available to you or your eligible Dependent, resulting in a loss of eligibility for coverage;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- contributions are no longer paid by the Employer;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Anadarko Benefits Center within 60 days of termination); and
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Anadarko Benefits Center within 60 days of determination of subsidy eligibility).

Unless otherwise noted above, if you wish to change your elections, you must contact the Anadarko Benefits Center at (866) 472-4711 within 31 days of the change in family status. Otherwise, you will need to wait until the next Annual Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At Annual Enrollment, she elects not to participate in Anadarko Petroleum Corporation's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the Plan outside of Annual Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Providers;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Providers

As a participant in the Plan, 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.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Your level of Benefits will be the same if you visit a Network provider or non-Network provider. Because the total amount of Eligible Expenses may be less when you use a Network provider, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** 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 Physicians available in your Plan.

Network Providers

UnitedHealthcare or its Affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

See Attachment I to this Benefits Booklet, *Health Care Reform Notices*, for additional information regarding your right under applicable law to designate a primary care provider and receive certain Covered Health Services without a referral.

Network providers are independent practitioners and are not employees of Anadarko Petroleum Corporation 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 by such providers.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Eligible Expenses

Eligible Expenses are the charges for Covered Health Services that are (i) incurred by a Covered Person while the Plan is in effect and (ii) determined by UnitedHealthcare to be payable as Benefits under the Plan.

The Plan Administrator has delegated to UnitedHealthcare, in its capacity as the Claims Administrator and Claims Fiduciary, the discretion and authority to (a) decide whether a treatment or supply is a Covered Health Service, (b) formulate the methods by which Eligible Expenses will be determined, and (c) determine Eligible Expenses that are payable as Benefits under the Plan.

For Network Benefits, you are not responsible for any difference between the amount the provider bills and the portion of such amount that UnitedHealthcare determines constitutes Eligible Expenses. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills and the portion of such amount UnitedHealthcare determines constitutes Eligible Expenses.

Eligible Expenses are determined solely in accordance with (i) UnitedHealthcare's reimbursement policy guidelines, as described under the definition of Eligible Expenses in Section 14, *Glossary*, and (ii) the other applicable terms and conditions of coverage under the Plan.

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are based on the amount that is required by applicable law (including the Affordable Care Act), or, if no

amount is required by applicable law, then an amount negotiated or authorized by UnitedHealthcare, as permitted by applicable law.

For Non-Network Benefits, (*i.e.*, Benefits that are payable when Covered Health Services are received from a non-Network provider, except as the result of an Emergency or as arranged by UnitedHealthcare, as provided in the paragraph above), Eligible Expenses are based on one of the following amounts:

- Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's authorized vendors, Affiliates or subcontractors, at UnitedHealthcare's discretion, including, without limitation, pursuant to the Shared Savings Program.
- If rates have not been negotiated, then one of the following amounts, as applicable:
  - 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, with the exception of the following:
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or CMS competitive bid rates.
  - When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
  - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented in UnitedHealthcare's systems within 30 to 90 days after *CMS* updates its data. The *CMS*

published rate that is applicable to a participant's claim is the *CMS* published rate as reflected in UnitedHealthcare's systems on the date that such claim is incurred.

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

When a Covered Person transfers from another Benefit Program under the Plan, as described in the SPD, to this HDHP Out of Area Options Plan, any amount already applied to the annual deductible provision under that prior Benefit Program for the year will apply to the Annual Deductible provision under this HDHP Out of Area Options Plan.

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.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the maximum amount you will be required to 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 Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Copays for Covered Health Services available in Section 15, *Prescription Drug Products*	Yes
Payments toward the Annual Deductible	Yes
Coinsurance payments, including those for Covered Health Services available in Section 15, *Prescription Drug Products*	Yes
Charges for non-Covered Health Services	No
Charges that exceed Eligible Expenses	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program; and
- Covered Health Services which require prior authorization.

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefits Booklet, the Personal Health Support Nurse 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. Covered Persons 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 toll-free number on your ID card.

Prior Authorization

The Plan requires that you obtain prior authorization from the Claims Administrator for certain Covered Health Services. Services for which prior authorization is required are identified below and in Section 6, *Additional Coverage Details* within each Covered Health Service category.

IMPORTANT: Prior authorization is not a guarantee of any payment of Benefits. In addition to any prior authorization requirement, Benefits are also subject to all other applicable requirements of the Plan, including, but not limited to, any limitations and exclusions regarding coverage, timely payment of required contributions toward your coverage, and your eligibility at the time care and services are provided.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization from the Claims Administrator, please review it carefully so that you understand what services are subject to the authorization 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.

Note: Any request made by a person or entity other than a Covered Person (including, but not limited to, a health care provider) for prior authorization of Covered Health Services to be rendered to the Covered Person will be deemed to be a request *on behalf of the Covered Person* by his or her authorized representative for such purpose, and not a request by such other person or entity on his or its own behalf.

Covered Health Services which Require Prior Authorization

The Plan requires prior authorization from the Claims Administrator for certain Covered Health Services. Any request for prior authorization that is required under the terms of the Plan as a condition for obtaining Benefits for Covered Health Services constitutes a "Pre-Service Claim" under the Plan, as described in Section 9, *Claims Procedures*, and ERISA.

When you choose to receive any of those Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Your obligation to obtain prior authorization is also applicable whenever a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services are subject to the authorization and what providers are authorized to deliver the services that are subject to the authorization.

If you choose to receive a service that has been determined to not be a Medically Necessary Covered Health Service or has otherwise not received prior authorization if and as required, you will be responsible for paying all charges and no Benefits will be paid for that service.

Services for which you are required to obtain prior authorization are identified in Section 6, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Covered Health Service Benefit description in Section 6, *Additional Coverage Details*, to determine how far in advance you must obtain prior authorization.

You are also required to obtain prior authorization whenever a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

Contacting the Claims Administrator for prior authorization is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB).*

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	PPO Without Differential
Annual Deductible[1]	
■ Individual	$1,500
■ Family (cumulative Annual Deductible[2])	$3,000
Annual Out-of-Pocket Maximum[3]	
■ Individual	$3,500
■ Family (cumulative Out-of-Pocket Maximum[4])	$6,850
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in the Plan.	Unlimited

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

[2]The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

[3]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

[4]The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
Acupuncture Services	Depending upon where the Covered Health Service is provided, Benefits for acupuncture services will be the same as those stated under each Covered Health Service category in this section.
Ambulance Services	
■ Emergency Ambulance	80% after you meet the Annual Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay *Cancer treatment provided at any other facility is covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Other facility* Not Applicable*
Clinical Trials	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 ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible
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 Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drug Products*.
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
Emergency Health Services - Outpatient	80% after you meet the Annual Deductible
Hearing Aids ■ Examinations and Testing ■ Devices Up to $2,000 per hearing impaired ear every 36 months	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Home Health Care Up to 120 visits per calendar year	80% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible
Infertility Services and Fertility Solutions (FS) Program See Section 6, *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.
Kidney Resource Services (KRS)[3] *Kidney disease treatment provided at any other facility is covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Other facility* Not Applicable*
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible
Mental Health Services ■ Inpatient ■ Outpatient	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Neonatal Resource Services (NRS)[4] *Neonatal intensive care services provided at any other facility are covered as stated under each Covered Health Service category in this section.	*Designated Provider* 80% after you meet the Annual Deductible *Other facility* Not Applicable*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
Neurobiological Disorders - Autism Spectrum Disorder Services	
■ Inpatient	80% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible
Nutritional Counseling	
Note: Nutritional or diet counseling billed as a preventive care will be paid as described under *Preventive Care Services*.	80% after you meet the Annual Deductible
Obesity Treatment	
■ Non-Surgical Treatment	Depending upon where the Covered Health Service is provided, Benefits for non-surgical obesity treatment will be the same as those stated under *Physician's Office Services* in this section and in Section 15, *Prescription Drug Products*.
■ Surgical Treatment	
- Physician's Office Services	*Designated Provider* 80% after you meet the Annual Deductible *Other facility* Not Covered
- Physician Fees for Surgical and Medical Services	*Designated Provider* 80% after you meet the Annual Deductible *Other facility* Not Covered
- Hospital - Inpatient Stay	*Designated Provider* 80% after you meet the Annual Deductible *Other facility* Not Covered
- Lab and X-ray	*Designated Provider* 80% after you meet the Annual Deductible *Other facility* Not Covered
Orthognathic Surgery	Depending upon where the Covered Health Services is provided, Benefits for orthognathic surgery will be the same as those stated under each Covered Health

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Services category in this section.
Ostomy Supplies	80% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible
Pregnancy – Maternity Services A separate Deductible will not apply for a well newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits for Pregnancy – Maternity Services will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services ■ Physician Office Services ■ Lab, X-ray or Other Preventive Tests	 100% Annual Deductible does not apply 100% Annual Deductible does not apply

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
■ Breast Pumps	100% Annual Deductible does not apply
Private Duty Nursing - Outpatient Up to 70 visits per calendar year	80% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits for Reconstructive Procedures will be the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	80% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	80% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient ■ Outpatient	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible
Transplantation Services ■ Cornea Transplants ■ Other Covered Transplants	 Depending upon where the Covered Health Services is provided, Benefits for cornea transplants will be the same as those stated under each Covered Health Services category in this section. *Designated Provider* 100%

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Annual Deductible does not apply *Other facility* Not Covered
Travel and Lodging (If services rendered by a Designated Provider) See Section 6, *Additional Coverage Details*, for limits	For patient and companion(s) of patient undergoing cancer treatment, obesity surgery services, Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services	80% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible
Wigs	80% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 4, *Personal Health Support and Prior Authorization* to receive full Benefits for certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Provider facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

[3]These Benefits are for Covered Health Services provided through KRS at a Designated Provider facility. For kidney disease treatment not provided through KRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

[4]These Benefits are for Covered Health Services provided through NRS at a Designated Provider facility. For neonatal intensive care services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services – Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Lab, X-Ray and Diagnostics – Outpatient* and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from UnitedHealthcare before you receive them.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call UnitedHealthcare. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy given by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

Covered Health Services also include acupuncture when provided in lieu of anesthesia.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as possible prior to transport.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. "Designated Provider" is defined in Section 14, *Glossary*.

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

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (855) 583-3161; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Clinical Trials

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

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as 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; and
- 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 eligible for participation in the qualifying Clinical Trial according to the Clinical Trial protocol and such participation would be appropriate based on 1) medical and scientific information provided by the Covered Person or 2) the conclusion of a referring health care professional that is participating in the Clinical Trial.

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and

- other items and services that meet specified criteria in accordance with 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; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - ♦ comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    - ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before

participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or

- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of participation in a Clinical Trial arises. This requirement does **not** apply to Clinical Trials for cancer or other life-threatening diseases or conditions.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a Designated Provider facility. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks (which is an Affiliate of UnitedHealthcare) or UnitedHealthcare to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or UnitedHealthcare at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Designated Provider facility.

Prior Authorization Requirement
Please remember that you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as CHD is suspected or diagnosed.

Dental Services - Accident Only

Important note: Additional dental care services are covered under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The Plan 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 immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Except with respect to any accidental Injury that occurred prior to the Covered Person's effective date of coverage under the Plan, dental services for final treatment to repair the damage caused by accidental Injury must be (a) started within three months following the accident (unless extenuating circumstances exist, such as prolonged hospitalization or the presence of fixation wires from fracture care) and (b) completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic X-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);

- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies in this Section 6. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Prescription Drug Products*.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) 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)

The Plan pays for Durable Medical Equipment (DME) that is:

- 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 Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the 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;
- orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, braces to treat curvature of the spine, cranial orthotics (helmets), shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period and are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the repair/replacement of a type 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, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another

item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted to a Hospital as a result of an Emergency, you must notify UnitedHealthcare within two business days after the admission or otherwise as soon as reasonably possible.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Please remember that you must notify UnitedHealthcare within two business days after the admission or as soon as reasonably possible if you are admitted to a Hospital as a result of an Emergency.

Hearing Aids

The Plan 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 a Physician. Benefits under this section are provided for services performed by an audiologist or specialist for a diagnosis, the hearing aid and for charges for associated fitting and testing.

Note: Benefits for routine hearing screenings are provided under *Preventive Care Services*.

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 $2,000 per hearing impaired ear every 36 months.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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.

Benefits are limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before receiving services including nutritional foods and Private Duty Nursing or otherwise as soon as is reasonably possible.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission for an Inpatient Stay in a hospice facility or otherwise as soon as is reasonably possible.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for:
- A scheduled admission, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

Infertility Services and Fertility Solutions (FS) Program

Infertility services must be ordered by a Network provider and received at an FS Designated Provider facility and coordinated through FS.

The Plan has specific guidelines regarding Benefits for Infertility Services. Contact Fertility Solutions at 1-866-774-4626 for information about these guidelines.

Infertility Services

Covered Health Services for infertility services and associated expenses include:

- Physician's office visits and consultations.
- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI).
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI).
- Embryo transportation related network disruption.
- Ovulation induction and controlled ovarian stimulation.

- Pre-implantation genetic diagnosis (PGD) for diagnosis of genetic disorders only.
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Cryopreservation - embryo's (storage is limited to 3 months).

To be eligible for Benefits, the Covered Person must:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Have failed to achieve Pregnancy following six months of unsuccessful donor insemination.
- Have failed to achieve Pregnancy due to impotence/sexual dysfunction.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
- Be under age 44, if female.

In addition, the male related procedures described above are only available to males covered under the Plan.

Infertility Services for Same Sex Couples

The Plan will also pay for certain services for same sex couples. A female Covered Person without a male partner may be considered infertile if she is unable to conceive or maintain a pregnancy after six cycles of donor insemination (a non-covered benefit under this definition); proof of insemination must be provided. If conception is not achieved with insemination, the female Covered Person would then become eligible for advanced reproductive treatment including IVF as defined above. Any resulting embryos would be transferred only to the individual from whom the oocytes were derived.

A male Covered Person without a female partner is not covered for artificial insemination of a female surrogate. However, he is covered for the diagnosis and treatment of the male factor causing infertility (*e.g.*, treatment of sperm abnormalities including the surgical recovery of sperm).

Infertility Services for eSET

Elective SET is defined as the transfer of a single embryo, in which more than one high-quality embryo exists but it is decided to transfer only one embryo that is selected from a larger number of available embryos, at either the cleavage or blastocyst stage of embryo development. An increased benefit under the infertility benefit applies when you meet the clinical criteria. Please contact FS for further details.

Infertility Services for Donor Insemination

The Plan will cover donor insemination for a female without a male partner. Any resulting embryos could be transferred either to the individual from whom the oocytes were derived

or to her legally married partner. However, the cost of the donor sperm itself and any storage thereof is excluded from coverage.

Pre-implantation Genetic Screening (PGS)

The Plan also covers pre-implantation genetic screening (PGS) when used in conjunction with elective single embryo transfer. These technologies include, but are not limited to, array comparative genomic hybridization, quantitative polymerase chain reaction and single nucleotide polymorphism array testing.

Donor Coverage

The Plan will also cover the use of donor ovum and donor sperm and related costs, including collection and preparation. The Plan will not pay for the cost of the donor sperm or egg or any related donor fees.

Planning Cancer Treatment

Covered Persons with a diagnosis of cancer who are planning cancer treatment, or medical treatment for any condition that is demonstrated to result in infertility are considered to meet the definition of infertility. Planned cancer treatments include bilateral orchiectomy bilateral oophorectomy, hysterectomy, chemotherapy or radiation therapy that is established in the medical literature to result in infertility. In order to use infertility benefits covered under the Plan, you must notify FS and meet the following eligibility criteria:

- Covered Persons or their partners must not have undergone a previous elective sterilization procedure, (e.g. hysterectomy, tubal ligation, vasectomy), with or without surgical reversal, regardless of post reversal results.

- Covered Person must have had a day 3 FSH test in the prior 12 months if age less than 35 or the prior six months if age 35 or greater.

- Day 3 FSH level of the female Covered Person must not have been greater than 15 mIU/mL in any (past or current) menstrual cycle regardless of the type of infertility services planned (Including donor egg, donor embryo or frozen embryo cycle).

- Only those infertility services that have a reasonable likelihood of success are covered.

Coverage is limited to:

- Collection of sperm.
- Cryopreservation of sperm.
- Ovulation induction and retrieval of eggs.
- In vitro fertilization.
- Embryo cryopreservation.

Long-term cryopreservation costs (anything longer than three months) are not covered under the Plan.

Any combination of Network Benefits and Non-Network Benefits for infertility services received through the FS program is limited to $20,000 per Covered Person during the entire period you are covered under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of the need for infertility services arises.

What is Coinsurance?
Coinsurance is the amount you pay for a Covered Health Service, not including the Deductible.

For example, if the Plan pays 80% of Eligible Expenses for care received from a provider, your Coinsurance is 20%.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Providers participating in the Kidney Resource Services (KRS) program. "Designated Provider" is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

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

- lab and radiology/X-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

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

Prior Authorization Requirement
For sleep studies, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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;
- Residential Treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- outpatient treatment; and

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Providers participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. "Designated Provider" is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, the Network provider must notify NRS or UnitedHealthcare if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- call UnitedHealthcare; or
- call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

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; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the 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.

Benefits include the following levels of care:

- inpatient treatment;
- Residential Treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment; and
- 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; and
- crisis intervention.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and an admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, if you are going to obtain Neurobiological Disorders – Autism Spectrum Disorder Services from a non-Network provider you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

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 Treatment

Non-Surgical Treatment

The Plan covers structured weight loss programs provided by or under the direction of a Physician. Covered Health Services include:

- examination and diagnostic testing provided in a Physician's office;
- program costs, including monitoring of weight loss; and
- Pharmaceutical Products provided as part of the program.

Covered Health Services also include Prescription Drug products for appetite suppression or weight loss provided under Section 15, *Prescription Drug Products*.

Surgical Treatment

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- the Covered Person has a minimum Body Mass Index (BMI) of 40; or

- the Covered Person has a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria, the following must also be true:

- the Covered Person is 18 years of age or older, or for adolescents, has achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4;
- there is documentation of a motivated attempt at weight loss for a minimum of six months, prior to bariatric surgery and within the last two years, through a structured diet program that includes Physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program;
- the Covered Person completes a pre-surgical psychological evaluation within 12 months of surgery;
- the surgery is performed at a Bariatric Resource Service (BRS) Designated Provider facility by a Network surgeon even if there are no BRS Designated Providers near you.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

You will have access to a certain Network of Designated Providers and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in Section 14, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling toll-free at (888) 936-7246.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider facility.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of obesity surgery arises.

It is important that you provide notification regarding your intention to have surgery by calling either the toll-free telephone number on the back of your ID card or Bariatric Resource Services at (888) 936-7246. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Orthognathic Surgery

The Plan covers orthognathic surgery in the following situations:

- a jaw deformity resulting from facial trauma or cancer; or
- a skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
  - inability to incise solid foods;
  - choking on incompletely masticated solid foods;
  - damage to soft tissue during mastication;
  - speech impediment determined to be due to the jaw deformity; or
  - malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Prior Authorization Requirement
Please remember that you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before orthognathic surgery is performed during an Inpatient Hospital Stay in a Hospital.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan 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 Physician house calls, allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by the Claims Administrator.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as is reasonably possible before Genetic Testing – BRCA is performed.

Please Note
Your Physician does not have a copy of your Benefits Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - 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. Benefits for Pregnancy and maternity services that constitute required preventive health services under the Affordable Care Act are covered as *Preventive Care Services*.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 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 the 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.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as reasonably possible with respect to any Inpatient Stay for the mother and/or the newborn that will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

It is important that you call the toll-free number on the back of your ID card with notification regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital, and as otherwise required by the Affordable Care Act. 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 the Affordable Care Act and any other applicable law:

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

Note: Screening for hearing loss in newborns is a preventive care service.

In addition to the above guidelines, the Plan covers the following as preventive care services regardless of the Covered Person's age:

- For men and women:
  - abdominal aortic aneurysm screening;
  - cholesterol screening;
  - colorectal cancer screening; and
  - shingles vaccine.
- For women:
  - BRCA testing;
  - cervical cancer screening; and
  - HPV DNA testing.
- For men: prostate screening.
- For children: autism screening.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consultations to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. 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; and
- timing of an acquisition.

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

Benefits for preventive care services will be administered and provided hereunder in accordance with any applicable requirements of the Affordable Care Act.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Benefits are limited to 70 visits per calendar year. One visit equals up to eight hours of Skilled Care services.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type 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.

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

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before obtaining prosthetic devices that exceed $1,000 in cost per device.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. 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 a changed or improved physical appearance.

Improving or restoring physiologic function means that the 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.

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 the Plan if the initial breast implant followed mastectomy. Other services required 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 other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. The Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement
For:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before a scheduled Reconstructive Procedures is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification to the Claims Administrator within one business day following such procedure or as soon as is reasonably possible thereafter.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- vision therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), 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. 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 can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary 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, vocational training and Residential Treatment 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.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan 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 Plan 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.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services.*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or

Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available 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.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is 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;
- it is ordered by a Physician;
- 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; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Prior Authorization Requirement
Please remember for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification to the Claims Administrator as soon as is reasonably possible.

Substance-Related and Addictive Disorders Services

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

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

Prior Authorization Requirement
Please remember for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification to the Claims Administrator as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section 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 - Sickness and Injury* in this section.

Prior Authorization Requirement
For blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgeries, cochlear implant and orthognathic surgeries you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received or, for non-scheduled services, within one business day following receipt of such services or as soon as is reasonably possible thereafter.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

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.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) five business days before scheduled services are received or, for non-scheduled services, within one business day following receipt of such services or as soon as is reasonably possible thereafter: Dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Provider facility (subject to the exception below for cornea transplants). Benefits are available to the donor and the recipient when the recipient is covered under the Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;

- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (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.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or UnitedHealthcare for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or UnitedHealthcare at the telephone number on your ID card for information about these guidelines.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

If you don't obtain prior authorization from the Claims Administrator, as required, you will be responsible for paying all charges and no Benefits will be paid.

Travel and Lodging

The Plan may provide you with travel and lodging assistance Benefits. Travel and lodging Benefits are only available for you or your eligible family member if you meet the qualifications for the Benefit, including receiving care at a Designated Provider facility that is beyond a specified distance from your home address, as further described below. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Claims Administrator's 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 Benefits 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 Plan's per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation and lodging Eligible 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 $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.

- Phone calls, newspapers, or movie rentals.

Transportation

Benefits are payable for:

- 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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

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

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

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

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis for:

- loss of hair resulting from treatment of a malignancy or any medical condition with a medical diagnosis; or
- permanent loss of hair due to an accidental Injury.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Anadarko Petroleum Corporation believes in giving you the tools you need to be an educated health care consumer. To that end, Anadarko Petroleum Corporation has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Anadarko Petroleum Corporation are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You, your Spouse and your Dependent children over age 18 are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – the Plan's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Anadarko Petroleum Corporation has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drug Products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, call (855) 583-3161.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Call NurseLine℠ toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

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

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;

- coronary disease and
- bariatric surgery.

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

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium℠ Tier 1 Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk survey to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (855) 583-3161.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS).*

Disease Management Services

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

These programs offer:

- educational materials mailed to your home that provide guidance on managing your

specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;

- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

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

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Medication Management

UnitedHealthcare provides a service called the Medication Therapy Management Report especially for individuals who use multiple medications. This service looks to identify and prevent potential problems which can occur in individuals who use more than one

medication. In order to help you make the most of your medications, a copy of this report is sent to your Physician for review.

Your specific Medication Therapy Management Report includes a list of medications dispensed for you under your pharmacy benefit plan within the past six months. Your Physician is asked to review this report:

- to identify potential drug interactions with the prescription medications that have been prescribed to you;
- to note if more than one medication is serving the same purpose; and
- to determine if a needed medication is missing.

If your Physician identifies any concerns after reviewing the report, he or she may contact you if appropriate.

If you have any questions about any of the information presented in the Medication Therapy Management Report after you receive it please call the number provided on the report.

Wellness Programs

Healthy Back Program

UnitedHealthcare provides a program that identifies, assesses, and supports members with acute and chronic back conditions. By participating in this program you may receive free educational information through the mail and may even be called by a registered nurse who is a specialist in acute and chronic back conditions. This nurse will be a resource to advise and help you manage your condition.

This program offers:

- education on back-related information and self-care strategies;
- management of depression related to chronic back pain; and
- support in choosing treatment options.

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

Maternity Support Program

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

This program offers:

- enrollment by an OB nurse;

- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;
- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

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

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

Wellness Coaching

UnitedHealthcare offers a personalized Wellness Coaching program that can help you identify health risks, set goals and develop personalized strategies that empower you to make positive lifestyle changes to help improve your health and well-being. The one-on-one coaching integrates phone- and mail-based communications with an online interactive health coach on **www.myuhc.com**.

The Wellness Coaching program gives you access to specially trained personal wellness coaches to get you started and provides support that can keep you on track. These certified wellness coaches are cross-trained in multiple wellness concentrations for a more complete coaching experience. You will be assigned one wellness coach at the onset of your program and will be guided by the same coach throughout the program. Through information sharing, the wellness coach will work with you to create a personalized action plan that evolves throughout the program.

Wellness Coaching supports individuals with the following lifestyle issues:

- diabetes;
- exercise;
- heart health;
- nutrition;
- stress management;
- exercise programs;

- tobacco cessation; and
- weight management.

This program is offered at no cost to you or your Dependents. To enroll in the program, call Wellness Coaching toll-free at (800) 478-1057.

Anadarko Advantage – Rally Coins and Thanks! Points Incentive Programs

As part of the "Anadarko Advantage" wellness program, eligible individuals may earn two types of rewards for completing certain designated health-related activities through the Rally Coins and Thanks! Points Incentive Programs.

Eligibility

The following individuals are eligible to sign up and participate in the Rally Coins and Thanks! Points Incentive Programs:

- Any Employee, whether or not enrolled in medical coverage under a Benefit Program of the Plan that is administered by UnitedHealthcare (a "UHC Medical Program"); and
- Any Spouse or Domestic Partner who is enrolled in a UHC Medical Program (Rally Coins incentive only).

Rally Coins Incentive

Rally is an online wellness incentive program administered by UnitedHealthcare.

If you are eligible to participate, you must go to www.myuhc.com (or www.anadarko.werally.com, if you are an Employee who is not enrolled in a UHC Medical Program) and click on the "Rally Health Survey" link to enroll. When using Rally for the first time, you must create a profile online, set up a Rally account and complete a Rally Health Survey. Through the Rally Health Survey, a measure of your overall health (your "Rally age") will be calculated and UnitedHealthcare will identify and recommend particular activities for you (known as "missions") which are designed to help improve your diet, fitness or mood.

You may earn points and "coins" for completing any of the activities for your coverage class listed in the "Thanks! Points Incentive" section below. In addition, you may earn Rally "coins" for performing other activities as described on the Rally website. Please refer to the Rally website to identify the number of Rally "coins" that can be earned per activity. Please note, however, that "private challenges" (as may be described on the Rally website) are not provided for through the Anadarko Advantage – Rally Coins incentive program.

The Rally "coins" that you earn will be reflected on your Rally dashboard on the Rally website. You may spend your Rally "coins" only by entering sweepstakes for prizes, as offered on the Rally website.

Rally "coins" are not taxable. However, if you enter a sweepstakes with Rally coins and win a prize, your prize is taxable. You are solely responsible for any federal, state or local taxes that you owe with respect to any prize that you win.

Thanks! Points Incentive

Thanks! Points is an incentive program administered by Optum. If you are eligible to participate in Thanks! Points, you will automatically be enrolled when you enroll in Rally, as discussed above.

Once you are enrolled, you may earn Thanks! Points when you complete the following (based on whether or not you are enrolled in a UHC Medical Program):

Employee with coverage under a UHC Medical Program:

- Annual physical exam [1] = 1,000 points
- Mammography screening [1] = 1,000 points
- Cervical screening [1] = 1,000 points
- Colorectal cancer screening [1] = 1,000 points
- Rally Health Survey (see above) = 500 points
- Three Rally missions = 500 points
- Biometric screening [2] = 500 points

[1] You will receive your reward for these activities once your provider or an Anadarko Health Center files a medical claim for your annual physical exam or preventive screening.

[2] In order to complete this activity and earn your reward, your health care provider must complete and sign a "Health Provider Screening Form" for you. The form is prepopulated and personalized for each participant to ensure accuracy. You can access the form by clicking "Sign Up" on the "Get Screened" tile on your Rally dashboard and following the prompts. Once downloaded, the form should be taken to your appointment at an Anadarko Health Center or your health care provider's office. Either you or your health care provider may fax the completed form to the number at the bottom of the form.

Employee without coverage under a UHC Medical Program:

- Rally Health Survey (see above) = 500 points
- Rally Health Survey attestation question [3] = 1,000 points
- Three Rally missions = 500 points
- Biometric screening [4] = 500 points

[3] In order to earn points for this activity, when you take the Rally Health Survey, you must answer "yes" when asked whether you have plans to visit your primary care doctor for an annual checkup (or preventive care screening) during the current calendar year. If you do not answer "yes", you will not earn points for this activity, even if you change your answer later.

[4] In order to complete this activity and earn your reward, your health care provider must complete and sign a "Health Provider Screening Form" for you. The form is prepopulated and personalized for each participant to ensure accuracy. You can access the form by clicking "Sign Up" on the "Get Screened" tile on your Rally dashboard and following the prompts. Once downloaded, the form should be taken to your appointment at an Anadarko Health Center or your health care provider's office. Either you or your health care provider may fax the completed form to the number at the bottom of the form.

A maximum of 2,000 Thanks! Points may be earned each calendar year. You may use your Thanks! Points to purchase items, such as electronics, camping gear, gift cards and jewelry, through Anadarko's designated vendor for the Thanks! Points incentive program. Note:

Thanks! Points are accumulated in the same account that may be established for you under Anadarko's service award, safety award and/or Employee Excellence award programs.

Four to six weeks following your receipt of any Thanks! Points that you earn, the value of those points will be reported on your paycheck as imputed income, and regular payroll taxes will be withheld.

Participation is Voluntary

Participation in the Rally Coins and Thanks! Points incentive programs is voluntary. If an eligible Employee (or eligible Spouse or Domestic Partner, as applicable) signs up to participate in the Rally Health Survey, he or she will be automatically enrolled in the Rally Coins and Thanks! Points incentive programs. If you do not wish to participate in these program, you should not sign up to participate in the Rally Health Survey. Additional details regarding the terms and conditions of the Rally Coins and Thanks! Points incentive programs are available by contacting Optum at 1-888-512-4093 or visit www.myuhc.com for incentives through Rally.

Applicable Laws

The Wellness Programs are intended to comply with the requirements of applicable law and regulation (which may include, but are not limited to, the Americans with Disabilities Act and the non-discrimination, privacy and security regulations under HIPAA, to the extent each is applicable) and shall be construed and administered accordingly.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN 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 6, *Additional Coverage Details*.

The Plan 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 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. 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 5, *Plan Highlights*. Please review all limits carefully, as the Plan 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 Benefits Booklet says "this includes," or "including but not limited to," it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefits Booklet specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*. **Important note: Additional dental care services are covered under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.**

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded;

2. preventive care, diagnosis or treatment of (or related to) the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided as required by applicable law under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement described under *Preventive Care Services* in Section 6, *Additional Coverage Details*. 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 6, *Additional Coverage Details*;

3. dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*;

Important note: Exclusion #3 does not apply under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*, and

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Important note: Exclusion #6 does not apply under this Program effective as of 1/1/18 through 12/31/18, as described in Section 5.1(b) of the Wrap-SPD.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease;

3. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses; and
   - ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; and

7. oral appliances for snoring.

Drugs

The exclusions listed below apply only with respect to the medical benefits coverage component of the Plan. Coverage of Prescription Drug Products (as defined in Section 15, *Prescription Drug Products*) is provided as a separate component of the Plan, and thus coverage of any of the services or supplies listed below, which are excluded from the medical benefits coverage component of the Plan, may be available under the Prescription Drug Products coverage component of the Plan. See Section 15, *Prescription Drug Products*, for coverage details and exclusions.

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.

5. Growth hormone therapy.

6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up by the Plan Sponsor or its designee to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made by the Plan Sponsor or its designee up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *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 for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes;

3. treatment of flat feet;

4. treatment of subluxation of the foot; and

5. shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to, compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - urinary catheters;
   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in Section 6, *Additional Coverage Details*.

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

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* in effect on the date that the services were performed.

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 edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* in effect on the date that the services were performed.

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 focused on primarily 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* in effect on the date that the services were performed.

7. Transitional Living services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to lower cholesterol or control diabetes;

- foods to control weight or treat obesity (including liquid diets) even if such foods are part of a structured weight loss program otherwise covered under the Plan;
- oral vitamins and minerals. This exclusion does not apply to vitamins and minerals included under the requirements shown under *Preventive Care Services* in Section 6, *Additional Coverage Details*;
- meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- other dietary and electrolyte supplements; and

3. health education classes unless offered by UnitedHealthcare or its Affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service; and

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

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs except as described under *Obesity Treatment* in Section 6, *Additional Coverage Details*;

4. wigs except as described in Section 6, *Additional Coverage Details*; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations and related services;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity, other than weight loss programs described under *Obesity Treatment* in Section 6, *Additional Coverage Details*; and
    - surgical treatment of obesity except as described under *Obesity Treatment* in Section 6, *Additional Coverage Details*;

15. 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 and dental restorations; and

16. 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 Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. the following infertility treatment-related services:

   - cryo-preservation and other forms of preservation of reproductive materials;
   - long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue; and
   - donor services;

2. in vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility;

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. services provided by a doula (labor aide); and

7. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Provider facility. This exclusion does not apply to cornea transplants; and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, except when required due to an Emergency or Urgent Care need; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses necessary to obtain treatment for Covered Health Services received from a Designated Provider may be reimbursed. In such cases, expenses would be reimbursed as described under *Travel and Lodging* in Section 6, *Additional Coverage Details*. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. 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; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for 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 in the Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

Note: Screening for hearing loss in newborns is covered under *Preventive Care Services* in Section 6, *Additional Coverage Details*.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force 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;
   - that are received after the date your coverage under the Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
   - that exceed Eligible Expenses or any specified limitation in this Benefits Booklet; or
   - for which a non-Network provider waives the Annual Deductible or Coinsurance amounts or with respect to which a non-Network provider does not bill the Covered Person;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. health services and supplies that do not meet the definition of a Covered Health Service (see the definition in Section 14, *Glossary*). "Covered Health Services" are those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be (a) Medically Necessary; (b) included in Section 5 and 6, *Plan Highlight*s and *Additional Coverage Details* described as a Covered Health Service; (c) provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and (d) not identified in Section 8, *Exclusions*.

9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - required solely for purposes of education, sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - 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 6, *Additional Coverage Details*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or 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 Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-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.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a Post-service Claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a Pre-service Claim as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the number on your ID card or visiting **www.anadarkoadvantage.ehr.com**. 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 Employee.

- 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 carrier or provider of the other coverage (for example, your Spouse's employer).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card within 12 months after the date of your service(s) (unless you are legally incapacitated). When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

Important – Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan 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.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay your non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Non-Network Benefits

Subject to the Assignment and Payment of Benefits section, below, UnitedHealthcare will pay any Non-Network Benefits to you, unless you make a written request to UnitedHealthcare at the time you submit your claim for such payment to be made directly to your non-Network provider, in which case, each such payment shall be made on your behalf, and not to such provider in its, his or her own right. Moreover, if any such direct payment is made, it shall not constitute a waiver by the Plan Administrator, the Claims Administrator or the Claims Fiduciary of the anti-assignment provisions of the Assignment and Payment of Benefits section, below. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to you for Benefits under the Plan to the full extent of such payment.

You may not direct UnitedHealthcare to pay your Non-Network Benefits to any third party other than your non-Network Provider, as described above.

Form of Payment of Benefits

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

Assignment and Payment of Benefits

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "Plan Agreement"), no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, a non-Network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to or on behalf of a Covered Person. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Covered Person or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan Benefits, (b) request the Plan document or other documents related to the Plan or a claim for benefits, (c) file an appeal of a denied claim for Plan benefits, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Covered Person's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Covered Person and the provider or its representative or agent), the Plan Administrator, Claims Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Covered Person, or to another designated person or entity, with or without the Covered Person's authorization, with each such payment being made on behalf of the Covered Person, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator, Claims Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator, Claims Administrator or Claims Fiduciary of the anti-assignment provisions of this section. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Covered Person for benefits under the Plan to the full extent of such payment. Accordingly, if a provider is overpaid as the result of accepting a payment for the same Covered Health Services from you and from the Plan, then the provider, and not the Plan, shall be responsible for reimbursing you for such overpayment. Disclosures of information about the Covered Person can only be made to a Covered Person or a Covered Person's authorized representative and in accordance with applicable law and the terms of the Plan.

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.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

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 14, *Glossary* for the definition of Explanation of Benefits.

Claim Denials and Appeals

Types of Claims

There are four different types of claims under the Plan: Urgent Care Claims, Pre-service Claims, Post-service Claims and Concurrent Care Claims.

- an "Urgent Care Claim" is a claim for medical care or treatment with respect to which the time frames for making non-urgent care determinations either: i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or ii) in the opinion of a Physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The person acting on behalf of the Plan shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine to determine if a claim is an Urgent Care Claim. Notwithstanding the above, any claim that a Physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim, as defined above, shall be treated as an Urgent Care Claim.
- a "Concurrent Care Claim" is any claim after the Plan has approved an ongoing course of treatment to be provided over a period of time that involves a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period or course or number of treatments or any request by or on behalf of the claimant to extend such treatment or expand the number of treatments.
- a "Pre-Service Claim" is any claim for Benefits under the Plan for which the Benefit is conditioned on obtaining approval or authorization prior to obtaining the medical care.
- a "Post-Service Claim" is any claim for Benefits under the Plan that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you will receive a written notice of the denial that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

If your claim for Benefits is denied, you may call UnitedHealthcare at the number on your ID card to try to resolve the issue before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, in order to preserve your rights under federal law you must file a formal appeal as described below.

To the extent required by applicable law, the Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-service Claim, 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 do not need to submit Urgent Care Claim appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

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

For Urgent Care Claims that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care Claim;
- Pre-service Claim;
- Post-service Claim; or
- Concurrent Care Claim.

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; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

The appeal will not give deference to the initial denial.

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 that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, in order to preserve your rights under federal law, you must 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, documents and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the denial of your appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

Before the Plan can deny your appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the denial of your

appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

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 that contains specific information as described in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Federal External Review Program

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:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- 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 toll-free 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; and
- 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; and

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

Expedited External Review

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

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; or
- 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 Plan at the time the health care service or procedure that is at issue in the request was provided; and
- 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 anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at 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.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The types of claims are described above under the heading *Types of Claims*.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

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.

The tables below describe the time frames which you and UnitedHealthcare are required to follow. The timeframes applicable to Concurrent Care Claims are described in a separate section below, under the heading *Concurrent Care Claims*.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving the request for additional information

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If UnitedHealthcare denies your initial claim, they must notify you of the denial within: ■ if the initial claim is complete: ■ after receiving the completed claim (if the initial claim is incomplete):	**72 hours** **72 hours** **48 hours**
If UnitedHealthcare denies your claim, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care Claim.

Pre-Service Claims*	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, UnitedHealthcare must notify you within:	**5 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving the request for additional information
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within: ■ after receiving the completed claim (if the initial claim is incomplete), within:	**15 days*** **15 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

Pre-Service Claims*	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days for its initial claim determination if more time is needed due to circumstances beyond control of the Plan. In that case, UnitedHealthcare will notify you prior to the initial 15-day decision timeframe of the circumstances which require the extension of time and the date by which UnitedHealthcare expects to render its decision on your claim.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice
If UnitedHealthcare denies you initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days***
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control, provided that within the initial 15 days, they notify the claimant of the circumstances requiring the extension and the date by which they expect to render a decision.

Concurrent Care Claims

In the event UnitedHealthcare determines to reduce or terminate a course of treatment or a series of treatments, the affected individual will be notified in writing of the intended termination or reduction (the adverse benefit determination) sufficiently in advance of the reduction or termination so that the affected individual may appeal the adverse benefit determination. Any decision on the appeal of the adverse benefit determination on the reduction or termination must be rendered before the reduction or termination of the care or course of treatment.

If UnitedHealthcare receives a request to extend care that is an Urgent Care claim, UnitedHealthcare must render a decision within 24 hours of receipt of the claim, provided the claim is received at least 24 hours before care is scheduled to expire. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

UnitedHealthcare shall render a decision on the appeal of a Concurrent Care Claim to extend care within the time period applicable to an appeal of an Urgent Care Claim, Pre-Service Claim or Post-Service Claim described above, respectively, depending upon whether the claim is also defined as an Urgent Care Claim, a Pre-Service Claim or a Post-Service Claim.

Limitation of Action

You cannot for any reason bring any action at law or in equity to recover benefits under the Plan unless you first complete all the steps in the appeals process described in this section. Any action at law or in equity with respect to any and all claims relating to the Plan (including against Anadarko Petroleum Corporation, the Plan Administrator or the Claims Administrator) must be brought for recovery within one year from the earlier of (1) the date of a final internal adverse benefit determination, if applicable, or (2) the accrual of any claim under or relating to the Plan that does not result in a final internal adverse benefit determination. Otherwise, you lose any rights to bring such an action.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:
- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one 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 (subject to the "Note" in the section entitled *Determining Which Plan is Primary*, below).
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided 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 paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans (including this Plan), the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. 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; or
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- 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 not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

Note: The Plan does not automatically coordinate with auto liability or no-fault insurance coverage; however, the subrogation and recovery provisions of Section 11, Subrogation and Reimbursement, may apply to a Covered Person's right to Benefits under the Plan.

The following examples illustrate how the Plan 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 employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
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. This Plan 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

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

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

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

Determining the Allowable Expense If 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 a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare*.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable

expense, as long as the provider accepts assignment of your Medicare benefits with respect to his, her or its services. If the provider accepts such assignment, 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 with respect to his, her or its services, the Medicare limiting charge (the most that such providers can charge you if they don't accept Medicare assignments – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

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

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

Medicare Crossover Program

The Plan 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 Plan 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 this Plan 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 this Plan.

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 go on 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 this Plan and other plans. UnitedHealthcare 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 this Plan and other plans covering the person claiming Benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this; provided, however, that any such use or disclosure of your information will be only as permitted by applicable privacy and security laws, including the privacy and security regulations issued under HIPAA. Each person claiming Benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine Benefits payable. If you do not provide UnitedHealthcare 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 a Covered Person is covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Covered Person or to (i) a health care or other services provider (including a Covered Person's assignee as described under *Assignment and Payment of Benefits* in Section 9, *Claims Procedures*), (ii) an insurance company or (iii) any other person or entity, for the benefit of a Covered Person (collectively, a "Third-Party Payee"), such erroneously-paid amount shall constitute an "Overpayment" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Covered Person or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount (Overpayment Reimbursement). Without limitation, the Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA and shall be construed accordingly. By accepting a benefit, premium or fee under the Plan, each Covered Person and Third-Party Payee automatically acknowledges and agrees that the Plan has the right to pursue Overpayment Reimbursement from the general assets of the Covered Person or Third-Party Payee to whom the Overpayment was made, to the full extent permitted by ERISA.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Covered Person (including, without limitation, to a covered Employee on behalf of any of his or her Dependents or beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable on behalf of the Covered Person, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary, as applicable, deems to be appropriate in its discretion, to the extent permitted by law.

The Plan or the Company may obtain Overpayment Reimbursement in the form of an offset against salary or wages (if the Covered Person is an Employee) or against benefits payable to or on behalf of the Covered Person under any Company-sponsored benefit plans, including, but not limited to the Plan (but not a qualified pension plan as defined by ERISA and the Internal Revenue Code), to the extent permissible under applicable law and the terms of the applicable benefit plan. For example, the selected recovery method may include, without limitation, payroll deduction in the case of an Employee or his/her Dependent or beneficiary (in which case the Employee must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his or her participation, or continued participation, in the Plan). Furthermore, the Plan Sponsor and the Plan each reserve the right to obtain Overpayment Reimbursement by legal action.

If the Plan overpays a Third-Party Payee that is a Covered Person's health care provider (for purposes of this *Overpayment and Underpayment of Benefits* section only, a "**Provider**"), then, in addition to the recovery actions permitted under the preceding paragraphs of this section, the Company and the Plan reserve the right to obtain Overpayment Reimbursement from the Provider pursuant to *Refund of Provider Overpayments*, below.

Refund of Provider Overpayments

If the Plan pays Benefits to a Provider for expenses incurred by or on account of a Covered Person, that Covered Person or Provider must make a refund to the Plan if:

- the Plan's obligation to pay the Benefits was contingent on the Covered Person's actual payment of the expenses or legal obligation to pay the expenses, and either some or all or some of the expenses were not paid by the Covered Person or the Covered Person had no legal obligation to pay the expenses;
- all or some of the payment made by the Plan exceeded the Benefits payable under the terms of the Plan; or
- all or some of the payment made by the Plan was made in error, according to the terms of the Plan.

The Overpayment amount that must be refunded to the Plan equals the amount the Plan paid in excess of the amount that was properly payable under the terms of the Plan. If such Overpayment refund is due from the Provider, the Covered Person agrees to reasonably assist the Plan in obtaining Overpayment Reimbursement when requested. If the Covered Person or Provider does not promptly refund the full amount of the Overpayment within a reasonable time period as determined by the Plan Administrator, the Plan may obtain Overpayment Reimbursement by (i) reallocating the Overpayment as an offset, in whole or in part, against future Benefits that are payable to or on behalf of the Covered Person under the Plan; or (ii) recouping the Overpayment by any other method which the Plan Administrator or Claims Fiduciary deems appropriate in its discretion, to the extent permitted by law, with the understanding that the reallocated or otherwise recouped payment will be reimbursed to the Plan. The amount of such payment will equal the amount of the Overpayment required to be refunded or, if less than the full amount of the required refund, will be deducted from the full amount of the refund owed to the Plan.

In the event of a Provider Overpayment, the Plan and the Company may have other legal rights to obtain Overpayment Reimbursement, in addition to the right to reallocate or otherwise recoup Overpayment amounts as enumerated above, including the right to commence a legal action to obtain Overpayment Reimbursement.

In the case of any Overpayment reallocation or other recoupment action described in this *Overpayment and Underpayment of Benefits* section, any such reallocation or recoupment against a payment to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to the ERISA claims and appeals procedures of the Plan. For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this section, the offset or other recoupment of the Overpayment hereunder is simply an adjustment to the amount owed to the Third-Party Payee to reflect the Overpayment to the Third-Party Payee and shall not be considered to be the denial or partial denial of any Benefit claim under the Plan.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The provisions of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable, will govern and control the Plan's rights to subrogation and reimbursement. These provisions are summarized in this section. Should there be any conflict between these subrogation and reimbursement provisions and those of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, the provisions in the applicable wrap-around Summary Plan Description will govern. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent permitted by applicable law as determined by the Plan Administrator.

Right of Subrogation and Reimbursement

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this section on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this section on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

Benefits Subject to this Provision

The provisions set forth in this section will apply to all benefits provided under the Plan. For purposes of this section, certain terms are defined as follows:

- **"Recovery"** means any and all monies and property paid by a Third Party to (i) the Covered Person, (ii) the Covered Person's attorney, assign, legal representative, or beneficiary, (iii) a trust of which the Covered Person is a beneficiary, or (iv) any other person or entity on behalf of the Covered Person, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the Injury or illness.
- **"Reimbursement"** means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Covered Person toward care and treatment of the Injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.
- **"Subrogation"** means the Plan's right to pursue the Covered Person's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.
- **"Third Party"** means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Covered Person's Injury or illness. The term "Third Party" will include the party or parties who caused the Injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the Injury or illness; a

Covered Person's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the Injury or illness.

When this Provision Applies

A Covered Person may incur medical or other charges related to any Injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the Injury or illness. If so, the Covered Person may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Covered Person has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Covered Person receives the Recovery or (b) the Covered Person's attorney, a trust of which the Covered Person is a beneficiary, or other person or entity receives the Recovery on behalf of the Covered Person. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Covered Person hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any Injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this section.

The Plan's equitable lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures, or may be entitled to procure, regardless of whether the Covered Person has received compensation for any or all of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Covered Person's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this section, and the Covered Person hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Covered Person:

- authorizes the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Covered Person's rights to Recovery when the provisions of this section apply;
- must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- must cooperate fully with the Plan in its exercise of its rights under this section, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Covered Person who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to the subsection *When a Covered Person Retains an Attorney* below, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this section (**S&R Agreement**).

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injury or illness. The Plan may file a copy of an S&R Agreement signed by the Covered Person and his or her attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Covered Person (and his or her attorney, as applicable), a Covered Person's claim for any medical or other benefits for any Injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Covered Person, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Covered Person's claim for benefits for the Injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injury or illness before an S&R Agreement

and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Covered Person who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Covered Person is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Covered Person automatically agrees, without further notice, to all the terms and conditions of this section and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this section and to make changes in its interpretation as it deems necessary or appropriate.

Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Covered Person receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Covered Person may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his or her charges and expenses.

When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or Injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this section.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses incurred are related to an illness or Injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Covered Person has already received a

Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, the Plan will not pay any portion of the Covered Person's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Covered Person's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Covered Person's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his or her pursuit of Recovery.

Any Recovery paid to the Covered Person's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Covered Person nor his or her attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

When the Covered Person is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent

The provisions of this section will apply to the parents, trustee, guardian or other representatives of a minor Dependent child and to the heirs or personal representatives of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this section, the term "Covered Person" will also include a COBRA qualified beneficiary who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Covered Person whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor (e.g., a full-time post-secondary student) and, in such event, the Employee will be liable for any breach of this section by the Employee or by such Dependent.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan

Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Covered Person and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce the provisions of this section, the Covered Person will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan 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.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Company ends;
- the date the Plan ends or is amended to eliminate your coverage;
- the date of your death;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the last day of the month you are no longer eligible to participate in the Plan (except that coverage may be continued until the last day of the month through which you are receiving disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan or have been certified as disabled by the Company's long-term disability insurance carrier for purposes of being eligible to receive income replacement payments under such disability insurance policy, unless such coverage is terminated earlier);
- the date, if any, on which you falsify information provided to the Plan, fraudulently or deceptively use Plan services or knowingly permit such fraud or deception by another person, including enrolling a person as a Spouse or other Dependent who does not qualify as a Dependent under the terms of the Plan;
- the last day of the month in which you complete six months of unpaid leave of absence; or
- if you are receiving long term disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan, the last day of the month in which you elect to receive your full distribution from the Anadarko Retirement Plan or the Kerr-McGee Corporation Retirement Plan.

See the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan for a complete description of when a Retired Employee's coverage ends under the Group Health Benefit of the APC Retiree Health Benefits Plan.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date on which the Plan is amended to eliminate coverage for the Dependent, for whatever reason;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the date the Dependent becomes covered under the Plan as an Employee;
- the date, if any, on which the Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person;
- the date Dependents' coverage ceases to be available to the Employee;
- the date on which an Employee elects to terminate coverage for his or her Dependent, provided that you notify Anadarko Petroleum Corporation of the intention to terminate coverage within 30 days prior to the date; or
- the last day of the calendar year in which a Dependent child ceases to be an eligible Dependent under the Plan; or the last day of the month in which any other Dependent ceases to be an eligible Dependent under the Plan.

Other Events Ending Your Coverage

If a Covered Person commits an act, practice, or omission that constitutes fraud, or makes 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, such Covered Person's coverage may be subject to rescission as permitted under the Affordable Care Act. In that case, the Plan will provide the Covered Person with a written notice as required by the Affordable Care Act which informs him or her of the date that his or her coverage will end; provided, however, the Covered Person will have the right to appeal any such rescission pursuant to the Plan's claim and appeal procedures, and his or her Plan coverage will remain in effect pending the outcome of any internal appeal under such procedures.

For purposes of the above, if the Covered Person is a Dependent, a failure by the covered Employee to provide timely notice to the Plan Administrator (or its designee) in accordance with the required notification procedures in this Benefits Booklet or the wrap-around Summary Plan Description of the APC Health Benefits Plan of an event that causes such Dependent to lose eligibility for coverage under the Plan shall be deemed to constitute an intentional misrepresentation of a material fact, in which case such Dependent's coverage may be subject to rescission as permitted under the Affordable Care Act.

Note: If a Covered Person's coverage is rescinded, the Plan Sponsor reserves the right to demand the repayment by such Covered Person of any Benefits paid to him or her (or paid in his or her name, or on his or her behalf) under the Plan following the effective date of his or her coverage rescission, as provided in Overpayment and Underpayment of Benefits in Section 10, Coordination of Benefits (COB).

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 Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability rendering the child medically incapacitated and unable to be self-supporting;
- the child depends mainly on you for support and resides with you for more than one-half of the year;
- either 1) you provide to Anadarko Petroleum Corporation proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age or 2) the child has such handicap or disability and is over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll in such coverage (i.e., the child cannot later be added to coverage under the Plan); and
- you provide proof, upon Anadarko Petroleum Corporation's request, that the child continues to meet these conditions.

The proof might include medical examinations at Anadarko Petroleum Corporation's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 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 Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available if the Plan is subject to the terms of COBRA. You can contact your Plan Administrator to determine if the Plan is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator 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 Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a

child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or

- an Employee's enrolled Spouse (or former Spouse).

A Domestic Partner, or the children of a Domestic Partner, who are covered under the Plan on the day prior to the qualifying event shall be treated as Qualifying Beneficiaries under the Plan, although such treatment is not a right required by COBRA.

A Retired Employee is not eligible to elect COBRA continuation coverage upon termination of his or her coverage under the Plan. However, for purposes of this section and a Spouse's or Dependent's eligibility to elect COBRA continuation coverage, a Retired Employee is considered a covered Employee.

Qualifying Events for Continuation Coverage under COBRA

The following table 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	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage because your employment terminates or your hours are reduced[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate) or dissolve a 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	N/A	See table below	See table below

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Anadarko Petroleum Corporation files for bankruptcy under Title 11, United States Code[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within 60 days after the latest of a) the determination of the disability, b) the date of the qualifying event, or c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2] This is a qualifying event for any Retired Employee 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.

[3] From the date of the Employee's death if the Employee dies during the continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your Spouse and/or Dependent children in your family can get additional months of COBRA continuation coverage, up to the maximum of 36 months. This extension is available to your Spouse and/or Dependent children if you die, enroll in Medicare (Part A, Part B, or both), or get divorced or legally separated, or dissolve a Domestic Partnership. The extension is also available to a dependent child when that child stops being eligible under the Plan as a Dependent. In all of these cases you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

*Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, dissolution of Domestic Partnership or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation, dissolution of Domestic Partnership or an enrolled Dependent's loss of eligibility as an enrolled Dependent;

- the date your enrolled Dependent would lose coverage under the Plan; or
- 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 Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Anadarko Benefits Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

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 a Qualified Beneficiary first becomes entitled to Medicare (for this purpose, "entitled to Medicare" means enrolled in either Part A or Part B of Medicare);
- the last day of the month for which the required premium payments have been made, if such payments are not made timely;
- the later of the date the entire Plan ends or Anadarko Petroleum Corporation ceases to maintain a group health plan within its controlled group;
- in the case of a disabled Qualified Beneficiary (and his or her disabled or non-disabled family members) receiving COBRA coverage under the 11-month disability extension described in the chart above, and with respect to such extension, the first day of the month that begins more than 30 days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not

be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Anadarko Petroleum Corporation;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator 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 Plan as your Dependent, and the Plan 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 Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Anadarko Petroleum Corporation

In order to make choices about your health care coverage and treatment, Anadarko Petroleum Corporation believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan 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 Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefits Booklet); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Anadarko Petroleum Corporation and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Anadarko Petroleum Corporation and UnitedHealthcare may use individually identifiable information about you as permitted or required by law, including in operations and in research. Anadarko Petroleum Corporation and UnitedHealthcare may use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Anadarko Petroleum Corporation, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Anadarko Petroleum Corporation's agents or employees, nor are they agents or employees of UnitedHealthcare. Anadarko Petroleum Corporation 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.

Anadarko Petroleum Corporation and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Anadarko Petroleum Corporation and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare'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 Anadarko Petroleum Corporation's employees nor are they employees of UnitedHealthcare. Anadarko Petroleum Corporation and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Anadarko Petroleum Corporation and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Anadarko Petroleum Corporation is solely responsible for funding the payment of Benefits on a timely basis through its general assets. The Plan Administrator is solely responsible for (a) determining and administering enrollment (and disenrollment) in the Plan, and (b) notifying you of the termination of, or modifications to, the Plan as required by ERISA.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a Covered Person's responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.

- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- 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).
- Must decide with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

Interpretation of Benefits

The Plan Administrator has delegated to UnitedHealthcare, in its capacity as the Claims Administrator and Claims Fiduciary, the sole discretion and authority to (a) interpret the terms, conditions, limitations and exclusions of the Plan, including this Benefits Booklet and any amendments thereto, and (b) make factual determinations under the Plan, for the purpose of making final decisions regarding Benefits payable under the Plan. All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal procedures of the Plan. Benefits under the Plan will be paid only if UnitedHealthcare determines in its discretion that the Covered Person is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination or action by any court. Any review of any such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

Information and Records

All uses and disclosures of your protected health information (as defined by the HIPAA privacy regulations, *i.e.*, "**PHI**") or any other individually identifiable information about you, as discussed in this Benefits Booklet, including this Section, shall be as permitted by, and in accordance with, applicable law, including the HIPAA privacy regulations.

Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare may use your PHI to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. In addition, UnitedHealthcare may request additional information from you to decide your claim for Benefits. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare will keep this information confidential. Anadarko Petroleum Corporation and UnitedHealthcare may also use your de-identified data for commercial purposes, including research.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you, to the extent permitted by applicable law. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time for any permitted purpose under applicable law. This

applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential. Anadarko Petroleum Corporation, the Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Anadarko Petroleum Corporation is required to do by law or regulation. During and after the term of the Plan, Anadarko Petroleum Corporation and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Anadarko Petroleum Corporation recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.
In some cases, Anadarko Petroleum Corporation and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designated persons or entities will be required to use or disclose your information only as permitted by applicable law, including the HIPAA privacy regulations.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Anadarko Petroleum Corporation recommends that you discuss participating in such programs with your Physician. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Anadarko Petroleum Corporation and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Anadarko Petroleum Corporation and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend the Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Code or ERISA, or any other reason. A Plan amendment may transfer coverage to another plan or split a plan into two or more parts. If the Company does amend or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

If the Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on the terms of the Plan and may also depend on any contract provisions affecting the Plan and Company decisions.

Plan Document

This Benefits Booklet describes certain terms of your Benefits under the Plan. When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet, or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out of Area

Options Plan, including this Benefits Booklet. If there should be an inconsistency between the contents of this Benefits Booklet and the contents of the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, your rights shall be determined as provided in the wrap-around Summary Plan Description of the APC Health Benefits Plan or the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, as applicable. A copy of the documents that constitute the Plan is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your authorized representative) may obtain a copy of these documents by written request to the Plan Administrator or its designee, for a nominal charge.

UnitedHealthcare Reimbursement Policies

UnitedHealthcare, as Claims Administrator and Claims Fiduciary, determines Eligible Expenses under the Plan in accordance with the applicable terms and conditions of coverage under the Plan, which include UnitedHealthcare's applicable reimbursement policies. To the extent required by ERISA, such policies are incorporated into the SPD and the Plan by reference. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies and the other applicable terms of the Plan are applied to provider billings. Network Physicians and providers are not permitted to bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because the Plan, including one of UnitedHealthcare's reimbursement policies, does not provide for reimbursement or payment (in whole or in part) for the amount that the provider billed for the service(s) rendered to you.

UnitedHealthcare shares its reimbursement policy guidelines with Network Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. You (or your authorized representative on your behalf) may also obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefits Booklet.

Many of the terms used throughout this Benefits Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefits Booklet, but it does not describe the Benefits provided by the Plan.

Affiliates – those entities (including, but not limited to, United Resource Networks) which are affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare's ultimate corporate parent, including direct and indirect subsidiaries.

Affordable Care Act – the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

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; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drug Products*.

Annual Enrollment – the period of time, determined by Anadarko Petroleum Corporation, during which eligible Employees may enroll themselves and their Dependents under the Plan. Anadarko Petroleum Corporation determines the period of time that is the Annual Enrollment period.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- in vitro fertilization (IVF);

- gamete intrafallopian transfer (GIFT);
- pronuclear stage tubal transfer (PROST);
- tubal embryo transfer (TET); and
- zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorders – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The BRS program provides:

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

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any amendments thereto.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its Affiliates, as designated by the Plan Administrator to provide certain claim and other administration services for the Plan.

Claims Fiduciary – UnitedHealthcare (also known as United HealthCare Services, Inc.), as designated by the Plan Administrator to make appeal determinations on all first and second levels of appeal (i.e., all internal appeals) regarding claims under the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Anadarko Petroleum Corporation.

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.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

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

- Medically Necessary;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefits Booklet are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- 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; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Provider - a 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 specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not related by blood or adoption;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- not be legally married to each other (in other words, the other person is not the Spouse of the Employee);
- be at least 18 years old;
- live together in a committed, monogamous relationship at the same place of residence for at least six months; and
- intend for their relationship to be continuous and of an indefinite duration.

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:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are (i) incurred by a Covered Person while the Plan is in effect and (ii) determined by UnitedHealthcare to be payable as Benefits under the Plan, in accordance with the provisions below and the "Eligible Expenses" provisions of Section 3, *How the Plan Works*.

The Plan Administrator has delegated to UnitedHealthcare in its capacity as the Claims Administrator and Claims Fiduciary, the discretion and authority to (a) decide whether a treatment or supply is a Covered Health Service, (b) formulate the methods by which Eligible Expenses will be determined in accordance with the terms of the Plan, and (c) determine Eligible Expenses that are payable as Benefits under the Plan.

Eligible Expenses are determined solely in accordance with the applicable terms and conditions of coverage under the Plan, which include UnitedHealthcare's applicable reimbursement policies (as described in Section 13, *Other Important Information*).

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

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

Emergency – a medical condition manifesting 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 to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- a medical screening examination (as required under section *1867 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; and
- 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 *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee – a regular employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Anadarko Petroleum Corporation.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

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

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not 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); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, Phase II or Phase 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 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described in Section 6, *Additional Coverage Details*, 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) – a statement provided by UnitedHealthcare 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 Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Fertility Solutions (FS) – a program administered by UnitedHealthcare or its affiliates made available to you under the Plan as provided in this Benefits Booklet. The FS program provides:

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

FS – see Fertility Solutions (FS).

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(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which 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; and
- 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 Skilled Nursing Facility, convalescent home or similar institution.

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 Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment – a structured outpatient Mental Health or Substance-related and Addictive Disorders treatment program that may be free-standing 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; or
- 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.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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 – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-related and Addictive Disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, Substance-related and Addictive Disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- 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 society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator – the organization or individual designated by Anadarko Petroleum Corporation who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its Affiliate made available to you by Anadarko Petroleum Corporation. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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 or with its Affiliate to participate in the 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 Shared Savings Program.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care 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 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.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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 Plan.

To the extent an item or service is otherwise a Covered Health Service under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment or setting for an item or service, the Plan shall not discriminate based on a health care provider's license or certification, to the extent the

provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require the Plan to accept all types of providers into a Network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

Plan – The Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan) or the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the wrap-around Plan document and wrap-around Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet or 2) the wrap-around Plan document and wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet.

Plan Administrator – Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee.

Plan Sponsor – Anadarko Petroleum Corporation.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Private Duty Nursing – shift or continuous nursing care that encompasses nursing services for Covered Persons who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Private Duty Nursing services are provided where longer durations of skilled nursing care are required and may include shift care or 24/7 continuous care in certain settings. Private Duty Nursing care is not care provided primarily for the convenience of the Covered Person.

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 Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an individual who, as of the date immediately preceding the individual's date of retirement, was enrolled as an active Employee in either the Anadarko Petroleum Corporation Health Benefits Plan (or its predecessor plan maintained by the Plan Sponsor) or a major medical, group health plan sponsored by another company on the date of such company's acquisition by the Company.

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 – UnitedHealthcare program under which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a scheduled rate previously agreed to by the non-Network provider with UnitedHealthcare (Scheduled Rate). When a discount is obtained based on the Scheduled Rate you may experience a lower amount of out-of-pocket expenses. The Plan's Coinsurance and Deductible would still apply to the reduced charge. Notwithstanding the foregoing, sometimes other Plan provisions regarding the basis for determining Eligible Expenses with respect to a non-Network provider's charges conflict with the Scheduled Rate, in which case a rate other than the Scheduled Rate may be applied by UnitedHealthcare as contractually permitted and in accordance with the "Eligible Expenses" subsection of Section 3, *How the Plan Works*, in order to determine Eligible Expenses. In that case, the non-Network provider may bill you for the difference between his or its billed amount and the amount of Eligible Expenses so determined by UnitedHealthcare. If this happens, you should call the number on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this Benefits Booklet does not include Mental Illness or Substance-related and Addictive Disorders, regardless of the cause or origin of the Mental Illness or Substance-related and Addictive Disorder.

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 dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a 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 Plan.

SPD – the complete Summary Plan Description of the APC Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the APC Health Benefits Plan and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet), or the complete Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan (which consists of the wrap-around Summary Plan Description of the Group Health Benefit under the APC Retiree Health Benefits Plan and any appendices attached thereto, as they relate to the HDHP Out of Area Options Plan, including this Benefits Booklet), as applicable.

Spouse – a person to whom you are lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, without limitation, the Code, ERISA, and Affordable Care Act), and any regulations promulgated under such applicable federal law, but will not include an individual divorced from you under a court-approved divorce decree. The term "Spouse" will also include a common law spouse if you and your spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. You must provide proof of a ceremonial or common law marriage if requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state. For purposes of this Benefits Booklet, the term "Spouse" will also include a Domestic Partner, as defined in this section, unless the context indicates otherwise.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of Substance-related and Addictive Disorders that are listed in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded pursuant to Section 8, *Exclusions*. 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.

Substance-related and Addictive Disorder - a maladaptive pattern of substance use, including alcoholism, leading to clinically significant impairment or distress, as defined in the applicable *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program℠ – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

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 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 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, at an Urgent Care Center. This definition of "Urgent Care" is not applicable for purposes of classifying an "Urgent Care Claim" under the Plan's claims and appeals procedures; see instead *Claim Denials and Appeals, Types of Claims* under Section 9, *Claims Procedures* for the applicable definition of "Urgent Care Claim".

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.

SECTION 15 - PRESCRIPTION DRUG PRODUCTS

What this section includes:

- Benefits available for Prescription Drug Products;
- How to utilize the retail and mail order service for obtaining Prescription Drug Products;
- Any benefit limitations and exclusions that exist for Prescription Drug Products; and
- Definitions of terms used throughout this section related to the Prescription Drug Products portion of the Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Products benefits. It includes Copay amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

Covered Health Services[1,2]	**Your Copayment Amount**[3]	
	Network	**Non-Network**
Retail - up to a 30-day supply[4,5]	After you meet the Annual Deductible:	After you meet the Annual Deductible:
■ Tier 1	$3 Copay	$3 Copay
■ Tier 2	20% of the Prescription Drug Charge but not less than $20 and not more than $200	20% of the Out-of-Network Reimbursement Rate but not less than $20 and not more than $200
■ Tier 3	30% of the Prescription Drug Charge but not less than $20 and not more than $200	30% of the Out-of-Network Reimbursement Rate but not less than $20 and not more than $200
■ Tier 4 (includes all Specialty Prescription Drugs)	$67 Copay	$67 Copay

Covered Health Services[1,2]	Your Copayment Amount[3]	
	Network	**Non-Network**
Mail order - up to a 90-day supply[4]	After you meet the Annual Deductible:	
■ Tier 1	$6 Copay	Not Covered
■ Tier 2	20% of the Prescription Drug Charge but not less than $40 and not more than $200	Not Covered
■ Tier 3	30% of the Prescription Drug Charge but not less than $40 and not more than $200	Not Covered
■ Tier 4 (includes all Specialty Prescription Drugs)	$67 Copay	Not Covered

[1]You must obtain prior authorization from UnitedHealthcare to receive full Benefits for certain Prescription Drug Products. Otherwise, you may pay more out-of-pocket. See *Prior Authorization Requirements* in this section for details.

[2]You are not responsible for paying a Copayment or Coinsurance for Preventive Care Medications.

[3]If you choose not to substitute a lower-tiered drug for a chemically equivalent higher-tiered drug, you will pay the cost difference between the two drugs, in addition to the higher-tiered drug's Copayment or Coinsurance. This difference in cost is called an Ancillary Charge. See *Prescription Drug Products that are Chemically Equivalent* and the definition under *Glossary – Prescription Drug Products* in this section for details.

[4]Specialty Prescription Drugs are limited to a 30-day supply.

[5]Up to a 90-day supply of a retail-purchased Prescription Drug Product is available. For a 31-60-day supply, the Copay shown above will be doubled. For a 61-90-day supply, the Copay shown above will be tripled.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this Benefits Booklet.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy and then submit a manual claim for Benefits to:

Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier 1, tier 2, tier 3 and tier 4 Prescription Drug Products. All Prescription Drug Products covered by the Plan are categorized into these four tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier 1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier 1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier 2 is your middle Copay/Coinsurance option. Consider a tier 2 drug if no tier 1 drug is available to treat your condition.
- Tier 3 and Tier 4 are your highest Copay/Coinsurance options. The drugs in tier 3 and tier 4 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

Note: Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:

- The applicable Copayment and/or Coinsurance; or
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay or Coinsurance; or
- the Prescription Drug Charge for that particular Prescription Drug Product.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail Pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drug Products:

- as written by a Physician;
- up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. (***Note:*** You may obtain up to a 90-day supply if you pay a Copay for each 30-day supply);
- when a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drug Products :

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Products portion of the Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Assigning Prescription Drug Products to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug Product placement in tiers. In its evaluation of each Prescription Drug Product, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug Product; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general

population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Product benefit.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

The Plan may also require you to obtain prior authorization from UnitedHealthcare so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

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

Non-Network Pharmacy Prior Authorization

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

If UnitedHealthcare has not provided prior authorization before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug Product order or refill. You will be required to pay for the Prescription Drug Product at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Product Charge) will not be available to you at a non-Network Pharmacy. If UnitedHealthcare has not provided prior authorization before you purchase the Prescription Drug Product, you can request reimbursement after you receive the Prescription Drug Product - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge and any Deductible that applies.

To determine if a Prescription Drug Product requires prior authorization, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drug Products requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the toll-free number on your ID card.

Prescription Drug Product Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drug Products are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug Product has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator have developed, subject to periodic review and

modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change and an Ancillary Charge may apply. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug Product is assigned.

Prescription Drug Products that are Chemically Equivalent

If two drugs are chemically equivalent (they contain the same active ingredient) and you choose not to substitute a lower-tiered drug for the higher-tiered drug, you will pay the difference between the higher-tiered drug and the lower-tiered drug, in addition to the higher-tiered drug's Copayment or Coinsurance. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is chemically the same available at a lower tier. An Ancillary Charge will not apply when a covered Prescription Drug Product is dispensed at your Physician's request if the prescription indicates to "dispense as written" (DAW).

Special Programs

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

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced benefit, or no benefit, based on whether the Prescription Drug Product was prescribed by a specialist physician. You may access information on which Prescription Drug Products are subject to benefit enhancement, reduction or no benefit through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Rebates and Other Discounts

UnitedHealthcare and Anadarko Petroleum Corporation may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays and Coinsurance.

The Claims Administrator and a number of its Affiliates, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Product section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Product section.

The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician or your pharmacy that communicate a variety of messages, including information about Prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drug Products are excluded.

Medications that are:

1. for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

2. any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drug Products*) portion of the Plan;

   This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

5. compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product;

6. dispensed outside of the United States, except when required due to an Emergency or Urgent Care need;

7. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

8. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition;

9. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;

10. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;

11. certain Prescription Drug Products that have not been prescribed by a specialist physician;

12. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

13. prescribed, dispensed or intended for use during an Inpatient Stay;

14. Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that UnitedHealthcare (and Anadarko Petroleum Corporation, for purposes other than claims decisions) determines do not meet the definition of a Covered Health Service;

15. a Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product, as determined by UnitedHealthcare. In its discretion, UnitedHealthcare may make such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

16. a Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product, as determined by UnitedHealthcare. In its discretion, UnitedHealthcare may make such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

17. certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, as determined by UnitedHealthcare, unless otherwise required by law or approved by UnitedHealthcare. In its discretion, UnitedHealthcare may make

such determinations up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

18. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

19. unit dose packaging of Prescription Drug Products;

20. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Anadarko Petroleum Corporation have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

21. used for cosmetic purposes;

22. Prescription Drug Product as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed;

23. certain Prescription Drug Products for smoking cessation;

24. dental products, including but not limited to prescription fluoride topicals;

25. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

26. any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury;

27. medications used for cosmetic purposes; and

28. a Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

Glossary - Prescription Drug Products

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or MAC List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Out-of-Network Reimbursement Rate or MAC List price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Out-of-Network Reimbursement Rate or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier.

Brand-name - a Prescription Drug Product that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Prescription Drug Products.

Generic - a Prescription Drug Product that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drug Products to Covered Persons;

- agreed to accept specified reimbursement rates for Prescription Drug Products; and
- been designated by the Claims Administrator as a Network Pharmacy.

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

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

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

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

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

- Inhalers (with spacers);
- Insulin;
- [[Certain immunizations][Immunizations] administered in a pharmacy]; and
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips – glucose;
  - Urine-testing strips – glucose;
  - Ketone-testing strips and tablets;

- Lancets and lancet devices; and
- Glucose meters (this does not include continuous glucose monitors; Benefits for continuous glucose monitors are provided as described in the portion of this Benefits Booklet regarding the medical benefits coverage component of the Plan).

Preventive Care Medications - the medications that are obtained at a Network Pharmacy and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- 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;
- 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; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Note: The Plan considers all Prescription Drug Products used for contraceptive purposes to be Preventive Care Medications. This includes oral contraceptives, injectable drugs and contraceptive devices.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Specialty Prescription Drug - Prescription Drug Product that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Infertility. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutically Equivalent – when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

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

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the Plan, as well as information required of all summary plan descriptions by ERISA as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Plan Administrator

Anadarko Petroleum Corporation is the Plan Sponsor of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan. The Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee is the Plan Administrator of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan and has the discretionary authority and control to interpret the Plan, control and manage the operation and administration of the Plan and make all decisions and determination incident thereto, except to the extent otherwise delegated to other persons or entities. You may contact the Plan Administrator at:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Attn: Director, Global Benefits
1201 Lake Robbins Drive
The Woodlands, TX 77380
(832) 636-1000

Claims Administrator and Claims Fiduciary

UnitedHealthcare is the Plan's Claims Administrator and Claims Fiduciary. The role of the Claims Administrator and Claims Fiduciary is to administer, review and make final determinations regarding claims for Benefits under the Plan. As Claims Administrator, UnitedHealthcare also provides other day-to-day administrative services with respect to the Plan pursuant to an administrative services agreement with the Company. UnitedHealthcare shall not be deemed, or construed as, an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. UnitedHealthcare shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator/Claims Fiduciary by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent for Service is:

With respect to the Anadarko Petroleum Corporation Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

With respect to the Anadarko Petroleum Corporation Retiree Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Retiree Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

Other Administrative Information

This section of your Benefits Booklet contains information about how the Plan is administered as required by ERISA.

Type of Administration

The HDHP Out of Area Options Plan is a component of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan, with administration provided through one or more third party administrators. The HDHP Out of Area Options Plan is incorporated by reference into the APC Health Benefits Plan and the APC Retiree Health Benefits Plan, each of which is a separate employee welfare benefit plan for purposes of ERISA.

Plan Names and Plan Numbers:	Anadarko Petroleum Corporation Health Benefits Plan, Number 501 Anadarko Petroleum Corporation Retiree Health Benefits Plan, Number 504
Employer ID:	76-0146568
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee/Retiree Employee/Surviving Dependent and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan 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 Plan information, including insurance contracts and collective bargaining agreements (if applicable), and any updated SPD, by writing to the Plan Administrator or its designee. The Plan Administrator may make a reasonable charge for copies; and
- receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the SPD and the wrap-around Plan document to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan 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. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or summary annual report from the Plan, 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 disagree with that denial, you must file an appeal (and second level appeal if the appeal is denied) in accordance with the claim and appeal procedures described in Section 9, *Claims Procedures*. If your second level appeal is denied, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a

domestic relations order, you may file suit in federal court after exhausting the claim and appeal procedures described in Section 9, *Claims Procedures*. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. 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 (866) 444-3272.

The Plan's Benefits are administered by the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee, which is the Plan Administrator. UnitedHealthcare is the Claims Administrator and Claims Fiduciary and processes claims for the Plan and provides appeal services; however, UnitedHealthcare, Anadarko Petroleum Corporation, and the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare, Anadarko Petroleum Corporation, and the Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act (PPACA)

Patient Protection Notices

The Plan 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 and who is available to accept you or your family members. If you are required to designate a primary care provider, the Plan will designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator 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.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits for 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; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. See Section 5, *Plan Highlights* for details. Limitations on Benefits are the same as for any other Covered Health Service. If you would like more information on these Benefits, contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

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

Under federal law, group health plans, such as the Plan, and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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 mother's or newborn's attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

In addition, the Plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization from the Plan 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 the Plan Administrator (or its designee) or issuer.

ATTACHMENT III - NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꭰ ᏏᏢ ᏗCZᏢᏗ Ꭷ4ᎧᏗ ᏂAᏯW ᎥᏓ GᏙᏢ ᏙᎯ ᏏR ᏗJAVᏗ ACᎧᏙᏗ ᎢΘᏂᎧᏗT, ᎺᏐ0ᵕᎧᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n’efu n’akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒီးနွဲ့ဘဉ်တါ်မၤစၢးဒီးတါ်ဂ့ၢ်တါ်ကျိုၤလၢနကျိုဉ်ဒဉ်နဲဝဲလၢတဖလိဉ်ဟုဉ်အ ပူၤဘဉ်နွဲဉ်လီၤ.လၢတါ်ကဃ့နွံပှၤကတိၤကျိုးထံတါ်တက၊အစီၢ်ကီးဘဉ်လီတဲစီအကျိုၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတါ်အိဉ်ဆူဉ်အိဉ်ချအတါ်ရဲဉ်တါ်ကျဲၤ အကၤအလိၤဒီးဆိဉ်လီၤနီၢ်ဂ်ၢ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor a□ maroñ ñan bok jipañ im me□e□e ilo kajin eo a□ ilo ejje□□k wō□āān. Ñan kajjitōk ñan juon ri-ukok, kūr□ok nō□ba eo e□ōj an jeje ilo kaat in ID in karōk in ājmour eo a□, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee

Language	Translated Taglines
	niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yínikeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíilchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wëräyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и

Language	Translated Taglines
	информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma faʻamatalaga i lau gagana e aunoa ma se totogi. Ina ia faʻatalosagaina se tagata faʻaliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo”u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	□□□□□□□□ □□□□□□□□□□□ □□□□□□□□ □□□□□□□□□□□□ □□□□□□□ □□□ □□□□□□□□□□ □□□□□□□□□□ □□□□□□□□□□□□□ □□□□□□□□□□□□□ □□□□□□□ □□□□□□□□□ □□□□□□□□ □□□ □□□□□ □□□□□□□□□□□ □□□ TTY 711. 0 □□□□□ □□□□□□□□□□ □□□□□□ □□□□□ □□□□□□□□□
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

Program Document 4

UnitedHealthcare Dental PPO Plan Booklet (2015) (Plan Number P9568), Group Number 755494

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2018)

Benefits Booklet

Anadarko Petroleum Corporation
Dental PPO Plan (Plan Number: P9568**)**

Effective: January 1, 2015
Group Number: 755494

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services and claim inquiries: (888) 512-4093;
- Claims submittal address: Dental Claims, P.O. Box 30567, Salt Lake City, UT 84130-0567; and
- Online assistance: **www.myuhcdental.com**.

This Benefits Booklet describes the Dental PPO Coverage available to you and your covered family members under the Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan) and the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the Plan document and Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the Dental PPO Plan, including this Benefits Booklet or 2) the Plan Document and Summary Plan Description of the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the Dental PPO Plan, including this Benefits Booklet. Read this document carefully so that you will have a clear understanding of your Coverage under the Plan. If you have any questions regarding your Coverage or procedures for obtaining Dental Services, you may call the toll-free number shown on your ID card or contact the Plan Administrator. Anadarko Petroleum Corporation is utilizing the services of UnitedHealthcare Dental in the administration of Coverage under the Plan.

The Summary Plan Description of the APC Health Benefits Plan and the Summary Plan Description of the APC Retiree Health Benefits Plan are each referred to in this Benefits Booklet as the "SPD."

Coverage is subject to the terms, conditions, exclusions, and limitations of the Plan. As a Benefits Booklet, this document describes the provisions of Coverage under the Plan but does not constitute the entire Plan. You may examine the entire Plan at the office of the Plan Sponsor during regular business hours.

For Dental Services rendered after the effective date of the Plan, this Benefits Booklet replaces and supersedes any Benefits Booklet which may have been previously issued to you by the Plan Sponsor. Any subsequent Benefits Booklets issued to you by the Plan Sponsor will in turn supersede this Benefits Booklet.

How to Use This Benefits Booklet

This Benefits Booklet should be read and re-read in its entirety. Many of the provisions of this Benefits Booklet are interrelated; therefore, reading just one or two provisions may not give you an accurate understanding of your Coverage.

Your Benefits Booklet may be modified by the attachment of amendments. Please read the provision described in these documents to determine the way in which provisions in this Benefits Booklet may have been changed.

Many words used in this Benefits Booklet have special meanings. These words will appear capitalized and are defined for you in Section 11, *Glossary*. By reviewing these definitions, you will have a clearer understanding of your Benefits Booklet.

Your Benefits Booklet should be kept in a safe place for your future reference.

Network and Non-Network Benefits

This Benefits Booklet describes both Network and Non-Network benefit levels available under the Plan.

Network Benefits - These benefits apply when you choose to obtain Dental Services from a Network Dentist. Section 3, *How the Plan Works* describes the procedures for obtaining Covered Dental Services as Network Benefits.

Non-Network Benefits - These benefits apply when you decide to obtain Dental Services from non-Network Dentists. Section 3, *How the Plan Works* describes the procedures for obtaining Coverage of Dental Services as Non-Network Benefits. When you obtain Dental Services from non-Network Dentists, you must file a claim to be reimbursed for Eligible Expenses.

For information on the Plan's reimbursement policy guidelines used to determine Eligible Expenses, you should contact UnitedHealthcare Dental at the telephone number on your ID card.

Dental Services Covered Under the Plan

In order for Dental Services to be Covered as Network Benefits, you must obtain all Dental Services directly from or through a Network Dentist.

You should always verify the participation status of a Dentist prior to seeking services. From time to time, the participation status of a Dentist may change. You can verify the participation status by calling UnitedHealthcare Dental. If necessary, UnitedHealthcare Dental can provide assistance in referring you to Network Dentists. If you use a Dentist that is not a participating Dentist, you will be required to pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.

Only Necessary Dental Services are Covered under the Plan. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is Covered under the Plan.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the Dentists have no way of knowing that you are Covered under a Plan issued by the Plan Sponsor.

Contact the Plan Administrator

Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Plan Administrator or call the telephone number stated on your ID card.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time or part-time Employee who is eligible to enroll in the APC Health Benefits Plan in accordance with the Summary Plan Description of the APC Health Benefits Plan or a Retired Employee who is eligible to enroll in the APC Retiree Health Benefits Plan in accordance with the Summary Plan Description of the APC Retiree Health Benefits Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse (including your Domestic Partner), as defined in Section 14, *Glossary;*
- your or your Spouse's child through the end of the year in which the child turns age 26; for purposes of this and the next bullet point, "child" includes a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse have a court appointed guardianship or conservatorship but only if such child primarily lives with you and is a member of your household; or
- your or your Spouse's child, beginning with the year of the child's 27th birthday, who is dependent upon you or your Spouse because of a mental or physical handicap rendering the child medically incapacitated and unable to be self-supporting (Disabled). The child must satisfy either of the following requirements:
  - prior to the end of the year of the child's 26th birthday, the child is Disabled and covered as a Dependent under the Plan; or
  - the child is Disabled and over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll for coverage (i.e., the Disabled child cannot later be added to coverage under the Plan).

  In addition, the child must reside with the Employee in his household for more than one-half of the year, and the child must not provide more than one-half of his own support for the year. Periodic proof of incapacity may be required by the Plan Administrator to continue coverage for the child.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both Employees and covered under the APC Health Benefits Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. If you and your Spouse are both Retired Employees and covered under the APC Retiree Health Benefits Plan, you may each be enrolled as a Retired Employee or be covered as a Dependent of the other person, but not both. However, if you are eligible for coverage as an Employee under the APC Health Benefits Plan and your Spouse is eligible for coverage as a Retired Employee under the APC Retiree Health Benefits Plan, you are not eligible for coverage as a Dependent under the APC Retiree Health Benefits Plan and your Spouse is not eligible for coverage as a Dependent under the APC Health Benefits Plan. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 10, *Other Important Information*.

Cost of Coverage

You and Anadarko Petroleum Corporation share in the cost of the Plan. Your contribution amount depends on the options under the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children to be *per se* dependents for federal tax purposes (unless they meet the specific requirements for qualifying as tax dependents under the Internal Revenue Code of 1986, as amended (the "Code")). Therefore, the value of Anadarko Petroleum Corporation's cost in covering a Domestic Partner and the Domestic Partner's children may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children will be paid using after-tax payroll deductions.

Your contributions are subject to review and Anadarko Petroleum Corporation reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Anadarko Benefits Center at (866) 472-4711 or logging onto **www.anadarkoadvantage.ehr.com**.

How to Enroll

To enroll, call the Anadarko Benefits Center at (866) 472-4711, or log onto **www.anadarkoadvantage.ehr.com**, within 31 days of the date you first become eligible for dental Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Annual Enrollment to make your benefit elections.

Each year during Annual Enrollment, you have the opportunity to review and change your dental election. Any changes you make during Annual Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, the birth of a child, adoption of a child, placement for adoption of a child or other family status change, you must do so within 31 days of the event. You may log in to **www.anadarkoadvantage.ehr.com** to process your family status change or contact the Anadarko Benefits Center at (866) 472-4711. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

Once the Anadarko Benefits Center receives your properly completed enrollment, coverage will begin on your initial date of eligibility, as described in the SPD. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify the Anadarko Benefits Center within 31 days of your marriage. 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 Anadarko Benefits Center within 31 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status that affects eligibility for coverage or you have a special enrollment right. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.), but you can generally enroll yourself and/or your Dependents in any Benefit Program offered under the Plan for which you are otherwise eligible as provided in the SPD if you have a special enrollment right. The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- establishing or dissolving a Domestic Partnership;
- the birth, adoption, placement for adoption or legal guardianship of a Dependent child;
- any of the following that change your or your Dependent's employment status: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your residence;

- a change in your or your Dependent's position or work schedule that impacts eligibility for health coverage;
- your or your Dependent's gain or loss of entitlement to Medicaid;
- a court or administrative order; and
- any other change in status event provided under the Anadarko Petroleum Corporation Pre-Tax Premium and Benefits Plan.

The following create special enrollment rights for purposes of the Plan:

- your marriage;
- the birth, adoption, placement for adoption of a Dependent child;
- loss of eligibility for other health coverage as a result of legal separation, divorce, loss of dependent status, death of an employee, termination of employment, or reduction in hours;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- contributions are no longer paid by the Employer;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Anadarko Benefits Center within 60 days of termination); and
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Anadarko Benefits Center within 60 days of determination of subsidy eligibility).

Unless otherwise noted above, if you wish to change your elections, you must do so within 31 days of the event. You may log in to **www.anadarkoadvantage.ehr.com** to process your family status change or contact the Anadarko Benefits Center at (866) 472-4711. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all dental Plan coverage for the child will end when the placement ends.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance;
- Annual Maximum Benefit; and
- Lifetime Maximum Benefit for Orthodontic Services.

Network and Non-Network Benefits

As a participant in the Plan, you have the freedom to choose the Dentist you prefer each time you need to receive Covered Dental Services. The choices you make affect the amounts you pay.

You are eligible for the Network level of Benefits under the Plan when you receive Covered Dental Services from Dentists who have contracted to provide those services.

Generally, when you receive Covered Dental Services from a Network Dentist, you pay less than you would if you receive the same care from a non-Network Dentist. Your level of Benefits will be the same if you visit a Network Dentist or non-Network Dentist. Because the total amount of Eligible Expenses may be less when you use a Network Dentist, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Dentist.

If you choose to seek care outside the Network, although the Plan generally pays Benefits at the same level, you are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant. You may want to ask the non-Network Dentist about their billed charges before you receive care. Emergency services received at a non-Network Dentist are covered at the Network level.

Looking for a Network Dentist?
In addition to other helpful information, **www.myuhcdental.com** contains a directory of Network health care professionals and facilities. While Network status may change from time to time, **www.myuhcdental.com** has the most current source of Network information. Use **www.myuhcdental.com** to search for Dentists available under your Plan.

Network Dentists

You may request a directory of Network Dentists free of charge. Keep in mind, a Dentist's Network status may change at any time. To verify a Dentist's current status or request a Dentist directory, you can call the toll-free number on your ID card or log onto **www.myuhcdental.com**.

Network Dentists are independent practitioners and are not employees of the Plan or the Claims Administrator.

Eligible Expenses

Eligible Expenses are charges for Covered Dental Services that are provided while the Plan is in effect, determined according to the definition in Section 11, *Glossary*. For certain Covered Dental Services, the Plan will not pay these expenses until you have met your Annual Deductible. Anadarko Petroleum Corporation has delegated to UnitedHealthcare Dental the discretion and authority to decide whether a treatment or supply is a Covered Dental Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your ID card every time you receive dental services from a Dentist. If you do not show your ID card, a Dentist has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Dental Services before you are eligible to begin receiving Benefits. There is a combined Annual Deductible for Network and Non-Network Benefits. 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 Dental Services after you meet the Annual Deductible.

Annual Maximum Benefit

The Annual Maximum Benefit is the maximum amount the Plan will pay each calendar year for Covered Dental Services. There is a combined Annual Maximum Benefit for Network and Non-Network Benefits. Benefits for services listed under Preventive Services and Diagnostic Services in Section 4, *Plan Highlights*, do not apply to the Annual Maximum Benefit.

Lifetime Maximum Benefit for Orthodontic Services

The Lifetime Maximum Benefit is the most the Plan will pay for orthodontic services during the entire period you are enrolled in the Plan and any other dental plans offered by Anadarko Petroleum Corporation. There is a combined Network and non-Network Lifetime Maximum Benefit for Orthodontic Services.

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible, Annual Maximum Benefit and Lifetime Maximum Benefits.

Plan Features	Network	Non-Network
Annual Deductible ■ Individual ■ Family	$50 $150	
Annual Maximum Benefit[1] ■ Individual	$2,000	
Lifetime Maximum Benefit for Orthodontic Services	$2,000 per Covered Person, per lifetime	

[1]Benefits for Preventive Services and Diagnostic Services do not apply to the Annual Maximum Benefit.

The table below provides a description of the Plan's Benefits, including any limitations that apply, and an overview of the Plan's coverage levels.

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	100%	100%
Viral Cultures	100%	100%
Bite-Wing Radiographs Limited to two series of films per calendar year	100%	100%

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Intraoral - Complete Series or Panorex Radiographs Limited to one time per 36 months.	100%	100%
Oral/Facial Photographic Images Limited to one time per consecutive 36 months.	100%	100%
Diagnostic Casts Limited to one time per 24 months.	100%	100%
Vertical Bitewings Limited to one time every three calendar years.	100%	100%
Individual Periapical Radiographs	100%	100%
Pulp Vitality Tests Limited to one charge per visit, regardless of how many teeth are tested.	100%	100%
Periodic Oral Evaluation Limited to two times per calendar year.	100%	100%
Comprehensive Oral Evaluation Limited to two times per calendar year. Not Covered if done in conjunction with other exams.	100%	100%
Limited or Detailed Oral Evaluation Only one exam is Covered per date of service.	100%	100%

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Comprehensive Periodontal Evaluation - new or established patient Limited to two times per calendar year.	100%	100%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to one time per consecutive 12 months.	100%	100%
PREVENTIVE SERVICES		
Dental Prophylaxis Cleanings Limited to two times per calendar year.	100%	100%
Periodontal Maintenance Limited to four times per calendar year following active or adjunctive periodontal therapy, exclusive of gross debridement.	100%	100%
Fluoride Treatments Limited to two times per calendar year (for all Covered Persons).	100%	100%
Sealants Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every three calendar years.	100%	100%
Space Maintainers Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	100%	100%

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Re-Cement Space Maintainers Limited to one per consecutive 6 months after initial insertion.	100%	100%
MINOR RESTORATIVE SERVICES		
Intraoral Occlusal Film	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Extraoral Radiographs Limited to two films per calendar year.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Amalgam Restorations Fillings Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Composite Resin Restorations Fillings Composite Resin Restorations Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
ENDODONTICS		
Apexification Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Apicoectomy and Retrograde filling Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Hemisection Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Root Canal Therapy (except for molar) Limited to one time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Retreatment of Previous Root Canal Therapy (except for molar) Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Endodontic Therapy, Molar (excluding final restoration) and Retreatment of Previous Root Canal Therapy – Molar Limited to one time per tooth per lifetime.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Root Resection/Amputation Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Therapeutic Pulpotomy Limited to one time per primary or secondary tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to one time per tooth per lifetime. Covered for anterior or posterior teeth only.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulp Caps - Direct/Indirect – excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Pulpal Debridement, Primary and Permanent Teeth Limited to one time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
PERIODONTICS		
Crown Lengthening Limited to one per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gingivectomy/Gingivoplasty Limited to one per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gingival Flap Procedure Limited to one per quadrant or site every three calendar years.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Osseous Graft Limited to one per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Osseous Surgery Limited to one per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Guided Tissue Regeneration Limited to one per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Soft Tissue Surgery Limited to one per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Full Mouth Debridement Limited to once per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Scaling and Root Planning Limited to one time per quadrant per consecutive 24 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
ORAL SURGERY		
Alveoloplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Biopsy Limited to one biopsy per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Frenectomy/Frenuloplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Incision and Drainage Limited to one per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of a Benign Cyst/Lesions Limited to one per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of Torus Limited to one per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of Lateral Exostosis	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Root Removal Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Simple Extraction Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Suture of Soft Tissue	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Surgical Extraction of Erupted Teeth or Roots Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Surgical Extraction of Impacted Teeth Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of Impacted Teeth – Partially Bony	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Primary Closure of a Sinus Perforation Limited to one per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to one time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Vestibuloplasty Limited to one time per site per consecutive 60 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Sialolithotomy	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Bone Replacement Graft for Ridge Preservation - per site Limited to one per site per lifetime Not Covered if done in conjunction with other bone graft replacement procedures.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to one per site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Tooth Reimplantation and/or Transplantation Services Limited to one per site per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Oroantral (Salivary) Fistula Closure Limited to one per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under six years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age six if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Desensitizing Medicament	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
General Anesthesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under six years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age six if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under six years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age six if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Adjustment	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Guards Limited to one guard every three calendar years and only covered if prescribed to control habitual grinding.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Guard Reline and Repair Limited to relining and repair performed more than six months after the initial insertion. Limited to one time per consecutive 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusion Analysis - Mounted Case Limited to one time per consecutive 60 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Histopathologic Examination	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not Covered if done with exams or professional visit. Limited to four per consecutive 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Office visit outside of regularly scheduled hours	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
MAJOR RESTORATIVE SERVICES Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time every five calendar years from initial or supplemental placement.		
Labial Veneer Limited to one time per tooth every five calendar years.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Coping Limited to one per tooth per consecutive 60 months. Not Covered if done at the same time as a crown on same tooth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Crowns – Retainers/Abutments Limited to one time per tooth every five calendar years. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Crowns - Restorations Limited to one time per tooth every five calendar years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Temporary Crowns - Restorations Limited to one time per tooth every five calendar years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Inlays/Onlays – Retainers/Abutments Limited to one time per tooth every five calendar years. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Inlays/Onlays - Restorations Limited to one time per tooth every five calendar years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Pontics Limited to one time per tooth every five calendar years.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to one time per tooth every five calendar years.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pin Retention Limited to two pins per tooth; not covered in addition to cast restoration. Limited to one time per consecutive 60 months	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Post and Cores Covered only for teeth that have had root canal therapy. Limited to one per tooth every five calendar years.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Re-cement Inlays/Onlays, Crowns and Bridges Limited to those performed more than 12 months after the initial insertion.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Sedative Filling Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the visit.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Prefabricated Resin or Stainless Steel Crowns Limited to one time per tooth every five calendar years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
FIXED PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time every five calendar years from initial or supplemental placement.		
Fixed Partial Dentures (Bridges)/ Stress Breakers Limited to one time per every five calendar years.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
REMOVABLE PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time every five calendar years from initial or supplemental placement.		
Full Dentures Limited to one every five calendar years. No additional allowances for precision or semi-precision attachments.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Partial Dentures Limited to one every five calendar years. No additional allowances for precision or semi-precision attachments.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Relining Dentures and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to one time per consecutive 12 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Tissue Conditioning - Maxillary or Mandibular Limited to one time per consecutive 12 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Repairs to Full Dentures, Partial Dentures, Bridges Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns. Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per consecutive 6 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Stress Breakers	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
IMPLANTS Replacement of implants, implant crowns, implant prosthesis, and implant supporting structures (such as connectors) previously submitted for payment under the plan is limited to one time per consecutive 60 months from initial or supplemental placement.		
Implant Placement Limited to one time per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Implant Supported Prosthetics Limited to one time per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Implant Maintenance Procedures, including removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis Limited to one time per consecutive 12 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Repair Implant Supported Prosthesis, by report Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to one per consecutive 6 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Abutment Supported Crown (titanium) or Retainer Crown for FPD - titanium Limited to one time per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Repair Implant Abutment, by report Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to one per consecutive 6 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Implant Removal, by report Limited to one time per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Radiographic/Surgical Implant Index, by report Limited to one time per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
ORTHODONTICS		
Orthodontic Services Services or supplies furnished by a Dentist in order to diagnose or correct misalignment of the teeth or the bite. The extended coverage provision does not apply to orthodontic services.	50%	50%

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Appliance Therapy, Fixed or Removable Limited to one time per consecutive 60 months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.	50%	50%
Cephalometric Film Limited to one per consecutive 12 months. Can only be billed for orthodontics.	50%	50%

SECTION 5 - EXCLUSIONS: WHAT THE DENTAL PLAN WILL NOT COVER

Except as may be specifically provided in the Section entitled *Plan Highlights* through an amendment to the Benefits Booklet, the following are not Covered:

1. Dental Services that are not Necessary.

2. Hospitalization or other facility charges.

3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

5. Any Dental Procedure not directly associated with dental disease.

6. Any Dental Procedure not performed in a dental setting.

7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8. Any implant procedures performed which are not listed as Covered implant procedures in Section 4, *Plan Highlights*.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

13. Replacement of complete dentures, and fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to Dental error. This

type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

14. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.

15. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

16. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.

17. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.

18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

19. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Services rendered by a Dentist with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

24. Dental Services otherwise Covered under the Plan, but rendered after the date individual Coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Plan terminates, except those conditions Covered under the *Extended Coverage* in Section 8, *When Coverage Ends*.

25. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

26. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to

correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

27. In the event that a non-Network Dentist routinely waives Coinsurance and/or the Deductible for a particular Dental Service, the Dental Service for which the Coinsurance and/or Deductible are waived is reduced by the amount waived by the non-Network Dentist.

28. Foreign Services are not Covered unless required as an Emergency.

29. Dental 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.

30. Any Dental Services or Procedures not listed in Section 4, *Plan Highlights*.

SECTION 6 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Dental Services from a Network Dentist, the Dentist will be paid directly. If a Network Dentist bills you for any Covered Health Service other than your Coinsurance, please contact the Dentist or call the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Coinsurance owed to a Network Dentist at the time of service, or when you receive a bill from the Dentist.

Non-Network Benefits

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

If Your Dentist Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhcdental.com**, calling the toll-free number on your ID card or contacting the Benefits Department. 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 Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the Dentist of the service(s);
- a diagnosis from the Dentist;
- the date of service;
- an itemized bill from the Dentist that includes:
  - the American Dental Association (ADA) codes;
  - a description of, and the charge for, each service;
  - the date the sickness or injury began; and
  - 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 you.

After your claim has been processed and your claim is approved, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network Dentist the charges you incurred, including any difference between what you were billed and what the Plan paid.

Non-Network Benefits will be paid to you unless:

- the Dentist provides notice that you have signed an authorization to assign Benefits directly to that Dentist; or
- you make a written request for the non-Network Dentist to be paid directly at the time you submit your claim.

Benefits will only be paid to you or, with written authorization by you, to your Dentist, and not to a third party, even if your Dentist has assigned Benefits to that third party.

Explanation of Benefits (EOB)

You may receive an Explanation of Benefits (EOB) after your claim is processed. 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. You can also view and print all of your EOBs online at **www.myuhcdental.com**. See Section 11, *Glossary* for the definition of Explanation of Benefits.

Important
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced. 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

Types of Claims

There are three different types of claims under the Plan: Urgent Care Claims, Pre-service Claims and Post-service Claims.

- an "Urgent Care Claim" is a claim for dental care or treatment with respect to which the time frames for making non-urgent care determinations either: i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or ii) in the opinion of a Physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The person acting on behalf of the Plan shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine to determine if a claim is an Urgent Care Claim. Notwithstanding the above, any claim that a Physician with knowledge of the

claimant's condition determines is an Urgent Care Claim, as defined above, shall be treated as an Urgent Care Claim.

- a "Pre-Service Claim" is any claim for Benefits under the Plan for which the Benefit is conditioned on obtaining approval or authorization prior to obtaining the dental care.
- a "Post-Service Claim" is any claim for Benefits under the Plan that is not a Pre- Service Claim or Urgent Care Claim.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you will receive a written notice of the denial that contains specific information as described in the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

If your claim for Benefits is denied, you may call UnitedHealthcare at the number on your ID card to try to resolve the issue before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, in order to preserve your rights under federal law you must file a formal appeal as described below.

To the extent required by applicable law, the Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or dental expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-service Claim, 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 do not need to submit Urgent Care Claim appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of dental service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O Box 30569
Salt Lake City, UT 84130-0569

For Urgent Care Claims that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care Claim;
- Pre-service Claim; or
- Post-service Claim.

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; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

The appeal will not give deference to the initial denial.

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 that contains specific information as described in the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, in order to preserve your rights under federal law, you must 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, documents and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the denial of your appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

Before the Plan can deny your appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale; the rationale must be provided as soon as

possible and sufficiently in advance of the date on which the notice of the denial of your appeal is required to be provided to you to give you a reasonable opportunity to respond prior to that date.

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 that contains specific information as described in the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, as applicable. However, you may receive oral notice of a denial of an Urgent Care Claim followed by a written notice.

Federal External Review Program

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:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- 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 toll-free 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; and
- 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; and
- 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; and
- 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; and
- 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 dental records;
- all other documents relied upon by UnitedHealthcare; and
- 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 anew 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's determination, the Plan will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

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 dental 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; or
- a final appeal decision, if the determination involves a dental 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 Plan at the time the health care service or procedure that is at issue in the request was provided; and
- 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 anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's dental 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.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The types of claims are described above under the heading *Types of Claims*.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

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.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving the request for additional information

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If UnitedHealthcare denies your initial claim, they must notify you of the denial within:	**72 hours**
■ if the initial claim is complete:	**72 hours**
■ after receiving the completed claim (if the initial claim is incomplete):	**48 hours**
If UnitedHealthcare denies your claim, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care Claim.

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, UnitedHealthcare must notify you within:	**5 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving the request for additional information
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**15 days***
■ after receiving the completed claim (if the initial claim is incomplete), within:	**15 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control, provided that within the initial 15 days, they notify the claimant of the circumstances requiring the extension and the date by which they expect to render a decision.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice
If UnitedHealthcare denies you initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days***
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days** after receiving the additional information
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare 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 (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control, provided that within the initial 15 days, they notify the claimant of the circumstances requiring the extension and the date by which they expect to render a decision.

Limitation of Action

You cannot bring any legal action against Anadarko Petroleum Corporation or the Claims Administrator for any reason unless you first complete all the steps in the appeals process described in this section. After completing that process, if you want to bring any action at law or in equity against Anadarko Petroleum Corporation or the Claims Administrator with respect to any claim relating to the Plan, you must do so within one year from the earlier of a final internal adverse benefit determination, if applicable, or the accrual of any claim under or relating to the Plan or you lose any rights to bring such an action against Anadarko Petroleum Corporation or the Claims Administrator.

SECTION 7 - SUBROGATION AND REIMBURSEMENT

The provisions of the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, as applicable, will govern and control the Plan's rights to subrogation and reimbursement. These provisions are summarized in this section. Should there be any conflict between these subrogation and reimbursement provisions and those of the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, the provisions in the applicable Summary Plan Description will govern. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent permitted by applicable law as determined by the Plan Administrator.

Note: All references in this section to medical benefits will include benefits for dental treatment.

Right of Subrogation and Reimbursement

The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this section on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this section on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

Benefits Subject to this Provision

The provisions set forth in this section will apply to all benefits provided under the Plan. For purposes of this section, certain terms are defined as follows:

- **"Recovery"** means any and all monies and property paid by a Third Party to (i) the Covered Person, (ii) the Covered Person's attorney, assign, legal representative, or beneficiary, (iii) a trust of which the Covered Person is a beneficiary, or (iv) any other person or entity on behalf of the Covered Person, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the Injury or illness.
- **"Reimbursement"** means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Covered Person toward care and treatment of the Injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.
- **"Subrogation"** means the Plan's right to pursue the Covered Person's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

- **"Third Party"** means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Covered Person's Injury or illness. The term "Third Party" will include the party or parties who caused the Injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the Injury or illness; a Covered Person's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the Injury or illness.

When this Provision Applies

A Covered Person may incur medical or other charges related to any Injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the Injury or illness. If so, the Covered Person may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Covered Person has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Covered Person receives the Recovery or (b) the Covered Person's attorney, a trust of which the Covered Person is a beneficiary, or other person or entity receives the Recovery on behalf of the Covered Person. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Covered Person hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any Injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this section.

The Plan's equitable lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures, or may be entitled to procure, regardless of whether the Covered Person has received compensation for any or all of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Covered Person's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan,

the Covered Person agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this section, and the Covered Person hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Covered Person:

- authorizes the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Covered Person's rights to Recovery when the provisions of this section apply;
- must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- must cooperate fully with the Plan in its exercise of its rights under this section, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Covered Person who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to the subsection *When a Covered Person Retains an Attorney* below, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this section (**S&R Agreement**).

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injury or illness. The Plan may file a copy of an S&R Agreement signed by the Covered Person and his or her attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Covered Person (and his or her attorney, as applicable), a Covered Person's claim for any medical or other benefits for any Injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Covered Person, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the

basis for denial of the Covered Person's claim for benefits for the Injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Covered Person who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Covered Person is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Covered Person automatically agrees, without further notice, to all the terms and conditions of this section and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this section and to make changes in its interpretation as it deems necessary or appropriate.

Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Covered Person receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Covered Person may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his or her charges and expenses.

When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or Injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for

payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this section.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses incurred are related to an illness or Injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Covered Person has already received a Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, the Plan will not pay any portion of the Covered Person's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Covered Person's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Covered Person's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his or her pursuit of Recovery.

Any Recovery paid to the Covered Person's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Covered Person's Injury or illness and expenses incurred by the Plan in enforcing the provisions of this section, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this section. A Covered Person's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Covered Person nor his or her attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

When the Covered Person is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent

The provisions of this section will apply to the parents, trustee, guardian or other representatives of a minor Dependent child and to the heirs or personal representatives of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this section, the term "Covered Person" will also include a COBRA qualified beneficiary who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Covered Person whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is

not a minor (e.g., a full-time post-secondary student) and, in such event, the Employee will be liable for any breach of this section by the Employee or by such Dependent.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Covered Person and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce the provisions of this section, the Covered Person will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

SECTION 8 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are receiving dental treatment on that date.

When your coverage ends, Anadarko Petroleum Corporation will still pay claims for Covered Dental Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for dental services that you receive after coverage ended, even if the underlying dental condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Company ends;
- the date the Plan ends or is amended to eliminate your coverage;
- the date of your death;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the last day of the month you are no longer eligible to participate in the Plan (except that coverage may be continued until the last day of the month through which you are receiving disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan or have been certified as disabled by the Company's long-term disability insurance carrier for purposes of being eligible to receive income replacement payments under such disability insurance policy, unless such coverage is terminated earlier);
- the date, if any, on which you falsify information provided to the Plan, fraudulently or deceptively use Plan services or knowingly permit such fraud or deception by another person, including enrolling a person as a Spouse or other Dependent who does not qualify as a Dependent under the terms of the Plan;
- the last day of the month in which you complete six months of unpaid leave of absence; or
- if you are receiving long term disability benefits under the Anadarko Petroleum Corporation Ancillary Benefits Plan, the last day of the month in which you elect to receive your full distribution from the Anadarko Retirement Plan or the Kerr-McGee Corporation Retirement Plan.

See the Summary Plan Description of the APC Retiree Health Benefits Plan for a complete description of when a Retired Employee's coverage ends under the APC Retiree Health Benefits Plan.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date on which the Plan is amended to eliminate coverage for the Dependent, for whatever reason;
- the last day of the period for which any required contribution for coverage has been made if the charge for the next period is not paid when due;
- the date the Dependent becomes covered under the Plan as an Employee;
- the date, if any, on which the Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person;
- the date Dependents' coverage ceases to be available to the Employee;
- the date on which an Employee elects to terminate coverage for his or her Dependent, provided that you notify Anadarko Petroleum Corporation of the intention to terminate coverage within 30 days prior to the date; or
- the last day of the calendar year in which a Dependent child ceases to be an eligible Dependent under the Plan; or the last day of the month in which any other Dependent ceases to be an eligible Dependent under the Plan.

Other Events Ending Your Coverage

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

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, in which case such termination of coverage may be retroactive;
- you fail to comply with the Plan's subrogation and reimbursement provisions; or
- you commit an act of physical or verbal abuse that imposes a threat to Anadarko Petroleum Corporation's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: Anadarko Petroleum Corporation has the right to demand that you pay back Benefits Anadarko Petroleum Corporation paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Extended Coverage

A 30 day temporary extension of Coverage, only for the services shown below when given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of: (a.) the end of the 30 day period; or (b.) the date the Covered Person becomes covered under a succeeding policy or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a.) a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Plan was in effect, by the attending Dentist; (b.) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c.) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

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 Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability rendering the child medically incapacitated and unable to be self-supporting;
- the child depends mainly on you for support and resides with you for more than one-half of the year;
- either 1) you provide to Anadarko Petroleum Corporation proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age or 2) the child has such handicap or disability and is over age 26 prior to the child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the child in the Plan when the Employee first becomes eligible to enroll in such coverage (i.e., the child cannot later be added to coverage under the Plan); and
- you provide proof, upon Anadarko Petroleum Corporation's request, that the child continues to meet these conditions.

The proof might include medical examinations at the Plan's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 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 Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available if the Plan is subject to the terms of COBRA. You can contact your Plan Administrator to determine if the Plan is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator 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 Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's enrolled Spouse (or former Spouse).

A Domestic Partner, or the children of a Domestic Partner, who are covered under the Plan on the day prior to the qualifying event shall be treated as Qualifying Beneficiaries under the Plan, although such treatment is not a right required by COBRA.

A Retired Employee is not eligible to elect COBRA continuation coverage upon termination of his or her coverage under the Plan. However, for purposes of this section and a Spouse's or Dependent's eligibility to elect COBRA continuation coverage, a Retired Employee is considered a covered Employee.

Qualifying Events for Continuation Coverage under COBRA

The following table 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	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage because your employment terminates or your hours are reduced[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate) or dissolve a Domestic Partnership	N/A	36 months	36 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
Anadarko Petroleum Corporation files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within 60 days after the latest of a) the determination of the disability, b) the date of the qualifying event, or c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Employee 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.

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your Spouse and/or Dependent children in your family can get additional months of COBRA continuation coverage, up to the maximum of 36 months. This extension is available to your Spouse and/or Dependent children if you die, or get divorced or legally separated, or dissolve a Domestic Partnership. The extension is also available to a dependent child when that child stops being eligible under the Plan as a Dependent. In all of these cases you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an

additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, dissolution of Domestic Partnership or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation, dissolution of Domestic Partnership or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- 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 Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Anadarko Benefits Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the

covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 9 - COORDINATION OF BENEFITS

What this section includes:
- How your Benefits under the Plan coordinate with other plans; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits Applicability

This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

Definitions

For purposes of this Section, Coordination of Benefits, terms are defined as follows:

- A "Coverage Plan" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
  - "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); dental benefits under group or individual automobile contracts (subject to the "Note" in the section entitled *Determining Which Plan is Primary*, below); and governmental benefits, as permitted by law.
  - "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-dental components of group long-term care policies; Medicaid policies and coverage under other governmental plans, unless permitted by law.

  Each contract for coverage under either definition of "Plan" is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.
- The order of benefit determination rules determine whether the Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

  When the Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When the Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

- "Allowable expense" means a health care service or expense, including deductibles and coinsurance, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
  - If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
  - If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
  - If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.
- "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under the Plan, or before the date this COB provision or a similar provision takes effect.
- "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.
- A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major dental coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

- A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.
  - **Non-Dependent or Dependent**. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, Subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. **Child Covered Under More Than One Plan**. The order of benefits when a child is covered by more than one Coverage Plan is:
    - The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
      - the parents are married; or
      - the parents are not separated (whether or not they ever have been married); or
      - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
    - If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.
    - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - the Coverage Plan of the custodial parent;
      - the Coverage Plan of the spouse of the custodial parent;
      - the Coverage Plan of the noncustodial parent; and then
      - the Coverage Plan of the spouse of the noncustodial parent.
  - **Active or inactive employee**. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule for "Non-Dependent or Dependent"
  - **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, Subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
  - **Longer or shorter length of coverage**. The Coverage Plan that covered the person as an employee, member, Subscriber or retiree longer is primary.

- If the preceding rules do not determine the primary Coverage Plan, the allowable expenses will be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, the Plan will not pay more than it would have paid had it been primary.

Note: The Plan does not automatically coordinate with auto liability or no-fault insurance coverage; however, the subrogation and recovery provisions of Section 7, *Subrogation and Reimbursement*, may apply to a Covered Person's right to Benefits under the Plan.

Effect on the Benefits of This Coverage Plan

When the Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses.

When the Plan is the secondary carrier, the Plan will only pay the difference between what the Plan would have paid as primary minus what the other carrier paid.

If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.

Right to Receive and Release Needed Information

Certain facts about health or dental care coverage and services are needed to apply these COB rules and to determine Benefits payable under the Plan and other Coverage Plans. UnitedHealthcare Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining Benefits payable under the Plan and other Coverage Plans covering the person claiming Benefits.

UnitedHealthcare Dental does not need to tell, or get the consent of, any person to do this. Each person claiming Benefits under the Plan must give UnitedHealthcare Dental any facts it needs to apply those rules and determine benefit payable. If you do not provide UnitedHealthcare Dental the information it needs to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under the Plan. If it does, the Claims Administrator (on behalf of the Plan Administrator) may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under the Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Claims Administrator (on behalf of the Plan Administrator) is more than it should have paid under this COB provision, it may recover

the excess from one or more of the persons it had paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 10 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with the Plan and the Claims Administrator;
- Relationships with Dentists;
- Interpretation of Benefits;
- Information and records;
- Incentives to Dentists and you;
- The future of the Plan; and
- How to access the official Plan documents.

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 dental benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a dental child support order for your child that instructs the Plan to cover the child, the Plan Administrator 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 Plan as your Dependent, and the Plan 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 Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare Dental and Anadarko Petroleum Corporation

In order to make choices about your dental coverage and treatment, Anadarko Petroleum Corporation believes that it is important for you to understand how UnitedHealthcare Dental interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare Dental helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare Dental does not provide dental services or make treatment decisions. This means:

- Anadarko Petroleum Corporation and UnitedHealthcare Dental do not decide what care you need or will receive. You and your Dentist make those decisions;

- UnitedHealthcare Dental communicates to you decisions about whether the Plan will cover or pay for the Dental Services that you may receive (the Plan pays for Covered Dental Services, which are more fully described in this Benefits Booklet); and
- the Plan may not pay for all treatments you or your Dentist may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Anadarko Petroleum Corporation and UnitedHealthcare Dental may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Anadarko Petroleum Corporation and UnitedHealthcare Dental will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. Anadarko Petroleum Corporation and UnitedHealthcare Dental will use de-identified data for commercial purposes including research.

Relationship with Dentists

The relationships between Anadarko Petroleum Corporation, UnitedHealthcare Dental and Network Dentists are solely contractual relationships between independent contractors. Network Dentists are not Anadarko Petroleum Corporation's agents or employees, nor are they agents or employees of UnitedHealthcare Dental. Anadarko Petroleum Corporation and any of its employees are not agents or employees of Network Dentists, nor are UnitedHealthcare Dental and any of its employees agents or employees of Network Dentists.

Anadarko Petroleum Corporation and UnitedHealthcare Dental do not provide dental services or supplies, nor do they practice dentistry. Instead, Anadarko Petroleum Corporation and UnitedHealthcare Dental arranges for Dentists to participate in a Network and pay Benefits. Network Dentists are independent practitioners who run their own offices and facilities. UnitedHealthcare Dental's credentialing process confirms public information about the Dentists' licenses and other credentials, but does not assure the quality of the services provided. They are not Anadarko Petroleum Corporation's employees nor are they employees of UnitedHealthcare Dental. Anadarko Petroleum Corporation and UnitedHealthcare Dental do not have any other relationship with Network Dentists such as principal-agent or joint venture. Anadarko Petroleum Corporation and UnitedHealthcare Dental are not liable for any act or omission of any Dentist.

UnitedHealthcare Dental is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of Benefits under the Plan.

Anadarko Petroleum Corporation and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Dentists

The relationship between you and any Dentist is that of Dentist and patient. Your Dentist is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Dentist and verifying if your Dentist is in the Network at the time of each service;
- are responsible for paying, directly to your Dentist, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Dentist, the cost of any non-Covered Dental Service;
- must decide if any Dentist treating you is right for you (this includes Network Dentists you choose and Dentists to whom you have been referred); and
- must decide with your Dentist what care you should receive.

Interpretation of Benefits

Anadarko Petroleum Corporation and UnitedHealthcare Dental have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this Benefits Booklet and any amendments thereto; and
- make factual determinations related to the Plan and its Benefits.

Anadarko Petroleum Corporation and UnitedHealthcare Dental may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Anadarko Petroleum Corporation may, in its sole discretion, offer Benefits for services that would otherwise not be Covered Dental Services. The fact that Anadarko Petroleum Corporation does so in any particular case shall not in any way be deemed to require Anadarko Petroleum Corporation to do so in other similar cases.

Information and Records

Anadarko Petroleum Corporation and UnitedHealthcare Dental may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Anadarko Petroleum Corporation and UnitedHealthcare Dental may request additional information from you to decide your claim for Benefits. Anadarko Petroleum Corporation and UnitedHealthcare Dental will keep this information confidential. Anadarko Petroleum Corporation and UnitedHealthcare Dental may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Anadarko Petroleum Corporation and UnitedHealthcare Dental with all information or copies of records relating to the services provided to you, to the extent permissible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Anadarko Petroleum Corporation and UnitedHealthcare Dental have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee's enrollment form. Anadarko Petroleum Corporation and UnitedHealthcare Dental agree that such information and records will be considered confidential.

Anadarko Petroleum Corporation and UnitedHealthcare Dental have the right to release any and all records concerning dental services which are necessary to implement and administer the terms of the Plan, for appropriate dental review or quality assessment, or as Anadarko Petroleum Corporation is required to do by law or regulation. During and after the term of the Plan, Anadarko Petroleum Corporation and UnitedHealthcare Dental and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your records or billing statements Anadarko Petroleum Corporation recommends that you contact your Dentist. Dentists may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from UnitedHealthcare Dental, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Anadarko Petroleum Corporation and UnitedHealthcare Dental will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Dentists

Network Dentists may be provided financial incentives by UnitedHealthcare Dental to promote the delivery of dental care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to dental care.

Examples of financial incentives for Network Dentists are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network Dentists receives a monthly payment from UnitedHealthcare Dental for each Covered Person who selects a Network Dentist within the group to perform or coordinate certain dental services. The Network Dentists receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's dental care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network Dentist is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network Dentist.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Anadarko Petroleum Corporation recommends that you discuss participating in such programs with your Dentist. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend the Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A Plan amendment may transfer coverage to another plan or split a plan into two or more parts. If the Company does amend or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

If the Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on the terms of the Plan and may also depend on any contract provisions affecting the Plan and Company decisions.

Plan Document

This Benefits Booklet describes certain terms of your Benefits under the Plan. When used in this Benefits Booklet, the term “Plan” means, as applicable, either 1) the Plan document and Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the Dental PPO Plan, including this Benefits Booklet or 2) the Plan Document and Summary Plan Description of the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the Dental PPO Plan, including this Benefits Booklet. If there should be an inconsistency between the contents of this Benefits Booklet

and the contents of the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, your rights shall be determined as provided in the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, as applicable. A copy of the documents that constitute the Plan is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your authorized representative) may obtain a copy of these documents by written request to the Plan Administrator, for a nominal charge.

SECTION 11 - GLOSSARY

This Section defines the terms used throughout this Benefits Booklet and is not intended to describe Covered or uncovered services.

Affordable Care Act – the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

Annual Deductible – the amount a Covered Person must pay for Dental Services in a calendar year before the Plan will begin paying for Network and Non-Network Benefits in that calendar year.

Annual Enrollment – the period of time, determined by Anadarko Petroleum Corporation, during which eligible Employees may enroll themselves and their Dependents under the Plan. Anadarko Petroleum Corporation determines the period of time that is the Annual Enrollment period.

Annual Maximum Benefit – the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under any Plan offered by Anadarko Petroleum Corporation. The Maximum Benefit is stated in Section 4, *Plan Highlights*.

Claims Administrator – UnitedHealthcare Dental (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Dental Services as described in Section 3, *How the Plan Works*.

Company – Anadarko Petroleum Corporation.

Congenital Anomaly – a physical developmental defect that is present at birth and identified within the first twelve months from birth.

Coverage or **Covered** – the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Plan, subject to the terms, conditions, limitations and exclusions of the Plan. Dental Services must be provided: (1) when the Plan is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the Section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Plan.

Covered Person – either the Employee or an Enrolled Dependent while Coverage of such person under the Plan is in effect. References to "you" and "your" throughout this Benefits Booklet are references to a Covered Person.

Deductible – see Annual Deductible.

Dental Service or Dental Procedures – dental care or treatment provided by a Dentist to a Covered Person while the Plan is in effect, provided such care or treatment is recognized by the Plan Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist – any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

To the extent an item or service is otherwise Covered under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment or setting for an item or service, the Plan shall not discriminate based on a health care provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require the Plan to accept all types of providers into a Network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not related by blood or adoption;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- not be legally married to each other (in other words, the other person is not the Spouse of the Employee);
- be at least 18 years old;
- live together in a committed, monogamous relationship at the same place of residence for at least six months; and
- intend for their relationship to be continuous and of an indefinite duration.

Eligible Expenses – Eligible Expenses for Covered Dental Services, incurred while the Plan is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Expenses are UnitedHealthcare Dental's contracted fee(s) for the Dental Service with that Dentist.

- For Non-Network Benefits, when Covered Dental Services are received from non-Network Dentist, Eligible Expenses are the Usual and Customary fees as defined below.

Eligible Expenses must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for Benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Eligible Expenses.

Emergency – a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Employee – a regular employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. The Employee is the person (who is not a Dependent) on whose behalf coverage under the Plan is provided.

Enrolled Dependent – a Dependent who is properly enrolled for Coverage under the Plan.

Experimental, Investigational or Unproven Services – medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare Dental makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Foreign Services – are defined as services provided outside the U.S. and U.S. territories.

Lifetime Maximum Benefit – the maximum amount paid for orthodontic services during the entire period of time that the Covered Person is Covered under the Plan or any Plan, offered by Anadarko Petroleum Corporation. The Lifetime Maximum Benefit is stated in Section 4, *Plan Highlights*.

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.

Necessary – Dental Services and supplies which are determined to be appropriate, and

- necessary to meet the basic dental needs of the Covered Person; and
- rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare Dental; and
- consistent with the diagnosis of the condition; and
- required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- demonstrated through prevailing peer-reviewed dental literature to be either:
  - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - safe with promising efficacy
    - ♦ for treating a life threatening dental disease or condition,
    - ♦ in a clinically controlled research setting; and
    - ♦ using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

    (For the purpose of this definition, the term "life threatening" is used to describe a dental disease, sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Benefits Booklet. The definition of Necessary used in this Benefits Booklet relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network – a group of Dentists who are subject to a participation agreement to provide Dental Services to Covered Persons. The participation status of Dentists will change from time to time.

Network Benefits – benefits available for Covered Dental Services when provided by a Dentist who is a Network Dentist.

Non-Network Benefits – coverage available for Dental Services obtained from non-Network Dentists.

Plan – The Anadarko Petroleum Corporation Health Benefits Plan (APC Health Benefits Plan) or the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Health Benefits Plan). When used in this Benefits Booklet, the term "Plan" means, as applicable, either 1) the Plan document and Summary Plan Description of the APC Health Benefits Plan, and any appendices attached thereto, as they relate to the Dental PPO Plan, including this Benefits Booklet or 2) the Plan Document and Summary Plan Description of

the APC Retiree Health Benefits Plan, and any appendices attached thereto, as they relate to the Dental PPO Plan, including this Benefits Booklet.

Plan Administrator – Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee.

Plan Sponsor – Anadarko Petroleum Corporation.

Procedure in Progress – all treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Retired Employee – an individual who, as of the date immediately preceding the individual's date of retirement, was enrolled as an active Employee in either the Anadarko Petroleum Corporation Health Benefits Plan (or its predecessor plan maintained by the Plan Sponsor) or a major medical, group health plan sponsored by another company on the date of such company's acquisition by the Company.

SPD – the Summary Plan Description of the APC Health Benefits Plan or the Summary Plan Description of the APC Retiree Health Benefits Plan, as applicable. The SPDs include any appendices attached thereto, including this Benefits Booklet.

Spouse – a person to whom you are lawfully married, which marriage was solemnized, authenticated, and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, without limitation, the Code, ERISA, and Affordable Care Act), but will not include an individual divorced or legally separated from you by court decree. The term "Spouse" will also include a common law spouse if you reside in a state that recognizes common law marriages and the relationship meets the requirements for common law marriage in that state. You must provide proof of a marriage or common law marriage as reasonably requested by the Plan Administrator such as, for example, an affidavit of common law marriage issued by the applicable state. The term "Spouse" will also include a Domestic Partner, as defined in this section, unless the context indicates otherwise.

Usual and Customary – Usual and Customary fees are calculated based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with reimbursement policy guidelines. The reimbursement policy guidelines are developed following evaluation and validation of all Dentist billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Dental Terminology (publication of the American Dental Association);
- as reported by generally recognized professionals or publications;
- as utilized for Medicare;
- as determined by dental staff and outside dental consultants; or
- pursuant to other appropriate source or determination.

SECTION 12 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the Plan, as well as information required of all summary plan descriptions by ERISA as defined in Section 11, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Plan Administrator

Anadarko Petroleum Corporation is the Plan Sponsor of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan. Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee is the Plan Administrator of the APC Health Benefits Plan and the APC Retiree Health Benefits Plan and has the discretionary authority and control to interpret the Plan , control and manage the operation and administration of the Plan and make all decisions and determination incident thereto. You may contact the Plan Administrator at:

Plan Administrator – Dental Plan
Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Attn: Director, Global Benefits
1201 Lake Robbins Drive
The Woodlands, TX 77380
(832) 636-1000

Claims Administrator

UnitedHealthcare Dental is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

With respect to the Anadarko Petroleum Corporation Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

With respect to the Anadarko Petroleum Corporation Retiree Health Benefits Plan:

Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee
Anadarko Petroleum Corporation Retiree Health Benefits Plan
Anadarko Petroleum Corporation
c/o CT Corporation System
350 N. St. Paul Street
Dallas, TX 75201
(832) 636-8614

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your Benefits Booklet contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare plan and the administration is provided through one or more third party administrators. The Dental PPO Plan is incorporated by reference into the APC Health Benefits Plan and the APC Retiree Health Benefits Plan, each of which is a separate employee welfare plan for purposes of ERISA

Plan Names and Plan Numbers:	Anadarko Petroleum Corporation Health Benefits Plan, Number 501 Anadarko Petroleum Corporation Retiree Health Benefits Plan, Number 504
Employer ID:	76-0146568
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee/Retired Employee and Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan 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), summary annual reports, and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest summary annual reports, and updated SPDs, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies; and
- receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue dental care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Benefits Booklet and the Plan document to understand the rules governing your COBRA continuation coverage rights.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or summary annual report from the Plan, 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 your claim for a Plan 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. See Section 6, *Claims Procedures*, for details.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal (and second level appeal if the appeal is denied) in accordance with the claim and appeal procedures described in Section 6, *Claims Procedures*. If your second level appeal is denied, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court after exhausting the claim and appeal procedures described in Section 6, *Claims Procedures*. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your

rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. 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 (800)-998-7542.

The Plan's Benefits are administered by Anadarko Petroleum Corporation, the Plan Administrator. UnitedHealthcare Dental is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare Dental and Anadarko Petroleum Corporation are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network Dentist. UnitedHealthcare Dental and Anadarko Petroleum Corporation are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network Dentists.

Program Document 5

UnitedHealthcare MedicareRx for Groups (PDP), Evidence of Coverage (2018), Group Number 00334

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2018)

2018 EVIDENCE OF COVERAGE

The details of your plan

UnitedHealthcare® MedicareRx℠ for Groups (PDP)
Group Name (Plan Sponsor): ANADARKO PETROLEUM CORPORATION
Group Number: 00334

Toll-Free **1-888-556-6648,** TTY **711**
8 a.m. - 8 p.m. local time, Monday - Friday

www.UHCRetiree.com

UnitedHealthcare®

Y0066_S5820_803_2018

January 1, 2018 to December 31, 2018

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of our plan

This booklet gives you the details about your Medicare prescription drug coverage from January 1, 2018 - December 31, 2018. It explains how to get coverage for the prescription drugs you need.

This is an important legal document. Please keep it in a safe place.

This plan, UnitedHealthcare® MedicareRx℠ for Groups (PDP), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means UnitedHealthcare® MedicareRx℠ for Groups (PDP).)

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This document may be available in an alternate format such as Braille, large print or audio. Please contact our Customer Service number at 1-888-556-6648, TTY: 711, 8 a.m. - 8 p.m. local time, Monday - Friday, for additional information.

Benefits and/or copayments/coinsurance may change on January 1, 2019.

The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary.

Y0066_S5820_803_2018
Form CMS 10260-ANOC/EOC
(Approved 05/2017)

OMB Approval 0938-1051 (Expires: May 31, 2020)

2018 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in UnitedHealthcare® MedicareRx℠ for Groups (PDP), which is a Medicare Prescription Drug Plan

You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, UnitedHealthcare® MedicareRx℠ for Groups (PDP).

There are different types of Medicare plans. UnitedHealthcare® MedicareRx℠ for Groups (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the Evidence of Coverage booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The words “coverage” and “covered drugs” refer to the prescription drug coverage available to you as a member of the plan.

It’s important for you to learn what the plan’s rules are and what coverage is available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

If you are confused or concerned or just have a question, please contact our plan’s Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It’s part of our contract with you

This **Evidence of Coverage** is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form, the **List of Covered Drugs (Formulary)**, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in the plan between January 1, 2018 and December 31, 2018.

Each plan year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the plan after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor)
- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B) (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- **– and –** You are a United States citizen or are lawfully present in the United States
- **– and –** You live in our geographic service area (Section 2.3 below describes our service area)

Section 2.2 What are Medicare Part A and Medicare Part B?

As discussed in Section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through our plan. Our plan has contracted with Medicare to provide you with most of these Medicare benefits. We describe the drug coverage you receive under your Medicare Part D coverage in Chapter 3.

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals for inpatient services, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for UnitedHealthcare® MedicareRx℠ for Groups (PDP)

Although Medicare is a Federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

The service area for this Plan includes the 50 United States, the District of Columbia and the U.S. Territories.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

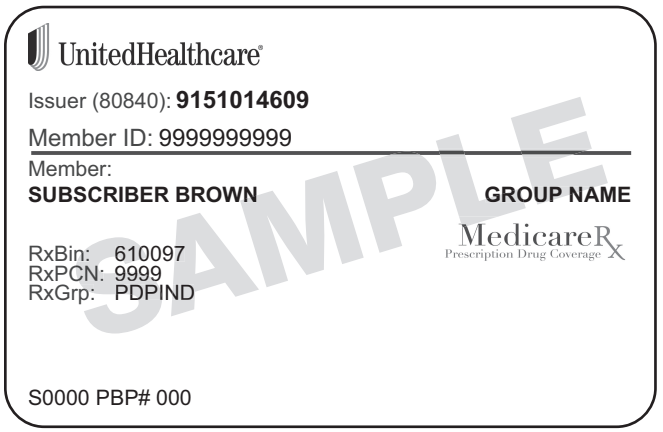
Section 2.4 U.S. Citizen or Lawful Presence

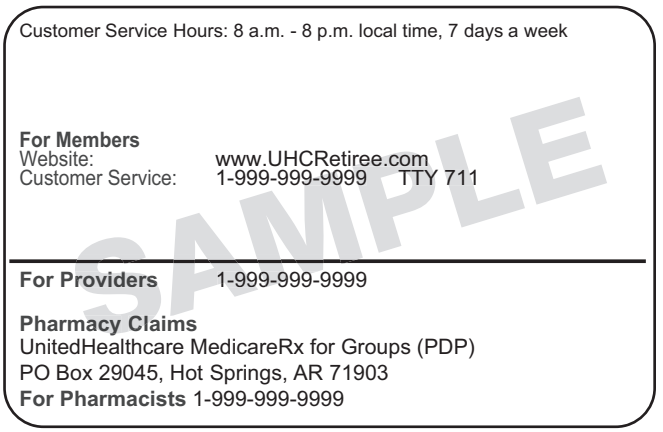
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UnitedHealthcare® MedicareRx℠ for Groups (PDP) if you are not eligible to remain a member on this basis. UnitedHealthcare® MedicareRx℠ for Groups (PDP) must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan member ID card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your member ID card for our plan for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample member ID card to show you what yours will look like:





Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the **Pharmacy Directory** to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.UHCRetiree.com. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network.**

If you don't have the **Pharmacy Directory**, you can get a copy from Customer Service (phone numbers are printed on the back cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.UHCRetiree.com.

Section 3.3 The plan's List of Covered Drugs (Formulary)

The plan has a **List of Covered Drugs (Formulary).** We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.UHCRetiree.com) or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.4 The Part D Explanation of Benefits (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the **Part D Explanation of Benefits** (or the "Part D EOB").

The **Part D Explanation of Benefits** tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 4 **(What you pay for your Part D prescription drugs)** gives more information about the **Part D Explanation of Benefits** and how it can help you keep track of your drug coverage.

A **Part D Explanation of Benefits** summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for the plan

Section 4.1 How much is your plan premium (if applicable)?

Your coverage is provided through a contract with your current employer or former employer or union. As a UnitedHealthcare® MedicareRx℠ for Groups (PDP) for Group retiree member, your plan sponsor may pay a monthly plan premium on your behalf. In some cases, however, your plan sponsor's administrators may have made arrangements with UnitedHealthcare to bill you, the member, directly for plan premiums. If this is the case, please see the "Monthly Plan Premium Payment Options" below for more details. Please contact the employer's or union's benefits administrator for information about your plan premium.

In some situations, your plan premium (if applicable) could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are **already enrolled** and getting help from one of these programs, the **information about premiums in this Evidence of Coverage may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

In some situations, your plan premium (if applicable) could be <u>more</u>

In some situations, if you pay a plan premium, your premium could be higher. Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare's standard drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

- If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.
- If you are required to pay the Part D late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 1, Section 5 explains the Part D late enrollment penalty.
- If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. (For members who must pay a late enrollment penalty, the amount of the penalty will be added to the bill we send to your plan sponsor.) When you first enroll in our plan, we let you know the amount of the penalty. Your Part D late enrollment penalty is considered part of your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2018, this average premium amount is $35.02.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $35.02, which equals $4.90. This rounds to $4.90. This amount would be added **to the plan sponsor's monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note that this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are **not** creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discounts websites.
    - For additional information about creditable coverage, please look in your **Medicare & You 2018** Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.

- If you are receiving “Extra Help” from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn’t enough to cover the extra amount owed. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium**.

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2016 was:	If you were married but filed a separate tax return and your income in 2016 was:	If you filed a joint tax return and your income in 2016 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$13.00
Greater than $107,000 and less than or equal to $133,500		Greater than $214,000 and less than or equal to $267,000	$33.60
Greater than $133,500 and less than or equal to $160,000		Greater than $267,000 and less than or equal to $320,000	$54.20
Greater than $160,000	Greater than $85,000	Greater than $320,000	$74.80

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B.

Some people pay an extra amount for Part D because of their yearly income; this is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 4, Section 11 of this booklet. You can also visit https://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of **Medicare & You** 2018 gives information about the Medicare premiums in the section called "2018 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You 2018** from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 7.1 There are several ways you can pay your plan premium (if applicable)

There are two ways you can pay your plan premium. Please contact Customer Service to notify us of your premium payment option choice or if you'd like to change your existing option. (You can find our phone number on the back cover of this booklet.)

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

We will send you a monthly bill for your monthly plan premium. Make your payment payable to UnitedHealthcare. Please see your monthly bill for the mailing address and other information. Include your member ID number on your check or money order. If making a payment for more than one member, include a payment coupon for each member. Include the member ID number for each member on the check or money order. All payments must be received on or before the due date shown on the monthly bill. If you need your monthly bill replaced, please call Customer Service.

Option 2: Electronic Funds Transfer

Instead of paying by check, you can have your monthly plan premium automatically deducted from your checking account. Your monthly payment will be deducted around the 5th of each month. If you wish to sign up for Electronic Funds Transfer (EFT), you may follow the instructions on your monthly bill, or you may call Customer Service.

What to do if you are having trouble paying your plan premium (if applicable)

Your plan premium is due in our office by the first day of the month. If we have not received your premium payment by the first day of the month, we will send you a delinquency notice. In addition, we have the right to pursue collection of these premium amounts you owe. If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your premium.

Section 7.2 Can we change your monthly plan premium (if applicable) during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year.

Monthly plan premium changes and employer-sponsored benefit changes are subject to contractual arrangements between your plan sponsor and us, and as a result, monthly plan premiums generally do not change during the plan year. Your plan sponsor is responsible for notifying you of any monthly plan premium changes or retiree contribution changes (the portion of your monthly plan premium your plan sponsor requires you to pay) prior to the date when the change becomes effective.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay all or part of the member's monthly plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, Workers' Compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' Compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2
Important phone numbers and resources

SECTION 1 UnitedHealthcare® MedicareRx℠ for Groups (PDP) Contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or member ID card questions, please call or write to our plan Customer Service. We will be happy to help you.

Method	Customer Service - Contact Information
CALL	**1-888-556-6648** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday
WRITE	UnitedHealthcare Customer Service Department P.O. Box 29675, Hot Springs, AR 71903-9675
WEBSITE	**www.UHCRetiree.com**

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	**1-888-556-6648** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday For expedited coverage decisions for Part D prescription drugs only:

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
	1-800-595-9532 Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday
FAX	**1-800-527-0531**
WRITE	UnitedHealthcare P.O. Box 29675, Hot Springs, AR 71903-9675
WEBSITE	**www.UHCRetiree.com**

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	**1-888-556-6648** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week For fast/expedited appeals for Part D prescription drugs: **1-800-595-9532** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday
FAX	For standard Part D prescription drug appeals: **1-866-308-6294** For fast/expedited Part D prescription drug appeals: **1-866-308-6296**

Method	Appeals for Part D Prescription Drugs – Contact Information
WRITE	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA124-0197, Cypress, CA 90630-0016
WEBSITE	**www.UHCRetiree.com**

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

Method	Complaints about Part D Prescription Drugs – Contact Information
CALL	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week For fast/expedited complaints about Part D prescription drugs: **1-800-595-9532** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday
FAX	For standard Part D prescription drug complaints: **1-866-308-6294** For fast/expedited Part D prescription drug complaints: **1-866-308-6296**
WRITE	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA124-0197, Cypress, CA 90630-0016
MEDICARE WEBSITE	You can submit a complaint about UnitedHealthcare® MedicareRx℠ for Groups (PDP) directly to Medicare. To submit an online complaint to Medicare go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx.**

Where to send a request asking us to pay for our share of the cost of a drug you have received.

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 **(Asking us to pay our share of the costs for covered drugs)**.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** for more information.

Method	Payment Requests – Contact Information
CALL	**1-888-556-6648** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, Monday - Friday
WRITE	Part D prescription drug payment requests: OptumRx P.O. Box 29046, Hot Springs, AR 71903
WEBSITE	**www.UHCRetiree.com**

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Prescription Drug Plans, including us.

Method	Medicare – Contact Information
CALL	**1-800-MEDICARE,** or **1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**https://www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Because your coverage is provided by a plan sponsor, you will not find UnitedHealthcare® MedicareRx℠ for Groups (PDP) plans listed on https://www.medicare.gov. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about UnitedHealthcare® MedicareRx℠ for Groups (PDP): • **Tell Medicare about your complaint:** You can submit a complaint about UnitedHealthcare® MedicareRx℠ for Groups (PDP) directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) .

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- Alaska - Senior and Disabilities Services
- Alabama - Alabama Department of Senior Services
- Arkansas - Senior Health Insurance Information Program
- American Samoa - Pago Pago Social Security Office
- Arizona - Arizona Department of Economic Security Division of Aging and Adult Services
- California - California's Health Insurance Counseling and Advocacy Program (HICAP)
- Colorado - Dora - Division of Insurance - State of Colorado
- Connecticut - State Department on Aging - CHOICES
- District of Columbia - Health Insurance Counseling Project (HICP)
- Delaware - Delaware Medicare Assistance Bureau (DMAB)
- Florida - SHINE Program Department of Elder Affairs
- Georgia - DHS Division of Aging Services - GeorgiaCares Program
- Guam - Division of Senior Citizens Guam
- Hawaii - HAWAII SHIP State Health Insurance Assistance Program
- Iowa - Senior Health Insurance Information Program
- Idaho - Idaho Senior Health Insurance Benefits Advisors (SHIBA)
- Illinois - Senior Health Insurance Program
- Indiana - Indiana Department of Insurance - State Health Insurance Program
- Kansas - Kansas Department for Aging and Disability Services
- Kentucky - Kentucky State Health Insurance Assistance Program (SHIP)
- Louisiana - Louisiana Department of Insurance, Senior Health Insurance Information Program
- Massachusetts - Executive Office of Elder Affairs / SHINE
- Maryland - The Maryland Department of Aging
- Maine - Maine Department of Health and Human Services
- Michigan - Michigan Medicare Assistance Program (MMAP)
- Minnesota - Minnesota Board on Aging - Senior LinkAge Line
- Missouri - Missouri CLAIM
- Northern Mariana Islands - Commonwealth of The Northern Mariana Islands SHIP Program
- Mississippi - Mississippi Department of Human Services, MS State Health Insurance Assistance Program (SHIP)
- Montana - Montana State Health Insurance Assistance Program (SHIP)

- North Carolina - Seniors' Health Insurance Information Program (SHIIP)
- North Dakota - State Health Insurance Counseling Program (SHIC)
- Nebraska - Nebraska Senior Health Insurance Information Program (SHIIP)
- New Hampshire - NH SHIP - ServiceLink Aging and Disability Resource Center
- New Jersey - Division of Aging and Community Services Department of Health (SHIP)
- New Mexico - New Mexico Aging & Long-Term Services (ADRC)
- Nevada - Nevada State Health Insurance Assistance Program
- Ohio - Ohio Department of Insurance
- Oklahoma - Senior Health Insurance Counseling Program (SHIP)
- Oregon - Senior Health Insurance Benefits Assistance Program
- Pennsylvania - Apprise Health Insurance Counseling Program
- Puerto Rico - State Health Insurance Assistance Program
- Rhode Island - Rhode Island Department of Human Services, Division of Elderly Affairs
- South Carolina - South Carolina Lieutenant Governor's Office on Aging
- South Dakota - South Dakota Department of Human Services SHINE
- Tennessee - Tennessee Commission on Aging and Disability
- Texas - Health Information Counseling & Advocacy Program of Texas (HICAP)
- Utah - Aging Services Administrative Office
- Virginia - Virginia Department for the Aging
- Virgin Islands of the U.S. - VI SHIP/Medicare
- Vermont - Department of Disabilities, Aging and Independent Living
- Washington - Consumer Advocacy/SHIBA
- Wisconsin - State of Wisconsin - Board on Aging & Long Term Care
- West Virginia - West Virginia SHIP
- Wyoming - Wyoming Senior Citizens Inc.

Your SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Alaska | Senior and Disabilities Services 240 Main ST, STE 601 Juneau, AK 99811-0680 http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx	1-866-465-3165 TTY 1-907-465-5430
Alabama | Alabama Department of Senior Services 201 Monroe ST, STE 350 Montgomery, AL 36104 www.AlabamaAgeline.gov	1-800-243-5463 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Arkansas | Senior Health Insurance Information Program 1200 W Third ST Little Rock, AR 72201-1904 https://insurance.arkansas.gov/pages/consumer-services/senior-health/	1-800-224-6330 TTY 711
American Samoa | Pago Pago Social Security Office Centennial BLDG, STE 302, FL 3 Utulei, AS 96799 www.medicaid.as.gov	1-684-622-3001 TTY 711
Arizona | Arizona Department of Economic Security Division of Aging and Adult Services 1789 W Jefferson ST, ATTN: SHIP 950A Phoenix, AZ 85007 https://des.az.gov/services/aging-and-adult/state-health-insurance-assistance-program-ship	1-800-432-4040 TTY 711
California | California's Health Insurance Counseling and Advocacy Program (HICAP) 1300 National DR, STE 200 Sacramento, CA 95834-1992 http://www.aging.ca.gov/hicap/	1-800-434-0222 TTY 1-800-735-2929
Colorado | Dora - Division of Insurance - State of Colorado 1560 Broadway, STE 850 Denver, CO 80202 https://www.colorado.gov/dora/division-insurance	1-800-930-3745 TTY 711
Connecticut | State Department on Aging - CHOICES 55 Farmington AVE, FL 12 Hartford, CT 06105-3730 http://www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313032	1-800-994-9422 TTY 711
District of Columbia | Health Insurance Counseling Project (HICP) 650 20th ST, NW Washington, DC 20052 https://www.law.gwu.edu/health-insurance-counseling-project	1-202-994-6272 TTY 711
Delaware | Delaware Medicare Assistance Bureau (DMAB) 841 Silver LK BLVD Dover, DE 19904 http://delawareinsurance.gov/DMAB/	1-800-336-9500 TTY 711
Florida | SHINE Program Department of Elder Affairs 4040 Esplanade Way, STE 270 Tallahassee, FL 32399-7000 www.floridashine.org	1-800-963-5337 TTY 1-800-955-8770

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Georgia | DHS Division of Aging Services - GeorgiaCares Program 2 Peachtree ST NW, FL 33 Atlanta, GA 30303 www.mygeorgiacares.org	1-866-552-4464 TTY 711
Guam | Division of Senior Citizens Guam 130 University DR, STE 8, University Castle Mall Mangilao, GU 96913 dphss.guam.gov	1-671-735-7421 TTY 1-671-735-7415
Hawaii | HAWAII SHIP State Health Insurance Assistance Program No. 1 Capitol District, 250 S Hotel ST, STE 406 Honolulu, HI 96813-2831 www.hawaiiship.org	1-888-875-9229 TTY 1-866-810-4379
Iowa | Senior Health Insurance Information Program 601 Locust ST, FL 4 Des Moines, IA 50309-3738 http://www.shiip.state.ia.us/	1-800-351-4664 TTY 1-800-735-2942
Idaho | Idaho Senior Health Insurance Benefits Advisors (SHIBA) 700 W State ST, P.O. Box 83720 Boise, ID 83720-0043 http://www.doi.idaho.gov/SHIBA/	1-800-247-4422 TTY 711
Illinois | Senior Health Insurance Program One Natural Resources Way, STE 100 Springfield, IL 62702-1271 http://www.illinois.gov/aging/ship/Pages/default.aspx	1-800-252-8966 TTY 1-888-206-1327
Indiana | Indiana Department of Insurance - State Health Insurance Program 311 W Washington ST, STE 300 Indianapolis, IN 46204-2787 http://www.in.gov/idoi/2495.htm	1-800-452-4800 TTY 1-866-846-0139
Kansas | Kansas Department for Aging and Disability Services New England BLDG, 503 S Kansas AVE Topeka, KS 66603-3404 http://www.kdads.ks.gov/SHICK/shick_index.html	1-800-860-5260 TTY 1-785-291-3167
Kentucky | Kentucky State Health Insurance Assistance Program (SHIP) 275 E Main ST Frankfort, KY 40621 http://www.chfs.ky.gov/dail/ship.htm	1-877-293-7447 TTY 1-800-627-4702

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Louisiana | Louisiana Department of Insurance, Senior Health Insurance Information Program P.O. Box 94214 Baton Rouge, LA 70802 http://www.ldi.la.gov/SHIIP/	1-800-259-5300 TTY 711
Massachusetts | Executive Office of Elder Affairs / SHINE One Ashburton Place, RM 517 Boston, MA 02108 http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html	1-800-243-4636 TTY 711
Maryland | The Maryland Department of Aging 301 W Preston ST, STE 1007 Baltimore, MD 21201 http://aging.maryland.gov/Pages/StateHealthInsuranceProgram.aspx	1-800-243-3425 TTY 711
Maine | Maine Department of Health and Human Services 11 State House Station, 41 Anthony AVE Augusta, ME 04333 http://www.maine.gov/dhhs/oads/	1-800-262-2232 TTY 711
Michigan | Michigan Medicare Assistance Program (MMAP) 5303 S Cedar ST Lansing, MI 48917 www.mmapinc.org	1-800-803-7174 TTY 711
Minnesota | Minnesota Board on Aging - Senior LinkAge Line P.O. Box 64976 St. Paul, MN 55164-0976 http://www.mnaging.org/en/Advisor/SLL.aspx	1-800-333-2433 TTY 1-800-627-3529
Missouri | Missouri CLAIM 200 N Keene ST, STE 101 Columbia, MO 65201 www.missouriclaim.org	1-800-390-3330 TTY 711
Northern Mariana Islands | Commonwealth of The Northern Mariana Islands SHIP Program P.O. Box 5795 CHRB Saipan, MP 96950 http://commerce.gov.mp/	1-670-664-3000 TTY 711
Mississippi | Mississippi Department of Human Services, MS State Health Insurance Assistance Program (SHIP) 750 N State ST Jackson, MS 39202 http://www.mdhs.state.ms.us/aging-adult-services/programs-daas/state-health-insurance-assistance-program/	1-800-948-3090 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Montana | Montana State Health Insurance Assistance Program (SHIP) 2030 11th AVE Helena, MT 59601 http://dphhs.mt.gov/sltc/aging/ship.aspx	1-800-551-3191 TTY 711
North Carolina | Seniors' Health Insurance Information Program (SHIIP) 1201 Mail Service CTR Raleigh, NC 27699-1201 http://www.ncdoi.com/SHIIP/Default.aspx	1-855-408-1212 TTY 711
North Dakota | State Health Insurance Counseling Program (SHIC) 600 E BLVD AVE Bismarck, ND 58505-0320 http://www.nd.gov/ndins/shic/	1-888-575-6611 TTY 1-800-366-6888
Nebraska | Nebraska Senior Health Insurance Information Program (SHIIP) 941 O ST, P.O. Box 82089 Lincoln, NE 68501-2089 http://www.doi.nebraska.gov/shiip/	1-800-234-7119 TTY 711
New Hampshire | NH SHIP - ServiceLink Aging and Disability Resource Center 2 Industrial Park DR, P.O. Box 1016 Concord, NH 03302-1016 http://www.nh.gov/servicelink/	1-866-634-9412 TTY 1-800-735-2964
New Jersey | Division of Aging and Community Services Department of Health (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/services/ship/index.html	1-800-792-8820 TTY 711
New Mexico | New Mexico Aging & Long-Term Services (ADRC) P.O. Box 27118 Santa Fe, NM 87502-7118 www.nmaging.state.nm.us	1-800-432-2080 TTY 711
Nevada | Nevada State Health Insurance Assistance Program 3416 Goni RD, STE D-132 Carson City, NV 89706 http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	1-800-307-4444 TTY 711
Ohio | Ohio Department of Insurance 50 W Town ST, STE 300, FL 3 Columbus, OH 43215 http://www.insurance.ohio.gov/Pages/default.aspx	1-800-686-1578 TTY 1-614-644-3745

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Oklahoma | Senior Health Insurance Counseling Program (SHIP) 5 Corporate Plaza, 3625 NW 56th ST, STE 100 Oklahoma City, OK 73112-4511 http://www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html	1-800-763-2828 TTY 711
Oregon | Senior Health Insurance Benefits Assistance Program P.O. Box 14480 Salem, OR 97309-0405 http://www.oregon.gov/DCBS/SHIBA/Pages/index.aspx	1-800-722-4134 TTY 711
Pennsylvania | Apprise Health Insurance Counseling Program 555 Walnut ST, FL 5 Harrisburg, PA 17101-1919 http://www.aging.pa.gov/Pages/default.aspx#.Vw6C06Mo7FN	1-800-783-7067 TTY 711
Puerto Rico | State Health Insurance Assistance Program Ponce de León AVE, PDA 16, EDIF 1064, 3er nivel San Juan, PR 00919-1179 http://www2.pr.gov/Directorios/Pages/InfoAgencia.aspx?PRIFA=152	1-787-721-6121 TTY 711
Rhode Island | Rhode Island Department of Human Services, Division of Elderly Affairs 57 Howard AVE, Louis Pasteur BLDG, FL 2 Cranston, RI 02920 http://www.dea.ri.gov/insurance/	1-401-462-3000 TTY 1-401-462-0740
South Carolina | South Carolina Lieutenant Governor's Office on Aging 1301 Gervais ST, STE 350 Columbia, SC 29201 http://aging.sc.gov/programs/medicare/Pages/default.aspx	1-800-868-9095 TTY 711
South Dakota | South Dakota Department of Human Services SHINE 800 E Dakota AVE Pierre, SD 57501 www.shiine.net	1-877-331-4834 TTY 711
Tennessee | Tennessee Commission on Aging and Disability 502 Deaderick ST, FL 9 Nashville, TN 37243-0860 https://www.tn.gov/aging/topic/ship	1-877-801-0044 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Texas | Health Information Counseling & Advocacy Program of Texas (HICAP) P.O. Box 149104 Austin, TX 78714-9104 http://www.tdi.texas.gov/consumer/hicap/	1-800-252-9240 TTY 711
Utah | Aging Services Administrative Office 195 N 1950 W Salt Lake City, UT 84116 https://daas.utah.gov/	1-800-541-7735 TTY 711
Virginia | Virginia Department for the Aging 1610 Forest AVE, STE 100 Henrico, VA 23229 www.vda.virginia.gov	1-800-552-3402 TTY 711
Virgin Islands of the U.S. | VI SHIP/Medicare Gov. Juan F. Luis Hospital & Medical CTR, 4007 Estate Diamond, FL 1 St. Croix, VI 00820 http://ltg.gov.vi/vi-ship-medicare.html	1-340-772-7368 TTY 711
Vermont | Department of Disabilities, Aging and Independent Living 280 State DR, HC 2 S Waterbury, VT 05671-2070 http://asd.vermont.gov/services/ship	1-802-241-0294 TTY 711
Washington | Consumer Advocacy/SHIBA P.O. Box 40255 Olympia, WA 98504-0256 https://www.insurance.wa.gov/medicare	1-800-562-6900 TTY 1-360-586-0241
Wisconsin | State of Wisconsin - Board on Aging & Long Term Care 1402 Pankratz ST, STE 111 Madison, WI 53704-4001 http://longtermcare.wi.gov/	1-800-242-1060 TTY 711
West Virginia | West Virginia SHIP 1900 Kanawha BLVD E Charleston, WV 25305 www.wvship.org	1-877-987-4463 TTY 711
Wyoming | Wyoming Senior Citizens Inc. 106 W Adams AVE Riverton, WY 82501 www.wyomingseniors.com	1-800-856-4398 TTY 711

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Here is a list of the Quality Improvement Organizations in each state we serve:

- Alaska - Livanta BFCC-QIO Program
- Alabama - KEPRO
- Arkansas - KEPRO
- American Samoa - Livanta BFCC-QIO Program
- Arizona - Livanta BFCC-QIO Program
- California - Livanta BFCC-QIO Program
- Colorado - KEPRO
- Connecticut - Livanta BFCC-QIO Program
- District of Columbia - KEPRO
- Delaware - KEPRO
- Florida - KEPRO
- Georgia - KEPRO
- Guam - Livanta BFCC-QIO Program
- Hawaii - Livanta BFCC-QIO Program
- Iowa - KEPRO
- Idaho - Livanta BFCC-QIO Program
- Illinois - KEPRO
- Indiana - KEPRO
- Kansas - KEPRO
- Kentucky - KEPRO
- Louisiana - KEPRO
- Massachusetts - Livanta BFCC-QIO Program
- Maryland - KEPRO
- Maine - Livanta BFCC-QIO Program
- Michigan - KEPRO
- Minnesota - KEPRO
- Missouri - KEPRO
- Northern Mariana Islands - Livanta BFCC-QIO Program
- Mississippi - KEPRO
- Montana - KEPRO
- North Carolina - KEPRO
- North Dakota - KEPRO
- Nebraska - KEPRO
- New Hampshire - Livanta BFCC-QIO Program
- New Jersey - Livanta BFCC-QIO Program
- New Mexico - KEPRO
- Nevada - Livanta BFCC-QIO Program
- Ohio - KEPRO
- Oklahoma - KEPRO
- Oregon - Livanta BFCC-QIO Program
- Pennsylvania - Livanta BFCC-QIO Program
- Puerto Rico - Livanta BFCC-QIO Program
- Rhode Island - Livanta BFCC-QIO Program
- South Carolina - KEPRO
- South Dakota - KEPRO

- Tennessee - KEPRO
- Texas - KEPRO
- Utah - KEPRO
- Virginia - KEPRO
- Virgin Islands of the U.S. - Livanta BFCC-QIO Program
- Vermont - Livanta BFCC-QIO Program
- Washington - Livanta BFCC-QIO Program
- Wisconsin - KEPRO
- West Virginia - KEPRO
- Wyoming - KEPRO

Your state's Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The state's Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact your state's Quality Improvement Organization if you have a complaint about the quality of care you have received.

For example, you can contact the Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

Quality Improvement Organization (QIO) – Contact Information	
Alaska | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Alabama | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Arkansas | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
American Samoa | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668
Arizona | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
California | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Colorado | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Connecticut | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
District of Columbia | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Delaware | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Florida | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Georgia | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Guam | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Hawaii | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Iowa | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Idaho | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Illinois | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Indiana | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Kansas | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Kentucky | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Louisiana | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Massachusetts | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
Maryland | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Maine | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
Michigan | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Minnesota | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Missouri | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Northern Mariana Islands | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668
Mississippi | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Montana | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
North Carolina | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
North Dakota | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Nebraska | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
New Hampshire | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
New Jersey | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
New Mexico | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Nevada | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Ohio | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Oklahoma | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Oregon | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Pennsylvania | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
Puerto Rico | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
Rhode Island | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
South Carolina | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
South Dakota | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Tennessee | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Texas | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Utah | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Virginia | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Virgin Islands of the U.S. | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289
Vermont | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA1.COM	1-866-815-5440 TTY 1-866-868-2289 8 a.m. - 8 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday

Quality Improvement Organization (QIO) – Contact Information	
Washington | Livanta BFCC-QIO Program 9090 Junction DR, STE 10 Annapolis Junction, MD 20701 www.BFCCQIOAREA5.COM	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Wisconsin | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-855-408-8557 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
West Virginia | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 http://www.keproqio.com	1-844-455-8708 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Wyoming | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 http://www.keproqio.com	1-844-430-9504 TTY 1-855-843-4776 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	**1-800-772-1213** Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	**https://www.ssa.gov**

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.
In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid agency.

State Medicaid Programs – Contact Information	
Alaska | State of Alaska Health & Social Services 350 Main ST, RM 404, P.O. Box 110601 Juneau, AK 99811-0601 http://dhss.alaska.gov/Pages/default.aspx	1-907-465-3030 TTY 1-907-586-4265
Alabama | Alabama Medicaid 501 Dexter AVE Montgomery, AL 36104 http://www.medicaid.alabama.gov/	1-800-362-1504 TTY 711
Arkansas | Arkansas Medicaid Donaghey Plaza S, P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437 https://www.medicaid.state.ar.us/	1-800-482-8988 TTY 711
American Samoa | American Samoa Medicaid State Agency P.O. Box 998383 Pago Pago, AS 96799 http://medicaid.as.gov/	1-684-699-4777 TTY 711
Arizona | Department of Economic Security/Division of Developmental Disabilities (DDD) 1789 W Jefferson AVE Phoenix, AZ 85004 https://www.azdes.gov/developmental_disabilities/	1-602-542-0419 TTY 711
Arizona | Arizona Health Care Cost Containment System (AHCCCS) 801 E Jefferson ST Phoenix, AZ 85034 https://www.azahcccs.gov/	1-602-417-4000 TTY 1-800-367-8939
California | Medi-Cal - Managed Care Operations Division 1501 Capitol AVE, MS 4400 Sacramento, CA 95899 www.medi-cal.ca.gov/	1-916-636-1200 TTY 711
Colorado | Colorado Department of Healthcare Policy and Financing 1570 Grant ST Denver, CO 80203-1818 https://www.colorado.gov/hcpf	1-303-866-2993 TTY 711
Connecticut | Connecticut Department of Social Services 55 Farmington AVE Hartford, CT 06105-3730 http://www.ct.gov/dss	1-855-626-6632 TTY 1-800-842-4524

State Medicaid Programs – Contact Information	
District of Columbia | Department of Human Services 64 New York AVE NE # 6 Washington, DC 20002 https://dhs.dc.gov/	1-202-671-4200 TTY 711
Delaware | Delaware Health and Social Services 1901 N Dupont HWY, Lewis BLDG New Castle, DE 19720 http://dhss.delaware.gov/dhss/	1-800-372-2022 TTY 711
Florida | Florida Medicaid Agency for Health Care Administration (AHCA) 2727 Mahan DR, MS 6 Tallahassee, FL 32308 www.ahca.myflorida.com	1-888-419-3456 TTY 1-800-955-8771
Georgia | Georgia Department of Community Health 2 Peachtree ST NW Atlanta, GA 30303 www.dch.georgia.gov	1-404-656-4507 TTY 711
Guam | Department of Public Health and Social Services Bureau of Healthcare Financing 123 Chalan Kareta Mangilao, GU 96913-6304 http://www.dphss.guam.gov/	1-671-735-7173 TTY 711
Hawaii | Department of Human Services 1390 Miller ST, RM 209 Honolulu, HI 96813 www.med-quest.us	1-800-316-8005 TTY 1-800-603-1201
Iowa | Department of Human Services 1305 E Walnut ST Des Moines, IA 50319 http://dhs.iowa.gov/	1-800-338-8366 TTY 1-800-735-2942
Idaho | Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720 www.healthandwelfare.idaho.gov	1-877-456-1233 TTY 711
Illinois | Illinois Department of Healthcare and Family Services 201 S Grand AVE E Springfield, IL 62763-0001 http://www2.illinois.gov/hfs/	1-800-843-6154 TTY 1-800-447-6404
Indiana | Indiana Medicaid for Members 402 W Washington ST, RM W382 Indianapolis, IN 46204-2739 www.indianamedicaid.com	1-800-457-4584 TTY 711

State Medicaid Programs – Contact Information	
Kansas | KanCare (Kansas Department of Health and Environment) 900 SW Jackson, STE 900 N Topeka, KS 66612-1220 www.kancare.ks.gov	1-866-305-5147 TTY 1-800-766-3777
Kentucky | Kentucky Cabinet for Health and Family Services 275 E Main ST Frankfort, KY 40621 www.chfs.ky.gov	1-800-372-2973 TTY 1-800-627-4702
Louisiana | Louisiana Department of Health 628 N 4th ST Baton Rouge, LA 70802 http://new.dhh.louisiana.gov/	1-225-342-9500 TTY 711
Massachusetts | Executive Office of Health and Human Services 1 Ashburton PL, FL 5 Boston, MA 02018 http://www.mass.gov/eohhs/gov/departments/masshealth/	1-888-665-9993 TTY 1-888-665-9997
Maryland | Maryland Department of Health 201 W Preston ST Baltimore, MD 21201 https://health.maryland.gov/pages/index.aspx	1-877-463-3464 TTY 1-800-735-2258
Maine | State of Maine MainCare Services 11 State House Station Augusta, ME 04333-0011 www.maine.gov/dhhs/oms	1-800-977-6740 TTY 711
Michigan | Department of Health and Human Services 333 S Grand AVE, P.O. Box 30195 Lansing, MI 48909 http://www.michigan.gov/mdhhs/	1-517-373-3740 TTY 1-800-649-3777
Minnesota | Minnesota Department of Human Services P.O. Box 64989 St. Paul, MN 55164-0989 http://mn.gov/dhs/	1-888-938-3224 TTY 711
Missouri | MO HealthNet Division Department of Social Services 615 Howerton CT, P.O. Box 6500 Jefferson City, MO 65102 www.dss.mo.gov/mhd/	1-573-526-4274 TTY 1-800-735-2966

State Medicaid Programs – Contact Information	
Northern Mariana Islands | State Medicaid Administration Office Government BLDG # 1252, Capital Hill RD, Caller Box 100007 Saipan, MP 96950 www.medicaid.cnmi.mp	1-670-234-8950 TTY 711
Mississippi | State of Mississippi Division of Medicaid 550 High ST, STE 1000 Sillers BLDG Jackson, MS 39201-1399 http://www.medicaid.ms.gov/	1-800-421-2408 TTY 711
Montana | Department of Public Health & Human Services P.O. Box 202925 Helena, MT 59602 www.medicaid.mt.gov	1-800-362-8312 TTY 1-800-833-8503
North Carolina | Division of Medical Assistance 2501 Mail Service CTR Raleigh, NC 27699-2501 https://dma.ncdhhs.gov/medicaid	1-800-662-7030 TTY 1-877-452-2514
North Dakota | Department of Human Services 600 E BLVD AVE Dept. 325 Bismarck, ND 58505-0250 www.nd.gov/dhs/services/medicalserv/medicaid/	1-800-755-2604 TTY 1-800-366-6888
Nebraska | NE Department of Health and Human Services 301 Centennial Mall S Lincoln, NE 68509 http://dhhs.ne.gov/Pages/default.aspx	1-800-358-8802 TTY 711
New Hampshire | NH Department of Health and Human Services 129 Pleasant ST Concord, NH 03301 www.dhhs.nh.gov/ombp/medicaid/	1-800-852-3345 TTY 1-800-735-2964
New Jersey | Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712 www.state.nj.us/humanservices/dmahs/	1-800-356-1561 TTY 711
New Mexico | NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504-2348 www.hsd.state.nm.us/mad/	1-888-997-2583 TTY 711

State Medicaid Programs – Contact Information	
Nevada | Nevada Department of Health and Human Services 1100 E Williams ST, STE 101 Carson City, NV 89701 http://dhcfp.nv.gov	1-800-992-0900 TTY 711
Ohio | Ohio Department of Medicaid 50 W Town ST, STE 400 Columbus, OH 43215 http://medicaid.ohio.gov/	1-800-324-8680 TTY 711
Oklahoma | Oklahoma Health Care Authority 4345 N Lincoln BLVD Oklahoma City, OK 73105 www.okhca.org	1-800-987-7767 TTY 711
Oregon | Oregon Health Plan 500 Summer ST NE Salem, OR 97310-1079 http://www.oregon.gov/oha/healthplan/Pages/contact_us.aspx#	1-800-527-5772 TTY 711
Pennsylvania | Pennsylvania Department of Human Services P.O. Box 2675 Harrisburg, PA 17105 http://www.dhs.pa.gov/	1-800-692-7462 TTY 1-800-451-5886
Puerto Rico | Programa Medicaid Departamento de Salud P.O. Box 70184 San Juan, PR 00936-8184 https://www.medicaid.pr.gov/?AspxAutoDetectCookieSupP.O.rt=1	1-787-641-4224 TTY 1-787-625-6955
Rhode Island | Executive Office of Health and Human Services (EOHHS) 57 Howard AVE Cranston, RI 02920 http://www.eohhs.ri.gov/	1-401-462-5274 TTY 711
South Carolina | Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 http://www.scdhhs.gov/	1-888-549-0820 TTY 1-888-842-3620
South Dakota | Department of Social Services Division of Medical Services 700 Governors DR Pierre, SD 57501 www.dss.sd.gov/medicalservices/	1-866-718-0084 TTY 711
Tennessee | Bureau of TennCare 310 Great Circle RD Nashville, TN 37243 http://www.tn.gov/tenncare/	1-800-342-3145 TTY 711

State Medicaid Programs – Contact Information	
Texas | Texas Medicaid Health and Human Services Commission 4900 N Lamar BLVD Austin, TX 78751 https://hhs.texas.gov/about-hhs/find-us	1-512-424-6500 TTY 1-512-424-6597
Utah | Department of Health Division Of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 https://medicaid.utah.gov/	1-800-662-9651 TTY 1-800-346-4128
Virginia | Department of Medical Assistance Services 600 E Broad ST Richmond, VA 23219 http://www.dmas.virginia.gov/	1-804-786-7933 TTY 711
Virgin Islands of the U.S. | Department of Human Services Knud Hansen Complex, 1303 Hospital Ground, BLDG A St. Thomas, VI 00802 https://www.vimmis.com/TradingPartnerContactInfo.aspx	1-340-774-0930 TTY 711
Vermont | Green Mountain Care Health Access 312 Hurricaine LN Williston, VT 05495 http://www.greenmountaincare.org/	1-800-250-8427 TTY 711
Washington | Washington State Health Care Authority P.O. Box 45502 Olympia, WA 98504-5502 http://www.hca.wa.gov/medicaid/Pages/index.aspx	1-800-562-3022 TTY 711
Wisconsin | Wisconsin Department of Health Services 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/health-care-coverage/index.htm	1-800-947-3529 TTY 711
West Virginia | Bureau for Medical Services 350 Capitol ST, RM 251 Charleston, WV 25301 http://www.dhhr.wv.gov/bms/Pages/default.aspx	1-800-642-8589 TTY 711
Wyoming | Department of Health 6101 Yellowstone RD, STE 210 Cheyenne, WY 82009 http://health.wyo.gov/healthcarefin/medicaideligibility/index.html	1-800-251-1269 TTY 1-855-329-5204

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible and prescription copayments **or** coinsurance. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please call the customer service number in Chapter 2 Section 1. Our Customer Service Advocates can help get your copayment amount corrected.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions (phone numbers are printed on the back cover of this booklet).

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE

(1-800-633-4227) 24 hours a day, 7 days a week and say “Medicaid” for more information. TTY users should call 1-877-486-2048. You can also visit https://www.medicare.gov for more information.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving “Extra Help.” For brand name drugs, the 50% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 35% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your **Part D Explanation of Benefits** (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (15%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 56% of the price for generic drugs and you pay the remaining 44% of the price. For generic drugs, the amount paid by the plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. **Because your plan sponsor offers additional gap coverage during the Coverage Gap Stage,** your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 4, Section 6 for more information about the amount of your copayment or coinsurance during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than “Extra Help”), you still get the 50% discount on covered brand name drugs. Also, the plan pays 15% of the costs of brand name drugs in the coverage gap. The 50% discount and the 15% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP office listed below.

AIDS Drug Assistance Program (ADAP) – Contact Information	
Alaska | Alaskan AIDS Assistance Association 1057 W Fireweed LN, #102 Anchorage, AK 99503 http://www.alaskanaids.org/index.php/client-services/adap	1-907-263-2050 8 a.m. - 5 p.m. local time, Monday - Friday
Alabama | Alabama AIDS Drug Assistance Program HIV/AIDS Division, 201 Monroe ST, STE 1400 Montgomery, AL 36104 http://www.adph.org/aids/Default.asp?id=995	1-866-574-9964 8 a.m. - 5 p.m. local time, Monday - Friday
Arkansas | Arkansas Department of Health,HIV/STD/Hepatitis ADAP Division 4815 W Markham ST Little Rock, AR 72205 http://www.healthy.arkansas.gov/programsServices/infectiousDisease/hivStdHepatitisC/Pages/ADAP.aspx	1-888-499-6544 8 a.m. - 5 p.m. local time, Monday - Friday
American Samoa | American Samoa Department of Health LBJ Tropical Medical CTR Pago Pago, AS 96799 https://www.americansamoa.gov/department-of-public-health	1-684-633-2437
Arizona | Arizona Department of Health Services ADAP 150 N 18th AVE, STE 110 Phoenix, AZ 85007 http://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/#aids-drug-assistance-program-home	1-800-334-1540 8 a.m. - 5 p.m. local time, Monday - Friday
California | Department of Health Services - ADAP P.O. Box 997377 Sacramento, CA 95899-7377 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	1-844-421-7050 8 a.m. - 5 p.m. local time, Monday - Friday
Colorado | Colorado AIDS Drug Assistance Program (ADAP) ADAP-3800, 4300 Cherry Creek DR S Denver, CO 80246-1530 https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap	1-303-692-2716 7:30 a.m. - 4 p.m. local time, Monday - Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Connecticut | Connecticut Department of Social Services Medical Operations Unit #4 55 Farmington AVE Hartford, CT 06105-3730 http://www.ct.gov/dss/cadap	1-800-233-2503 8 a.m. - 5 p.m. local time, Monday - Friday
District of Columbia | District of Columbia Department of Health 899 N Capitol ST NE Washington, DC 20002 https://doh.dc.gov/service/dc-aids-drug-assistance-program	1-202-671-4900 8:15 a.m. - 4:45 p.m. local time, Monday - Friday
Delaware | Delaware Division of Public Health Ryan White Program 540 S DuPont HWY Dover, DE 19901 http://www.dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html	1-302-744-1000 8 a.m. - 4:30 p.m. local time, Monday - Friday
Florida | Florida Department of Health ADAP HIV/AIDS Section, 4052 Bald Cypress Way Tallahassee, FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	1-800-352-2437 8 a.m. - 5 p.m. local time, Monday - Friday
Georgia | Georgia AIDS Drug Assistance Program (ADAP) 2 Peachtree ST NW, FL 15 Atlanta, GA 30303-3186 http://dph.georgia.gov/adap-program	1-404-463-0416 8 a.m. - 5 p.m. local time, Monday - Friday
Guam | Bureau of Communicable Disease Control - STD/HIV 123 Chalan Kareta, RM 156 Mangilao, GU 96913 http://www.dphss.guam.gov/document/ryan-white-hivaids-program-brochure	1-671-734-2437 8 a.m. - 5 p.m. local time, Monday - Friday
Hawaii | HIV Drug Assistance Program (HDAP) 3627 Kilauea AVE, STE 306 Honolulu, HI 96816 http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/	1-808-733-9360 8 a.m. - 5 p.m. local time, Monday - Friday
Iowa | Iowa AIDS Drug Assistance Program (ADAP) 321 E 12th ST Des Moines, IA 50319-0075 https://www.idph.iowa.gov/hivstdhep/hiv/support	1-515-725-2011 8 a.m. - 5 p.m. local time, Monday - Friday
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, FL 4 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	1-208-334-5612 8 a.m. - 5 p.m. local time, Monday - Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Illinois | Illinois ADAP 525 W Jefferson ST, FL 1 Springfield, IL 62761 http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids	1-800-243-2437 8 a.m. - 5 p.m. local time, Monday - Friday
Indiana | Indiana HIV Medical Services Program 2 N Meridian ST Indianapolis, IN 46206 http://www.in.gov/isdh/17740.htm	1-866-588-4948 8 a.m. - 5 p.m. local time, Monday - Friday
Kansas | Kansas AIDS Drug Assistance Program 1000 SW Jackson, STE 210 Topeka, KS 66612 http://www.kdheks.gov/sti_hiv/ryan_white_care.htm	1-785-296-6914 8 a.m. - 5 p.m. local time, Monday - Friday
Kentucky | Kentucky AIDS Drug Assistance Program (KADAP) HIV/AIDS Branch, 275 E Main ST, HS2E-C Frankfort, KY 40621 http://chfs.ky.gov/dph/epi/HIVAIDS/services.htm	1-866-510-0005 8 a.m. - 5 p.m. local time, Monday - Friday
Louisiana | Louisiana Office of Public Health STD/HIV Program, 1450 Poydras ST, STE 2136 New Orleans, LA 70112 http://new.dhh.louisiana.gov/index.cfm/page/1099	1-504-568-7474 8 a.m. - 5 p.m. local time, Monday - Friday
Massachusetts | Community Research Initiative/HDAP The Schrafft's City CTR, 529 Main ST, STE 301 Boston, MA 02120 http://crine.org/hdap/	1-800-228-2714 8 a.m. - 5 p.m. local time, Monday - Friday
Maryland | Maryland AIDS Drug Assistance Program 500 N Calvert ST, FL 5 Baltimore, MD 21202 https://phpa.health.maryland.gov/OIDPCS/CHCS/Pages/madap.aspx	1-410-767-6535 8:30 a.m. - 4:30 p.m. local time, Monday - Friday
Maine | Maine AIDS Drug Assistance Program 11 State House Station, 286 Water ST Augusta, ME 04330 http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/aids-drug-assist.shtml	1-207-287-3747 8 a.m. - 5 p.m. local time, Monday - Friday
Michigan | Michigan Drug Assistance Program HIV Care Section, 109 Michigan AVE, FL 9 Lansing, MI 48913 http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982_70541_70542—,00.html	1-888-826-6565 8 a.m. - 5 p.m. local time, Monday - Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Minnesota | Minnesota HIV/AIDS Programs Department of Human Services, P.O. Box 64972 St. Paul, MN 55164-0972 http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/contact-us/index.jsp	1-800-657-3761 8:30 a.m. - 4:30 p.m. local time, Monday - Friday
Missouri | Missouri Department of Health and Senior Services Bureau of HIV, STD and Hepatitis, P.O. Box 570 Jefferson City, MO 65102-0570 http://health.mo.gov/living/healthcondiseases/communicable/hivaids/index.php	1-573-751-6439 8 a.m. - 5 p.m. local time, Monday - Friday
Mississippi | Mississippi Department of Health, STD/HIV Office 570 E Woodrow Wilson DR, P.O. Box 1700 Jackson, MS 39215-1700 http://msdh.ms.gov/msdhsite/_static/14,0,150.html	1-601-576-7723 8 a.m. - 5 p.m. local time, Monday - Friday
Montana | Montana AIDS Drug Assistance Program (ADAP) DPHHS, Cogswell BLDG C-211, 1400 Broadway ST Helena, MT 59620-2951 http://dphhs.mt.gov/publichealth/hivstd/treatmentprogram.aspx	1-406-444-3565 8 a.m. - 5 p.m. local time, Monday - Friday
North Carolina | North Carolina HIV/STD Prevention and Care Unit Communicable Disease Branch, 1905 Mail Service CTR Raleigh, NC 27699-1905 http://epi.publichealth.nc.gov/cd/hiv/adap.html	1-919-733-3419 8 a.m. - 5 p.m. local time, Monday - Friday
North Dakota | North Dakota Department of Health, HIV/AIDS Program 2635 E Main AVE Bismarck, ND 58506-5520 http://www.ndhealth.gov/HIV/contact/contact.htm	1-800-472-2180 8 a.m. - 5 p.m. local time, Monday - Friday
Nebraska | Nebraska Department of Health & Human Services Ryan White HIV/AIDS Program, 301 Centennial Mall S Lincoln, NE 68509 http://dhhs.ne.gov/publichealth/Pages/dpc_ryan_white.aspx	1-866-632-2437 8 a.m. - 5 p.m. local time, Monday - Friday
New Hampshire | New Hampshire CARE Program 29 Hazen DR Concord, NH 03301 http://www.dhhs.nh.gov/dphs/bchs/std/care.htm	1-800-852-3345 8 a.m. - 4:30 p.m. local time, Monday - Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
New Jersey | New Jersey AIDS Drug Distribution Program (ADDP) P.O. Box 360 Trenton, NJ 08625-0360 http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml	1-877-613-4533 8 a.m. - 4:30 p.m. local time, Monday - Friday
New Mexico | New Mexico Department of Health. Infectious Disease Bureau 1190 S Saint Francis DR, STE 1200 Santa Fe, NM 87505 http://nmhealth.org/about/phd/idb/hats/	1-505-827-2435 8 a.m. - 5 p.m. local time, Monday - Friday
Nevada | Nevada Office of HIV/AIDS 4126 Technology Way, STE 200 Carson City, NV 89706 http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/	1-775-684-3499 8 a.m. - 5 p.m. local time, Monday - Friday
Ohio | Ohio HIV Drug Assistance Program (OHDAP) HIV Care Services Section, 246 N High ST Columbus, OH 43215 http://www.odh.ohio.gov/odhPrograms/hastpac/hivcare/aids1.aspx	1-800-777-4775 8 a.m. - 5 p.m. local time, Monday - Friday
Oklahoma | Oklahoma HIV/STD Services Division Oklahoma Department of Health, 1000 NE Tenth Oklahoma City, OK 73117 https://www.ok.gov/health/Disease,_Prevention,_Preparedness/HIV_STD_Service/Care_Delivery_(Ryan_White_ADAP_Hepatitis)/index.html	1-405-271-4636 8 a.m. - 5 p.m. local time, Monday - Friday
Oregon | Oregon CAREAssist 800 NE Oregon ST, STE 1105 Portland, OR 97232 http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx	1-800-805-2313 8 a.m. - 5 p.m. local time, Monday - Friday
Pennsylvania | Pennsylvania Special Pharmaceutical Benefits Program Department of Health, 625 Forster S, H&W BLDG, RM 611 Harrisburg, PA 17120 http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/E-H/HIV%20And%20AIDS%20Epidemiology/Pages/Special-Pharmaceutical-Benefits-Program.aspx#.Vw0vOXco61s	1-800-922-9384 8 a.m. - 5 p.m. local time, Monday - Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Puerto Rico | Puerto Rico Departmento de Salud, Programa Ryan White Parte B P.O. Box 70184 San Juan, PR 00936-8184 http://www.salud.gov.pr/Dept-de-Salud/Pages/Directorio.aspx	1-787-765-2829 8 a.m. - 5 p.m. local time, Monday - Friday
Rhode Island | Rhode Island AIDS Drug Assistance Program Department of Health, 3 Capitol Hill Providence, RI 02908 http://health.ri.gov/diseases/hivaids/about/stayinghealthy/	1-401-222-5960 8:30 a.m. - 4:30 p.m. local time, Monday - Friday
South Carolina | South Carolina AIDS Drug Assistance Program (ADAP) DHEC, STD/HIV Division, 2600 Bull ST Columbia, SC 29201 http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/	1-800-856-9954 8 a.m. - 5 p.m. local time, Monday - Friday
South Dakota | Ryan White Part B CARE Program South Dakota Department of Health, 615 E 4th ST Pierre, SD 57501-1700 http://doh.sd.gov/diseases/infectious/ryanwhite/	1-800-592-1861 8 a.m. - 5 p.m. local time, Monday - Friday
Tennessee | Tennessee HIV Drug Assistance Program (HDAP) Department of Health, 710 James Robertson PKWY Nashville, TN 37243 http://www.tn.gov/health/topic/STD-ryanwhite	1-615-741-7500 8 a.m. - 5 p.m. local time, Monday - Friday
Texas | Texas HIV Medication Program ATTN; MSJA, MC 1873, P.O, Box 149347 Austin, TX 78714-9387 www.dshs.state.tx.us/hivstd/meds	1-800-255-1090 8 a.m. - 5 p.m. local time, Monday - Friday
Utah | Utah Department of Health, Bureau of Epidemiology 288 N 1460 W, P.O. Box 142104 Salt Lake City, UT 84114-2104 http://health.utah.gov/epi/treatment/	1-801-538-6197 8 a.m. - 5 p.m. local time, Monday - Friday
Virginia | Virginia AIDS Drug Assistance Program (ADAP) Office of Disease Prevention, 109 Governor ST, FL 6 Richmond, VA 23219 http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/	1-855-362-0658 8 a.m. - 5 p.m. local time, Monday - Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Virgin Islands of the U.S. | US Virgin Islands STD/HIV/TB Program USVI Department of Health, Old Municipal Hospital Complex, BLDG 1 St. Thomas, VI 00802 www.healthvi.org/contact/index.html	1-340-774-9000
Vermont | VT Medication Assistance Program Health Surveillance Division, P.O. Box 70 Burlington, VT 05402 http://healthvermont.gov/prevent/aids/aids_index.aspx	1-802-863-7638 8:30 a.m. - 4:30 p.m. local time, Monday - Friday
Washington | Washington Early Intervention Program (EIP) HIV Client Services, P.O. Box 47841 Olympia, WA 98504-7841 http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices	1-877-376-9316 8 a.m. - 5 p.m. local time, Monday - Friday
Wisconsin | Wisconsin AIDS Drug Assistance Program (ADAP) Department of Health Services, 1 W Wilson ST, P.O. Box 2659 Madison, WI 53703 https://www.dhs.wisconsin.gov/aids-hiv/adap.htm	1-800-362-3002 8 a.m. - 5 p.m. local time, Monday - Friday
West Virginia | West Virginia AIDS Drug Assistance Program (ADAP) 350 Capitol ST, RM 125 Charleston, WV 25301 http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx	1-304-558-2195 8 a.m. - 5 p.m. local time, Monday - Friday
Wyoming | Wyoming Department of Health Communicable Disease Unit HIV Treatment Program, 401 Hathaway BLDG Cheyenne, WY 82002 https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/	1-307-777-5856 8 a.m. - 5 p.m. local time, Monday - Friday

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next **Part D Explanation of Benefits** (Part D EOB)

notice. If the discount doesn't appear on your **Part D Explanation of Benefits**, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- California - Department of Health Services - ADAP
- Colorado - Colorado AIDS Drug Assistance Program (ADAP)
- Connecticut - Connecticut Department of Social Services Medical Operations Unit #4
- District of Columbia - District of Columbia Department of Health
- Delaware - Delaware Pharmaceutical Assistance Program
- Guam - Division of Senior Citizens, Department of Public Health & Social Services
- Idaho - Idaho AIDS Drug Assistance Program (IDADAP)
- Indiana - HoosierRx
- Louisiana - Louisiana Department of Health
- Massachusetts - Prescription Advantage Executive Office of Elder Affairs
- Maryland - Maryland Senior Prescription Drug Assistance Program (SPDAP)
- Maine - Office of MaineCare Services
- Missouri - Missouri Rx Plan
- Montana - Montana Big Sky Rx
- New Jersey - New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD)
- Nevada - Nevada Senior/Disability Rx Program
- Pennsylvania - Pennsylvania PACE
- Rhode Island - Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)
- Texas - Texas Kidney Health Care Program
- Virginia - Virginia AIDS Drug Assistance Program (ADAP)
- Virgin Islands of the U.S. - US Virgin Islands Department of Human Services
- Vermont - Green Mountain Care Prescription Assistance
- Wisconsin - Wisconsin SeniorCare Pharmaceutical Assistance Program

State Pharmaceutical Assistance Programs – Contact Information	
California | Department of Health Services - ADAP P.O. Box 997377 Sacramento, CA 95899-7377 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	1-844-421-7050 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday

State Pharmaceutical Assistance Programs – Contact Information	
Colorado | Colorado AIDS Drug Assistance Program (ADAP) ADAP-3800, 4300 Cherry Creek DR S Denver, CO 80246-1530 https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap	1-303-692-2716 TTY 711 7:30 a.m. - 4 p.m. local time, Monday - Friday
Connecticut | Connecticut Department of Social Services Medical Operations Unit #4 55 Farmington AVE Hartford, CT 06105-3730 http://www.ct.gov/dss/cadap	1-800-233-2503 TTY 1-800-842-4524 8 a.m. - 5 p.m. local time, Monday - Friday
District of Columbia | District of Columbia Department of Health 899 N Capitol ST NE Washington, DC 20002 https://doh.dc.gov/service/dc-aids-drug-assistance-program	1-202-671-4900 TTY 711 8:15 a.m. - 4:15 p.m. local time, Monday - Friday
Delaware | Delaware Pharmaceutical Assistance Program EDS DPAP, P.O. Box 950 New Castle, DE 19720-0950 http://dhss.delaware.gov/dhss/dmma/dpap.html	1-800-996-9969 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday
Guam | Division of Senior Citizens, Department of Public Health & Social Services 130 University DR, STE 8, University Castle Mall Mangilao, GU 96913-6304 http://dphss.guam.gov	1-671-735-7421 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, FL 4 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	1-208-334-5612 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Indiana | HoosierRx P.O. Box 6224 Indianapolis, IN 49206 http://www.in.gov/fssa/ompp/2669.htm	1-866-267-4679 TTY 711 7 a.m. - 3 p.m. local time, Monday - Friday
Louisiana | Louisiana Department of Health 628 N 4th ST Baton Rouge, LA 70802 http://dhh.louisiana.gov/index.cfm/page/236	1-888-544-7996 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday

State Pharmaceutical Assistance Programs – Contact Information	
Massachusetts | Prescription Advantage Executive Office of Elder Affairs One Ashburton Place, RM 517 Boston, MA 02108-1618 http://www.mass.gov/elders/healthcare/prescription-advantage/about-prescription-advantage-benefits.html	1-800-243-4636 TTY 1-877-610-0241 9 a.m. - 5 p.m. local time, Monday - Friday
Maryland | Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o Pool Administrators, 628 Hebron Ave, STE 100 Glastonbury, CT 06033 www.marylandspdap.com	1-800-551-5995 TTY 1-800-877-5156 8 a.m. - 5 p.m. local time, Monday - Friday
Maine | Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011 http://www.maine.gov/dhhs/oms/member/index.shtml	1-800-977-6740 TTY 711 7 a.m. - 6 p.m. local time, Monday - Friday
Missouri | Missouri Rx Plan P.O. Box 6500 Jefferson City, MO 65102-6500 www.morx.mo.gov	1-800-375-1406 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Montana | Montana Big Sky Rx P.O. Box 202915 Helena, MT 59620-2915 www.bigskyrx.mt.gov	1-866-369-1233 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
New Jersey | New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD) P.O. Box 715 Mercerville, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/paad/	1-800-792-9745 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday
Nevada | Nevada Senior/Disability Rx Program 3416 Goni RD, STE D-132 Carson City, NV 89706 http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/	1-775-687-4210 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Pennsylvania | Pennsylvania PACE P.O. Box 8806 Harrisburg, PA 17105-8806 https://pacecares.magellanhealth.com	1-800-225-7223 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday

State Pharmaceutical Assistance Programs – Contact Information	
Rhode Island | Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) 57 Howard AVE, Louis Pasteur BLDG, FL 2 Cranston, RI 02920 http://www.dea.state.ri.us/programs/prescription_assist.php	1-401-462-3000 TTY 1-401-462-0740 8:30 a.m. - 4 p.m. local time, Monday - Friday
Texas | Texas Kidney Health Care Program Specialty Health Care Services, MC 1938, P.O. Box 149347 Austin, TX 78714-9347 http://www.dshs.texas.gov/kidney/default.shtm?terms=kidney%20health%20care	1-800-222-3986 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Virginia | Virginia AIDS Drug Assistance Program (ADAP) Office of Disease Prevention, 109 Governor ST, FL 6 Richmond, VA 23219 http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/	1-855-362-0658 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Virgin Islands of the U.S. | US Virgin Islands Department of Human Services 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 http://www.dhs.gov.vi/seniors/pharmaceutical.html	1-340-774-0930 TTY 711
Vermont | Green Mountain Care Prescription Assistance 280 State DR Waterbury, VT 05671-1020 http://www.greenmountaincare.org/perscription	1-800-250-8427 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday
Wisconsin | Wisconsin SeniorCare Pharmaceutical Assistance Program Department of Health Services, 1 W Wilson ST Madison, WI 53716-0710 http://www.dhs.wisconsin.gov/seniorcare	1-800-657-2038 TTY 711 8 a.m. - 6 p.m. local time, Monday - Friday

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	**1-877-772-5772** Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
WEBSITE	**https://secure.rrb.gov**

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

Using the plan's coverage for your Part D prescription drugs

Chapter 3
Using the plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter 4, **What you pay for your Part D prescription drugs**).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your Medicare & You Handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask

your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You generally must use a network pharmacy to fill your prescription. (See Section 2, **Fill your prescriptions at a network pharmacy or through the plan's preferred mail-order service.)**
- Your drug must be on the plan's **List of Covered Drugs (Formulary)** (we call it the "Drug List" for short). (See Section 3, **Your drugs need to be on the plan's "Drug List"**.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's preferred mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered **only** if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website (www.UHCRetiree.com) or call Customer Service (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the back cover of this booklet) or use the **Pharmacy Directory**. You can also find information on our website at www.UHCRetiree.com.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your **Pharmacy Directory** or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's preferred mail-order services

Our plan's preferred mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, please reference your **Pharmacy Directory** to find the mail service pharmacies in our network. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 10 business days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps:

If your prescription is on file at your local pharmacy, go to your pharmacy to fill the prescription. If your delayed prescription is not on file at your local pharmacy, then please ask your doctor to call in a new prescription to your pharmacist. Or, your pharmacist can call the doctor's office for you to request the prescription. Your pharmacist can call the Pharmacy help desk at 1-877-889-6510, (TTY) 711, 24 hours a day, 7 days a week if he/she has any problems, questions, concerns, or needs a claim override for a delayed prescription.

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by phone or mail.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by phone or mail.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by phone or mail.

Refills on mail order prescriptions. For refills, please contact your pharmacy at least 10 business days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your **Pharmacy Directory** tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan's preferred network **mail-order services**. Our plan's preferred mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **Prescriptions for a Medical Emergency**
  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Drug List without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling or out of the service area**
  When traveling within the U.S. you have access to network pharmacies nationwide. Bring your prescriptions and medication with you and be sure to check the pharmacy directory for your

travel plans to locate a network pharmacy while traveling. If you are leaving the country, you may be able to obtain a greater day supply to take with you before leaving the country where there are no network pharmacies available.

- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or preferred mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "**List of Covered Drugs (Formulary)**." In this **Evidence of Coverage**, **we call it the "Drug List" for short**.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is **either**:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- **– or –** Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is not on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are 4 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Tier 1 – Generic Drugs (includes all generic and some lower-cost brand name prescription drugs)

Tier 2 – Preferred Brand Drugs (includes many common brand name drugs)

Tier 3 – Non-Preferred Drugs (includes non-preferred brand name drugs. In addition, Part D eligible Compounded Medications are covered in Tier 3.)

Tier 4 – Specialty Tier Drugs (includes unique or very high-cost drugs)

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 **(What you pay for your Part D prescription drugs)**.

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it.)
2. Visit the plan's website (www.UHCRetiree.com). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our Drug List. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy.**"

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are printed on the back cover of this booklet) or check our website (www.UHCRetiree.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts each covered drug into one of 4 different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- – or – the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:**
  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the plan year if you were in the plan last year**. This temporary supply will be for at least a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide at least a 30-day supply of medication. The prescription must be filled at a network pharmacy.
- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**
  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the plan year if you were in the plan last year**. The total supply will be for at least a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide at least a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**
  We will cover at least a 31-day supply of a particular drug. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 31 day supply. This is in addition to the above long-term care transition supply.

- **For those current members with level of care changes:**
  There may be unplanned transitions such as hospital discharges or level of care changes that occur while you are enrolled as a member in our plan. If you are prescribed a drug that is not on our Drug List or your ability to get your drugs is limited, you are required to use the plan's exception process. You may request a one-time temporary supply of at least 30 days to allow you time to discuss alternative treatment with your doctor or to pursue a formulary exception. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 30 day supply.

To ask for a temporary supply, call Customer Service (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.
If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

For drugs in Tiers 2 and 3, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Specialty Tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each plan year. However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage **for a drug you are taking**, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until the next plan year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happen for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until the next plan year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on the first day of the next plan year, the changes will affect you.

In some cases, you will be affected by the coverage change before the next plan year:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are not covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Please note: Your plan sponsor **may** have elected to offer some of the drugs listed above to you as an additional benefit. If so, you will receive additional information about the drugs they have chosen to offer to you separately, in your plan materials.

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your plan member ID card when you fill a prescription

Section 8.1 Show your member ID card

To fill your prescription, show your plan member ID card at the network pharmacy you choose. When you show your plan member ID card, the network pharmacy will automatically bill the plan for **our** share of your covered prescription drug cost. You will need to pay the pharmacy **your** share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your member ID card with you?

If you don't have your plan member ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 8, **Ending your membership in the plan**, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your **Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for at least a 98-day supply. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 98 day supply. (Please note that the long-term care (LTC)

pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover at least a 31-day supply. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 31 day supply.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in UnitedHealthcare® MedicareRx℠ for Groups (PDP) doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through UnitedHealthcare® MedicareRx℠ for Groups (PDP) in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or UnitedHealthcare® MedicareRx℠ for Groups (PDP) for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or another retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or another retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the retiree group prescription drug coverage you get from us through your plan sponsor will be **secondary** to coverage through your current employer.

Special note about 'creditable coverage':

Each year your plan sponsor should send you a notice that tells if your prescription drug coverage for the next plan year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your plan sponsor, you can get a copy from your former employer or retiree plan's benefits administrator, or your former employer or union.

Section 9.6 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 4 **(What you pay for your Part D prescription drugs)** gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Medication Therapy Management (MTM) programs to help members manage their medications

We have programs that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take.

One program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

CHAPTER 4

What you pay for your Part D prescription drugs

Chapter 4
What you pay for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. Your Plan Sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. **Section 5.2 of this chapter contains a table that shows your costs for a** drug that is covered by both your Part D prescription drug benefit and your supplemental drug coverage. Please review the separate document included with this Evidence of Coverage, called the "**Certificate of Coverage**", for more information about this supplemental drug coverage. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's List of Covered Drugs (Formulary)**. To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the 4 "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Customer Service (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at www.UHCRetiree.com. The Drug List on the website is always the most current.

- **Chapter 3 of this booklet**. Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.
- **The plan's Pharmacy Directory**. In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The **Pharmacy Directory** has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for our plan members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1	Stage 2	Stage 3	Stage 4
Yearly Deductible Stage	**Initial Coverage Stage**	**Coverage Gap Stage**	**Catastrophic Coverage Stage**
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $3,750. (Details are in Section 5 of this chapter.)	The plan continues to pay its share of the cost of your drugs and **you pay your share of the cost**. For generic drugs in all Tiers you pay your share of the cost or 44% of the costs whichever is lower. For brand name drugs in all Tiers you pay your share of the cost or 35% of the price (plus a portion of the dispensing fee) whichever is lower. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year. (Details are in Section 7 of this chapter.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the **Part D Explanation of Benefits** (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1**. This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your member ID card when you get a prescription filled**. To make sure we know about the prescriptions you are filling and what you are paying, show your plan member ID card every time you get a prescription filled.
- **Make sure we have the information we need**. There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.

- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you**. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you**. When you receive a **Part D Explanation of Benefits** (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for the plan

Section 4.1 Your plan does not have a deductible for your Part D drugs

Your plan provides additional coverage, which means you do not pay a deductible for your Part D drugs. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

While your plan does not have a deductible for your Part D drugs, the “Extra Help” program may have a deductible. If you are in Medicare’s Extra Help program you could be responsible for an upfront $83 deductible. You will get a Low Income Subsidy Rider or LIS Rider in a separate mailing. It explains Extra Help and tells you the amount of your deductible.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 4 cost-sharing tiers

Every drug on the plan’s Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

Tier 1 – Generic - Includes all generic and some lower-cost brand name prescription drugs. This is the lowest cost-sharing tier.

Tier 2 – Preferred Brand - Includes many common brand name drugs.

Tier 3 – Non-Preferred drugs - Includes non-preferred brand name drugs. In addition, Part D eligible Compounded Medications are covered in Tier 3.

Tier 4 – Specialty Tier - Includes unique or very high-cost drugs. This is the highest cost-sharing tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and the plan's **Pharmacy Directory**.

Section 5.2 A table that shows your costs for a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- "**Copayment**" means that you pay a fixed amount each time you fill a prescription.
- "**Coinsurance**" means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay **either** the full price of the drug **or** the copayment amount, **whichever is lower**.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3.)

The table below shows what you pay when you get a 30-day supply and a long-term up to a 90-day supply of a drug.

Your share of the cost when you get a covered Part D prescription drug:			
Tier	**Standard retail cost-sharing (in-network)** (up to a 30-day supply)	**Preferred Mail-order cost-sharing** (up to a 90-day supply)	**Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 Generic Drugs	$10 copayment	$20 copayment	$10 copayment*
Cost-Sharing Tier 2 Preferred Brand Drugs	$25 copayment	$50 copayment	$25 copayment*
Cost-Sharing Tier 3 Non-Preferred Drugs	$75 copayment	$150 copayment	$75 copayment*
Cost-Sharing Tier 4 Specialty Tier Drugs	$75 copayment	$150 copayment	$75 copayment*

*You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a **percentage** of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the **amount** you pay will be less.
- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
  - Here's an example: Let's say the copayment for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure certain drugs work for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,750

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,750 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2018, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The **Part D Explanation of Benefits** (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $3,750 limit in a year.
We will let you know if you reach this $3,750 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,000

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are on the back cover of this booklet).

After you leave the Initial Coverage Stage, we will continue to pay our share of the cost of your drugs and you pay your share of the cost. For generic drugs in all Tiers you pay your share of the cost or 44% of the costs whichever is lower. For brand name drugs in all Tiers you pay your share of the cost or 35% of the price (plus a portion of the dispensing fee) whichever is lower. You pay these amounts until your yearly out-of-pocket costs reach a maximum amount that Medicare has set. In 2018, that amount is $5,000.

Medicare has rules about what counts and what does **not** count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,000, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments are included in your out-of-pocket costs

When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.

- These payments are **also included** if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $5,000 in out-of-pocket costs within the plan year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The **Part D Explanation of Benefits** (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $5,000 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $5,000 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be a $3.35 for a generic drug or a drug that is treated like a generic and $8.35 for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 8 Additional benefits information

Section 8.1 Our plan has benefit limitations

This part of Chapter 4 talks about limitations of our plan.

1. Early refills for lost, stolen or destroyed drugs are not covered except during a declared “National Emergency”.
2. Early refills for vacation supplies are limited to a one-time fill of up to 30 days per calendar year.
3. Medications will not be covered if prescribed by physicians or other providers who are excluded from Medicare program participation.
4. You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days supply.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage for a number of Part D vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's **List of Covered Drugs (Formulary)**.
   - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment and/or coinsurance for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.

- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet **(Asking us to pay our share of the costs for covered drugs)**.
- You will be reimbursed the amount you paid less your normal copayment and/or coinsurance for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your copayment and/or coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Section 9.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on the back cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 5

Asking us to pay our share of the costs for covered drugs

Chapter 5
Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Section 2.5 to learn more).

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's **List of Covered Drugs (Formulary)**; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.).

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet).

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

Mail your request for payment together with any receipts to us. See Chapter 2 for the address.

You must submit your Part D (prescription drug) claim to us within 36 months of the date you received the drug.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered). We will send payment within 30 days after your request was received.

- If we decide that the drug is **not** covered, or you did **not** follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))**. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- **Please note:** If you are in the Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 6

Your rights and responsibilities

Chapter 6
Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats)

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service for additional information.

Section 1.2 You have a right to be treated with respect and recognition of your dignity and right to privacy. We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of our Plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs

within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, **we are required to get written permission from you first**. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

HEALTH PLAN NOTICES OF PRIVACY PRACTICES
MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2017

We[1] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.UHCRetiree.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment**. We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations**. We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors**. If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders**. We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

  1. HIV/AIDS;
  2. Mental health;
  3. Genetic tests;
  4. Alcohol and drug abuse;
  5. Sexually transmitted diseases and reproductive health information; and
  6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website for your particular health plan, you may also obtain a copy of this notice on your health plan website, such as www.UHCRetiree.com.

Exercising Your Rights

- **Contacting your Health Plan**. If you have any questions about this notice or want information about exercising your rights, please **call the toll-free member phone number on the back of your health plan ID card** or you may contact a UnitedHealth Group Customer Call Center Representative at 1-888-556-6648 (TTY 711).
- **Submitting a Written Request**. You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare Privacy Office

  MN017–E300

  PO Box 1459

  Minneapolis, MN 55440
- **Filing a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

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[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC;

Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2017

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

[2] For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; Connextions HCI, LLC; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; and UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where

required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card** or contact the UnitedHealth Group Customer Call Center at 1-888-556-6648 (TTY 711).

UNITEDHEALTH GROUP
HEALTH PLAN NOTICE OF PRIVACY PRACTICES:
FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2017

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other

laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws
Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws	
General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclosure information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes	KS

Summary of State Laws	
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IL, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	

Summary of State Laws	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, RI, TN, TX, UT, WI

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies**.
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the **Pharmacy Directory**.
  - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.UHCRetiree.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's **List of Covered Drugs (Formulary)**. These chapters, together with the **List of Covered Drugs (Formulary)**, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6 You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, **if you want to**, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form**. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency, for example, your State Department of Health.

Section 1.7 You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, **and** it's **not** about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- For information on the Quality Improvement Program for your specific health plan, call the Customer Service number on the back of your member ID card. You may also access this information via the website (https://www.uhcmedicaresolutions.com/health-plans/medicare-advantage-plans/resources-plan-material/ma-medicare-forms). Select, "Commitment to Quality."
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.

- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: https://www.medicare.gov/ Pubs/pdf/ 11534.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs**. Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us**. Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan member ID card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Pay what you owe**. As a plan member, you are responsible for these payments:

- Your prescription drug coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium, if applicable. If you have a plan premium, you must pay your plan premiums to continue being a member of our plan.
- For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your Part D prescription drugs.
- If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- **Tell us if you move**. If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
  - **If you move outside of our plan service area, you cannot remain a member of our plan**. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns**. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 7
What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

COVERAGE DECISIONS AND APPEALS

MAKING COMPLAINTS

Background

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals.**
- For other types of problems, you need to use the **process for making complaints.**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (https://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?	
(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)	
Yes. My problem is about benefits or coverage.	**No.** My problem is <u>not</u> about benefits or coverage.
Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**	Skip ahead to **Section 7** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

Coverage Decisions And Appeals

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).

- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you**. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (A guide to "the basics" of coverage decisions and appeals)? If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's **List of Covered Drugs (Formulary)**. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only**. To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the **List of Covered Drugs (Formulary)**, rules and restrictions on coverage, and cost information, see Chapter 3 (**Using the Plan's coverage**

for your Part D prescription drugs) and Chapter 4 (**What you pay for your Part D prescription drugs**).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's **List of Covered Drugs (Formulary)**
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's **List of Covered Drugs (Formulary)** but we require you to get approval from us before we will cover it for you.)
  - **Please note**: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 5.2** of this chapter.
Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 5.4** of this chapter.

If you are in this situation:	This is what you can do:
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our plan's List of Covered Drugs (formulary)**. (We call it the "Drug List" for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on the plan's coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on the plan's **List of Covered Drugs (Formulary)** (for more information, go to Chapter 3).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - **Getting plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - **Being required to try a different drug first** before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - **Quantity limits**. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier**. Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- You cannot ask us to change the cost-sharing tier for any drug in Tier 4 Specialty Tier.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception. If you ask us for a tiering exception, we will generally **not** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

1 **STEP 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are asking for a coverage decision about your Part D prescription drugs**. Or if you are asking us to pay

you back for a drug, go to the section called, **Where to send a request that asks us to pay for our share of the cost for a drug you have received**.

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug,** start by reading Chapter 5 of this booklet: **Asking us to pay our share of the costs for covered drugs**. Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which are available on our website.

If your health requires it, ask us to give you a "fast coverage decision"

Legal Terms	A "fast coverage decision" is called an **"expedited coverage determination."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements**:
  - You can get a fast coverage decision **only** if you are asking for a **drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function**.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

2 STEP 2: Our plan considers your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

3 STEP 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If our plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

1 STEP 1: You contact our plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us**.
  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, **How to contact us when you are making an appeal about your Part D prescription drugs.**
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact us when you are making an appeal about your Part D prescription drugs).

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms	A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.4 of this chapter.

2 STEP 2: Our plan considers your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast" appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but no **later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

3 STEP 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

1 STEP 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

2 STEP 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for a "fast" appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for a "standard" appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

3 **STEP 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Making complaints

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems **only**. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Service or other staff at our plan? ◦ Examples include waiting too long on the phone or when getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the **timeliness** of our actions related to coverage	The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.

Complaint	Example
decisions and appeals)	• If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms	• What this section calls a **"complaint"** is also called a **"grievance."** • Another term for **"making a complaint"** is **"filing a grievance."** Another way to say "using the process for complaints" is **"using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

1 STEP 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step**. If there is anything else you need to do, Customer Service will let you know. 1-888-556-6648, 711, 8 a.m. - 8 p.m. local time, Monday - Friday
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us**. If you put your complaint in writing, we will respond to your complaint in writing.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address/fax numbers for filing complaints is located in Chapter 2 under "How to contact us when you are making an appeal or complaint about your Part D prescription drugs."

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal", we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

2 STEP 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar day's total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (**without** making the complaint to our plan).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about UnitedHealthcare® MedicareRx℠ for Groups (PDP) directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8
Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you **want** to leave.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 4 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

In the event you choose to end your membership in our plan, re-enrollment may not be permitted, or you may have to wait until your plan sponsor's next Open Enrollment Period. You should consult with your plan sponsor regarding the availability of other coverage prior to ending your plan membership outside of your plan sponsor's Open Enrollment Period. It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting your request to end your membership in our plan.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. Please contact your plan sponsor for more information on ending your membership in our plan.

Section 2.1 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- Call your plan sponsor
- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You** 2018 Handbook.
  - Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 Until your membership ends, you must keep getting your drugs through our plan

Section 3.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends**. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

SECTION 4 We must end your membership in the plan in certain situations

Section 4.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- We are notified that you no longer meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).
- Your former employer, union group or trust administrator's (plan sponsor's) contract with us is terminated.
- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your member ID card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

Section 4.2 We cannot ask you to leave our plan for any reason related to your health.

Our plan is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 4.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9
Legal notices

SECTION 1 Notice about governing law

Many laws apply to this **Evidence of Coverage** and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Third party liability and subrogation

In the case of injuries or illness caused by or alleged to have been caused by any act or omission of a third party, and any complications incident thereto, we shall cover all Part D covered drugs. However, you agree to promptly notify UnitedHealthcare of the injury or illness and agree to reimburse us or our designee for the cost of all such drugs provided immediately upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of UnitedHealthcare or its designee under this provision. You shall not settle any claim, or release any person from liability, without the written consent of UnitedHealthcare, wherein such release or settlement will extinguish or act as a bar to our right of reimbursement. Should you settle your claim against a third party and compromise the

reimbursement rights of UnitedHealthcare or its nominee without our written consent, or otherwise fail to cooperate in protecting the reimbursement rights of UnitedHealthcare or its nominee, we may initiate legal action against you. Attorney fees will be awarded to the prevailing party.

Benefits paid by us may also be considered to be benefits advanced.

The Plan has a right to subrogation and reimbursement. Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

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

You agree to assign us all rights of recovery against such Third Parties; to the extent of the reasonable value of services and benefits we provide to you, plus reasonable costs of collection. We or any of our subsidiaries or owned affiliates are not a Third Party under this plan.

The following is agreed upon between you and us:

- You will cooperate with us in protecting our legal rights to subrogation and reimbursement; and you acknowledge that our rights under this Section will be considered as the first priority claim against any Third Parties, to be paid before any of your other claims are paid. Specifically, but without limitation, you agree to: (i) provide any relevant information we may request; (ii) sign and deliver such documents as we or our agents may reasonably request to secure the subrogation claim; (iii) respond to requests for information about any accidents or injuries; (iv) make court appearances; (v) obtain the consent of the plan or our agents before releasing any party from liability for or payment of medical expenses. We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf; and (vi) you may not accept any settlement that does not fully reimburse us without its written approval.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or

party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- You will do nothing to prejudice our rights under this provision, either before or after the need for drugs under this EOC. We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit on our own behalf as your subrogee. Your failure to cooperate in this manner shall be deemed a breach of this contract and may result in the institution of legal action against you.
- We will not use the rights enumerated throughout this Section to affect or impair any parental financial obligations, such as child support, associated with Pregnancy.
- No court costs or attorneys fees may be deducted from our recovery without our express written consent; and no so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right. We are not required to participate in or pay court costs or attorneys fees to any attorney or other representative or agent hired by you to pursue a claim relating to your Sickness or Injury.
- We may collect, at our opinion, amounts from proceeds of any Third Party settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether you or your legal representative have been made whole. You will hold any proceeds of such a Third Party settlement or judgment in a constructive trust for our benefit under these subrogation provisions. We will be entitled to recover from you reasonable attorney fees incurred in collecting proceeds held by you.
- The plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.
- The plan’s rights to recovery will not be reduced due to your own negligence.
- We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative or other third party and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor’s Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- We have the responsibility for administering the terms and conditions of the subrogation and reimbursement rights and have such powers and duties as are necessary to discharge these duties and functions, including the exercise of discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

SECTION 5 Member liability

In the event we fail to reimburse a network pharmacy's charges for covered drugs, or in the event that we fail to pay a non-network pharmacy for prior authorized covered drugs occurring when you were actively enrolled in the plan, you will not be liable for any sums owed by us.

We will pay for certain drugs dispensed by a non-network pharmacy under certain circumstances, subject to the limitations contained in Chapter 3.

If you enter into a private contract with a non-network provider, neither the plan nor Medicare will pay for those services.

SECTION 6 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your drugs exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership**.

SECTION 7 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the

control of us, network pharmacies may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network pharmacies shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

SECTION 8 Contracting network pharmacies

The relationships between us and our network pharmacy providers are independent contractor relationships. None of the network pharmacy providers or their pharmacists or employees are employees or agents of UnitedHealthcare Insurance Company. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company is an employee or agent of the network pharmacy.

SECTION 9 Disclosure

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

SECTION 10 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered drugs under this Evidence of Coverage and the Schedule of Benefits or be used in defense of a legal action unless it is contained in a written application.

SECTION 11 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

SECTION 13 Commitment of Coverage Decisions

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

CHAPTER 10

Definitions of important words

Chapter 10

Definitions of important words

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $5,000 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug that a plan requires when a specific drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring

your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Daily Cost Share applies only if the drug is in the form of a solid oral dose (e.g., tablet or capsule) when dispensed for a supply less than 30 days under applicable law. The Daily Cost Share requirements do not apply to either of the following:

1. Solid oral doses of antibiotics.
2. Solid oral doses that are dispensed in their original container or are usually dispensed in their original packaging to assist patients with compliance.

Deductible – The amount you must pay for prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not

on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a preferred lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000.00 and married couples with income greater than $170,000.00 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Independent Practitioner Associations (IPAs) – Individual physicians and medical groups contracted by the plan to provide medical services and with hospitals to provide services to members. The contracting medical groups/IPAs in turn, employ or contract with individual physicians. (See Chapter 9, Section 10)

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $3,750.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Programs of All-inclusive Care for the Elderly (PACE) plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our plan at higher cost-sharing levels than apply at a preferred network pharmacy.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a late enrollment penalty.

Plan Sponsor – Your former employer, union group or trust administrator.

Plan Year – The period of time your plan sponsor has contracted with us to provide covered services to you through the plan. Your plan sponsor's plan year is listed inside the front cover of the Evidence of Coverage.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered

Part D drugs at certain network pharmacies.

Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our plan that may have lower cost-sharing levels than at other network pharmacies.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Standard Cost-sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

UnitedHealthcare® MedicareRx℠ for Groups (PDP) Customer Service:

Call **1-888-556-6648**

Calls to this number are free. 8 a.m. - 8 p.m. local time, Monday - Friday. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**
Calls to this number are free. 8 a.m. - 8 p.m. local time, Monday - Friday.

Write P.O. Box 29675
Hot Springs, AR 71903-9675

Website **www.UHCRetiree.com**

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.
You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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Program Document 6

UnitedHealthcare RxSupplement, Certificate of Coverage (2018), Group Number 00334

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2018)

2018 CERTIFICATE OF COVERAGE

Specifics about your extra prescription drug coverage

UnitedHealthcare® RxSupplement™
Group Name (Plan Sponsor): ANADARKO PETROLEUM CORPORATION
Group Number: 00334

Toll-Free **1-888-556-6648,** TTY **711**
8 a.m. - 8 p.m. local time, Monday - Friday

www.UHCRetiree.com

UnitedHealthcare®

GRPRETRX-0112-TX

Underwritten by

UnitedHealthcare® Insurance Company
Hartford, Connecticut

Group Outpatient Prescription Drug
INSURANCE CERTIFICATE

UnitedHealthcare Insurance Company (the "Company") hereby delivers to the Group Policyholder a Policy providing outpatient Prescription Drug insurance for certain eligible Covered Persons who are covered by Medicare Part D Drug coverage. The Certificate describes the benefits and provisions of the insurance provided by the Policy.

You may receive the benefits specified in the Certificate if You are eligible for insurance under the provisions of the Policy.

The Certificate is not a contract of insurance and only summarizes the primary provisions of the Policy. The Certificate supersedes and replaces any similar Certificate that the Company previously issued to You.

The Certificate is valid only if it includes Your Schedule of Benefits.

Please read the following information so you will know from whom or what group of providers prescription benefits may be obtained.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey D. Alter, President

GRPRETRX-0112-TX

Table Of Contents

Welcome to

UNITEDHEALTHCARE

The Company provides outpatient Prescription Drug benefits to Covered Persons who have properly enrolled and meet the Employer's eligibility requirements.

To learn more about these requirements, see **Section Three: Covered Person Eligibility.**

What is this Publication?

This publication is called a Certificate of Coverage (Certificate). It is a legal document that explains Your outpatient Prescription Drug plan and should answer many important questions about Your benefits. Many of the words and terms are capitalized because they have special meanings.

To better understand these terms, please see **Section Five: Definitions**.

Whether You are the Insured Person for this coverage or enrolled as an eligible Dependent, Your Certificate and Schedule of Benefits (Section Seven) are key to making the most of Your coverage.

What Else Should I Read to Understand My Benefits?

Along with reading this Certificate, which includes Your Schedule of Benefits in **Section Seven**, be sure to review any supplemental benefit materials. Your Schedule of Benefits provides the details of Your particular outpatient Prescription Drug plan, including any Deductibles, Copayments and/or Coinsurance that You may have to pay when receiving a health care service. Together, these documents explain Your coverage.

What if I Still Need Help?

After You become familiar with Your benefits, You may still need assistance. Please don't hesitate to contact Our Customer Service Department as shown below:

- By calling 1-888-556-6648 from 8 a.m. - 8 p.m. local time, Monday - Friday
- By accessing Our customer service Web site at www.UHCRetiree.com

NOTE: Your Certificate, which includes Your Schedule of Benefits, provides the terms and conditions of Your benefits. These forms should be read completely and carefully. You also may correspond with the Company at the following address:

UnitedHealthcare
P.O. Box 29675, Hot Springs, AR 71903-9675

1-888-556-6648

www.UHCRetiree.com

GRPRETRX-0112-TX

Important Notice

To obtain information or make a complaint:

You may call UnitedHealthcare Insurance Company's toll-free number for information or to make a complaint at:

1-888-556-6648

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1 (800) 252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: http//www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

Premium or Claim Disputes

Should You have a dispute concerning your premium or about a claim, You should contact UnitedHealthcare Insurance Company first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

Attach This Notice to Your Policy

This notice is for information only and does not become a part or condition of the attached document.

Aviso Importante

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de UnitedHealthcare Insurance Company para obtener información o para presentar una queja al:

1-888-556-6648

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1 (800) 252-3439

Usted puede escribir al Departamento de Seguros de
Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio beb: http//www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

Disputas por Primas de Seguros o Reclamaciones

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la UnitedHealthcare Insurance Company primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento

Adjunte Este Aviso a Su Póliza

Este aviso es solamante para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

GRPRETRX-0112-TX

Administrators

Certain provisions of the Certificate are administered by one or more of the Company's Administrators. They are as follows:

FOR ELIGIBILITY AND BENEFITS VERIFICATION:

UnitedHealthcare
P.O. Box 29675
Hot Springs, AR 71903-9675
1-888-556-6648

FOR PAYMENT OF CLAIMS:

OptumRx
P.O. Box 29046
Hot Springs, AR 71903

All inquiries and notifications required by the terms and conditions of the Policy or Certificate are to be mailed or phoned to the Company's Administrator. Notification requirements to the Company are fulfilled by contacting the Company's Administrator in this manner.

Section One - Your Outpatient Prescription Drug Benefits

- Outpatient Prescription Drug Benefits
- Limitations and Exclusions

This section explains Your outpatient Prescription Drug benefits, including what is and isn't covered by the Company. All Covered Services must be Medically Necessary. If You have any questions as to whether an outpatient Prescription Drug is a Covered Service, please consult this Certificate or contact Us at 1-888-556-6648. Our Customer Service Department can assist You in determining Your benefits. For any Deductibles, Copayments and/or Coinsurance that may be associated with a benefit, You should refer to Your Schedule of Benefits. Some Drugs require Prior Authorization by Your Part D coverage, have limitations, or are excluded from Coverage. Please consult Your Part D coverage, Your Schedule of Benefits in this Certificate, and this **Section One** for an explanation of Your outpatient Prescription Drug benefits, as well as the Limitations and Exclusions Section of this Certificate. You can also find some helpful definitions in **Section Five** at the back of this Certificate.

The benefits of the Policy described in this Certificate are based on the assumption that the Covered Person is enrolled in Medicare Part D coverage issued by the Company. The Company will pay the following benefits up to the Covered Expense, only to the extent that the Covered Expense has not been paid by the Part D plan, and subject to all other limitations and exclusions set forth in this Policy and in the Schedule of Benefits in Section Seven of this Certificate.

If a specific service or supply is not included in this **Section One: Your Outpatient Prescription Drug Benefits** purchased by the Covered Person's Employer, it is not a Covered Service and no benefits will be provided under the Policy.

I. Outpatient Prescription Drug Benefits

You or Your Physician may contact the Company at 1-888-556-6648, or Our Web site www.UHCRetiree.com, to determine if a particular Drug is covered under this plan or to obtain a list of covered Drugs. Your Physician is not obligated to prescribe a covered Drug and may prescribe any FDA approved Drug he or she feels is appropriate for Your treatment. **However, prescriptions for medications not on the list of covered Drugs which have not received Prior Authorization from Your Part D coverage will not be a Covered Expense under this Policy.**

Covered Expense. Covered Expense includes expenses that are incurred for a Covered Service and provided to a Covered Person in accordance with the provisions of this Certificate. The Covered Expense will not exceed the negotiated or contract cost for prescriptions filled at a Participating Pharmacy. Covered Expenses include the Unit supply usually prescribed by a provider or a 30-day supply.

Covered Services. Covered Services include outpatient Prescription Drugs prescribed by a licensed provider and dispensed by a pharmacy for the treatment of an injury or sickness as outlined in Your Certificate or Drug List. Covered Services consist only of Medically Necessary Drugs and medications which, in accordance with federal or state laws, may not be dispensed without the written prescription of a provider, and which are dispensed by a provider who dispenses outpatient Prescription Drugs to patients when required to do so in the course of his or her regular practice.

Mail Service Pharmacy Program. The Company offers a Mail Service Pharmacy Program. The Mail Service Pharmacy Program provides convenient service on medications that You may take on a regular basis by allowing You to purchase certain Drugs for receipt by mail. You get high quality medications mailed directly to Your home or address of Your choice within the United States. Shipping and handling is at no additional charge. Prescription maintenance Drugs may be dispensed for up to three Prescription Units or up to a 90-day supply. The Copayment and/or Coinsurance amount is specified in the Schedule of Benefits.

If You use Our Mail Service Pharmacy Program, You will generally get Your medication within seven (7) to fourteen (14) working days after receipt of Your order. All orders are shipped in discreetly labeled envelopes for privacy and safety.

When You receive Your prescription, You will get detailed instructions that tell You how to take the medication, possible side effects and any other important information about the medication. If You have questions, registered pharmacists are available to help You by calling 1-888-279-1828 or for the hearing impaired at 711.

If You are starting a new medication, please request two prescriptions from Your provider. Have one filled immediately at a Participating Pharmacy while mailing the second prescription to UnitedHealthcare's Mail Service Pharmacy. Once You receive Your medication through the mail service, You should stop filling the prescription at the Participating Pharmacy.

Prior Authorization For Selected Drugs. This Policy does not require Prior Authorization; however, coverage provided under Your Medicare Part D plan issued by the Company might require Prior Authorization for selected Drugs. You must satisfy any Prior Authorization requirements under Your Part D coverage in order to be eligible to receive a benefit under this Policy. Please check Your Part D coverage for any Prior Authorization requirements.

Quantity Limits for Selected Drugs. A “quantity limit” is a management tool that is designed to limit the use of selected Drugs for quality, safety, or utilization purposes. Limits may be included on the amount of the Drug that We cover per prescription or for a defined period of time. Please check Your Part D coverage to determine if any quantity limits apply.

6

II. Limitations and Exclusions of Benefits

No benefits are payable for any of the following:

1. Drugs or medicines purchased and received prior to the Covered Person's Effective Date or subsequent to the Covered Person's termination.
2. Prescriptions or devices that are covered under Medicare Part B benefits. Therapeutic devices or appliances, even though they may require a prescription. This includes: hypodermic needles; syringes (except insulin syringes when provided for use with covered Self-Injectable medications); support garments; and other non-medical substances.
3. All non-prescription contraceptive jellies, ointments, foams or devices.
4. Drugs dispensed by a Hospital, rest home, sanitarium, skilled nursing facility, convalescent care facility, nursing home or similar institution while confined as a patient or when covered under Medicare Part A.
5. Self-Injectable Drugs.
6. Dietary supplements, including vitamins, mineral products, and fluoride supplements; health or beauty aids and diet pills, herbal supplements and/or alternative medicine; and dental related products, such as topical fluoride, medicated dental rinses and children's fluoride vitamins.
7. Medications which may be properly received without charge under local, state or federal programs or which is reimbursable under other insurance programs, including Workers' Compensation and Medicare, or medications furnished by any other Drug or medical service for which no charge is made to the Covered Person.
8. Medications prescribed for experimental or non-FDA approved indications, unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopoeial Convention or in the American Hospital Formulary Services edition of Drug Information; medications limited to investigational use by law; or medications that are determined not to be effective for the specific diagnosis or that do not follow community practice standards unless prior authorized under Your Part D plan.
9. Patent Drugs for which there is a non-prescription equivalent available, even if ordered by a Physician.
10. Drugs or medicines used or taken primarily to improve or otherwise modify the Covered Person's external appearance.
11. Over-the-Counter smoking cessation products including, but not limited to, nicotine gum, nicotine patches, nicotine nasal spray or any other Drug containing nicotine or other smoking deterrent medications.
12. Administration or injection of any Drug.
13. Drugs purchased outside the United States and its territories.
14. Off-Label Drugs. There are certain exceptions. Please see the definition of "Off-Label Drug" in the **Definitions** section of this Certificate.
15. Drugs used to promote fertility, including injectable infertility Drugs.
16. Drugs used to promote hair growth.
17. Drugs when used for the treatment of sexual or erectile dysfunction, impotence, and anorgasmy or hyporgasmy.

18. Drugs when used for treatment of anorexia, weight loss, or weight gain, including, but not limited to, prescription or non-prescription weight loss medications, weight control programs, supplies or supplements.
19. Outpatient Drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
20. Barbiturates and Benzodiazepines.
21. Immunizing agents and injectables, biological sera, blood plasma or medications prescribed for parenteral use.
22. Federal Legend oral contraceptives and prescription diaphragms.
23. Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: athletic performance, cosmetic purposes, anti-aging and mental performance.
24. New prescription medications or supplies until they are reviewed for safety, efficacy and cost effectiveness.
25. Compound Medication: any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount, unless prior authorized by Your Part D coverage.
26. Drugs prescribed by a dentist or Drugs used for dental treatment.
27. Drugs used for diagnostic purposes.
28. Saline and irrigation solutions.
29. Replacement of lost, stolen or destroyed medications.
30. Unit dose/convenience dosage forms: Unit dose, pre-packaged medications, individual packets, etc.
31. Medications that are prescribed by Physicians or other providers who are excluded from Medicare program participation.
32. Drugs used for the symptomatic relief of cough and colds.

Please note: Your Group Policyholder **may** have elected to offer some of the Drugs listed above to You as an additional benefit. If so, You will receive additional information about the Drugs they have chosen to offer to You separately in Your Plan materials.

Early Refills

Early refills for lost, stolen or destroyed Drugs are not covered except during a declared “National Emergency.”

Early refills for vacation supplies are limited to a one-time fill of up to 30 days per calendar year.

You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days supply. This limit is set at seventy percent (70%) for prescription eye drops.

8

Section Two - Payment Responsibility

- Claims Policies and Procedures
- Coordination of Benefits

This section explains Claims payment procedures and related Claims matters. It also explains when the Company needs to coordinate Your benefits with another plan.

I. Claims Policies and Procedures

Participating Pharmacy Reimbursement. You should present Your UnitedHealthcare identification card at any Participating Pharmacy. At Participating Pharmacies, outpatient Prescription Drug Claims will be processed electronically online at point-of-sale, in accordance with the National Council for Prescription Drug Program ("NCPDP") guidelines and standards and guidelines established by the Company. UnitedHealthcare's Participating Pharmacies include most major pharmacy and supermarket chains, as well as many independent pharmacies. For an up-to-date listing of Participating Pharmacies, visit Our Web site at www.UHCRetiree.com, or contact Our Customer Service Department at 1-888-556-6648 or for the hearing impaired TTY 711, to locate a Participating Pharmacy near You.

If a UnitedHealthcare Participating Pharmacy is Not Available. The outpatient Prescription Drug benefit is generally honored only at a Participating Pharmacy. If a Participating Pharmacy is not available, the Covered Person must pay the Non-Participating Pharmacy the retail price for the Prescription Drug and then file a Claim for direct reimbursement, in accordance with the instructions in the Non-Participating Pharmacy Reimbursement or Direct Reimbursement section below.

Non-Participating Pharmacy Reimbursement or Direct Reimbursement. For prescriptions obtained at a Non-Participating Pharmacy or when submitting a Claim for direct reimbursement for Drugs, the Covered Person must complete a Claim form and submit a receipt from the pharmacist. The receipt must specify: the prescription number, name of Drug, date filled, name of pharmacy, name of patient, and proof of payment. Call the Customer Service Department at 1-888-556-6648 or for the hearing impaired TTY 711, or visit UnitedHealthcare's Web site at www.UHCRetiree.com to obtain the direct reimbursement form. The Company will reimburse the Covered Person for those Covered Services shown in the Schedule of Benefits and Covered Services section of this Certificate. Claims should be submitted to:
OptumRx
P.O. Box 29046
Hot Springs, AR 71903

Payment of Benefits. The Company will pay a benefit under the Policy for the Covered Expenses. Benefits will be paid as set forth in the Schedule of Benefits. Benefits will not exceed any maximums or limits set forth in the Policy. Benefits are subject to the Exclusions and Limitations specified in the Policy. The Definitions and all other terms and conditions of the Policy that may limit or exclude benefits also apply in determining the payment of the benefits.

Non-Duplication of Benefits. Benefits provided under the Policy will not duplicate any benefits paid by a Medicare Part D plan. The combined benefits provided under the Policy and Medicare or other coverage will never exceed one hundred percent (100%) of the charges incurred for outpatient Prescription Drug services and supplies. Additionally, if a service is covered under more than one provision of the Policy, benefits will be provided under the provision that provides the greatest benefit, but not under both provisions.

Limitation of Liability. The Company shall not be obligated to pay any benefits under the Policy for any Claims if the proof of loss for such Claim was not submitted within the period provided, unless it is shown that: (1) it was not reasonably possible to have submitted the proof of loss within such period; and (2) the proof of loss was submitted as soon as it was reasonably possible.

In no event will the Company be obligated to pay benefits for any Claim if the proof of loss for such Claim is not submitted to the Company within one (1) year after the date of loss, except in the case of legal incapacity of the Covered Person.

Notice of Claim. A written notice of Claim must be furnished to the Company within twenty (20) days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

Claim Forms. The Company will, upon receipt of notice of Claim, furnish to the Covered Person such forms as are usually furnished for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements of the Policy as to the proof of loss upon submitting within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, and the character and the extent of the loss for which a Claim is made.

Proof of Loss. Written proof of loss must be furnished to the Company at its office within ninety (90) days after the date of the loss. The Company will not reduce or deny a Claim for failure to furnish such proof within the time required, provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, the Company will not accept proof more than one (1) year from the time proof is otherwise required.

Time of Payment of Claims. Benefits for incurred outpatient Prescription Drug expenses that are covered under the Policy will be paid within forty-five (45) days of receipt of a proper Claim by the Company. If a Claim does not contain all of the information necessary to pay or deny the

Claim, the Company will request the required additional information within thirty (30) days of receipt of the Claim by the Company. If the requested information is not provided within forty-five (45) days of the date it is requested, the Company will deny the Claim and provide the reasons for denial in writing.

Time of Payment of Claims. Benefits for incurred outpatient Prescription Drug expenses that are covered under the Policy will be paid upon receipt of a proper Claim by the Company.

Payment of Benefits to Covered Person. All benefits, unless assigned under the Policy, are payable to the Covered Person.

Death or Incapacity of Covered Person. In the event of the Covered Person's death or incapacity and in the absence of written evidence to the Company of the qualification of a guardian for the Covered Person's estate, the Company may, in its sole discretion, make any and all payments of benefits under the Policy to the individual or institution that, in the opinion of the Company, is or was providing the Covered Person's care and support.

Assignments. Benefits for Covered Expenses may be assigned by the Covered Person to the person or institution providing the outpatient Prescription Drug. No such assignment will bind the Company prior to the payment of the benefits assigned. The Company will not be responsible for determining an assignment's validity. Payment of assigned benefits will be made directly to the assignee, unless a written request not to honor the assignment, signed by the Covered Person and the assignee, is received prior to payment.

Legal Actions. Any Person may not bring legal action for benefits against the Company:

1. Until at least sixty (60) days after proof of loss is sent to the Company as required; or
2. More than three (3) years after the time for submitting proof has ended.

II. Coordination Of Benefits

Coordination of Benefits. The Company will coordinate benefits with benefits available under other similar insurance policies. Coordination of Benefits between policies may result in a reduction in the amount of benefits ordinarily payable, so that the Covered Person never receives a total, from all Plans, of more than one hundred percent (100%) of Covered Expense incurred. All benefits provided under the Policy are subject to this coordination provision.

What is a Plan?

A "Plan," as used in this Coordination of Benefits provision, means any of the following policies that provide benefits or services for outpatient Prescription Drug benefits:

1. group, blanket or franchise insurance coverage;
2. prepaid coverage under service Plan contracts, or under group or individual practice;

3. any coverage under labor-management trusteed plans, union welfare plans, Employer organization Plans, or employee benefit organizations Plans;
4. any coverage in group, group-type and individual automobile “no-fault” and traditional automobile “fault” type plans;
5. Medicare or other governmental benefits, not including a state plan under Medicaid, and not including a Plan when, by law, its benefits are in excess to those of any private insurance Plan or other non-governmental Plan; or
6. any coverage under group-type contracts that is not available to the public and can only be obtained and maintained because of membership in or association with a particular organization or group.

Each Plan, or other arrangement for coverage described above, is a separate Plan. If a Plan has two parts and the Coordination of Benefits provisions only apply to one part, each part is a separate Plan. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits between those separate contracts.

What is a Covered Expense?

A Covered Expense, as used in this Coordination of Benefits provision, means any expense that is covered by at least one Plan during a Claim Determination Period; however, any expense that is not payable by the primary Plan because of the claimant’s failure to comply with cost containment requirements will not be considered a Covered Expense by the secondary Plan.

Order of Benefit Determination Rules. The following rules determine the order of benefit payment:

1. A Plan without a Coordination of Benefits provision pays before one with such a provision;
2. A Plan that covers a person other than as a Dependent pays before a Plan that covers a person as a Dependent;
3. When rules 1. and 2. do not establish the order of benefit determination, the Plan covering the Person for a longer period pays first; however:
   a. the Plan covering the person as a retired employee, or as a Dependent of a retired employee, will pay after any other Plan covering that person as a full-time employee, or Dependent of a full-time employee; and
   b. if the other Plan does not have an Order of Benefit Determination Rule regarding retired employees, then the provisions of rule 3.a. will not apply.

Effect on Benefits. Benefits will be reduced when the Policy is secondary to one or more other Plans. Benefits will be reduced when the sum of:

1. the benefits payable for the Covered Expense under this Plan without this provision; and
2. the benefits payable for the Covered Expense under the other Plans, without this provision, whether or not a Claim is made, exceed the Covered Expense in a Plan Year. Thereafter, benefits will be reduced so that coordination with benefits payable under the other Plans do not total more than the Covered Expense.

Right to Receive and Release Information. For determining the applicability and implementing the terms of this Coordination of Benefits provision or any provision of similar purpose of any other Plan, the Company may release or obtain from any insurance company or other organization or person any information, with respect to any Covered Person, which the Plan deems to be necessary for such purposes. Any Covered Person claiming benefits must furnish information necessary to implement this provision.

Reimbursement of Payment. Payments made by any organization may be reimbursed by the Company subject to Policy limitations. Such reimbursements will fully discharge the Company's liability under the Policy.

Right of Recovery. Whenever payments for Covered Expenses exceed the maximum payment necessary to satisfy the Coordination of Benefits provisions, the Company may recover such excess payments. The term "payments for Covered Expenses" includes the reasonable cash value of any benefits provided in the form of services.

Third Party Liability and Non-Duplication of Benefits

1. **Third Party Liability.** Expenses incurred due to liable Third Parties are not covered.

   Health care expenses incurred by a Covered Person for which a third party or parties or a third party's (parties') insurance Company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Certificate. However, in all cases, the Company will pay for the arrangement or provision of health care services for a Covered Person that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the Section of this Certificate captioned "The Company's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable For A Covered Person's Health Care Expenses."

   The Company's Right To The Repayment Of A Debt As A Charge Against Recoveries From Third Parties Liable For A Member's Health Care Expenses. Expenses incurred by a Covered Person for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Certificate. However, in all cases, the Company will pay for the arrangement or provision of health care services for a Covered Person that would have been Covered Services except that they were required due to a liable third party, in exchange for the following agreement:

If a Covered Person is injured by a liable third party, the Covered Person agrees to give the Company, or its representative, agent or delegate, a security interest in any money the Covered Person actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Covered Person does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect Claim against the liable third party, then the Covered Person will have no obligation to repay the Covered Person's debt to the Company, which debt shall include the cost of arranging or providing otherwise covered health care services to the Covered Person for the care and treatment that was necessary because of a liable third party.

The security interest the Covered Person grants to the Company, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Covered Person's health care services for injuries caused by a liable third party.

2. Non-Duplication of Benefits

a. Workers' Compensation. The Company shall not furnish benefits under the Policy to any Covered Person which duplicate benefits the Covered Person is entitled to under any Workers' Compensation law.
In the event of a dispute regarding the Covered Person's receipt of benefits under Workers' Compensation laws, the Company will provide the benefits described in the Policy until resolution of the dispute.

In the event the Company provides benefits which duplicate the benefits the Covered Person is entitled to under Workers' Compensation law, the Covered Person agrees to reimburse the Company, for all such benefits provided by the Company, immediately upon obtaining any monetary recovery. The Covered Person shall hold any sum collected as the result of a Workers' Compensation action in trust for the Company. Such sum shall equal the lesser of the amount of the recovery obtained by the Covered Person or the benefits furnished to the Covered Person by the Company on account of each incident.

The Covered Person agrees to cooperate in protecting the interests of the Company under this provision. The Covered Person must execute and deliver to the Company any and all liens, assignments or other documents necessary to fully protect the right of the Company, including, but not limited to, the granting of a lien right in any Claim or action made or filed on behalf of the Covered Person.

b. Medicare Benefits. The Company shall not furnish benefits under the Policy which duplicate the benefits the Covered Person is entitled to as a Medicare beneficiary.

c. TRICARE Benefits. The Company shall not furnish benefits under the Policy which duplicate the benefits to which the Covered Person is entitled under TRICARE. If payment is made by the Company in duplication of the benefits available under TRICARE, the Company may seek reimbursement up to the amount of benefits which duplicate such benefits under TRICARE.

d. Automobile, Accident or Liability Coverage. The Company shall not furnish benefits which duplicate benefits the Covered Person is entitled to under any automobile, accident or liability coverage. The Covered Person is responsible for taking whatever action necessary to obtain the available benefits of such coverage, and will notify the Company of receipt of such available benefits. If payment is provided by the Company in duplication of the benefits under other automobile, accident or liability coverage, the Company may seek reimbursement for the duplicate benefits. Should the cost of Covered Services exceed the benefits under any other liability coverage pursuant to this section, the Policy benefits will be provided over and above such liability coverage.

Section Three - Covered Person Eligibility

- Who is a Covered Person?
- Termination of Benefits

I. Who is a Covered Person?

There are two kinds of Covered Persons: the Insured Person who enrolls under the Policy through his or her former Employer and the Insured Person's eligible Dependents.

The coverage provided under the Policy is made available to You because of Your retirement from Your Employer or former Employer. In order for You to participate in the Employer's Retiree welfare benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the Employer's Retiree welfare benefit plan are determined by the Employer, or state and/or federal law. Eligibility requirements are described in general terms below. For more specific eligibility information You should contact the Human Resources or benefits department of Your former Employer.

The Insured Person must be a former employee of the Employer who: (1) has met all the eligibility requirements established by the Employer for participation in the Employer's Retiree welfare benefit plan (including, but not limited to, having attained retirement eligibility under the Employer's Retiree welfare benefit plan); and (2) is eligible for, and enrolled in, a Medicare Part D plan issued by the Company.

Eligible Dependents include a Spouse of the Insured Person enrolled under the Policy if such Spouse (1) is eligible for coverage under the Employer's Retiree welfare benefit plan; and (2) is eligible for, and enrolled in, a Medicare Part D plan issued by the Company.

Notification of Eligibility Change. Any Covered Person who no longer satisfies the eligibility requirements is not covered by the Policy and has no right to any of the benefits described in the Certificate. The Company must be notified within thirty-one (31) days of any condition that may affect eligibility.

II. Termination of Benefits

Individual Terminations. A Covered Person's coverage will terminate on the earliest of the following:

1. the date the Policy terminates;
2. the last day of the Insurance Month in which the Covered Person requests termination;
3. the last day of the last Insurance Month for which premium payment is made on behalf of the Covered Person;

4. the date the Covered Person ceases to be eligible for coverage under the Policy; or
5. with respect to any particular insurance benefit, the date that benefit terminates.

Fraud or Deception. At its discretion, the Company may terminate or rescind the Policy or a Covered Person's coverage thereunder, if the following are true:

1. such Covered Person knowingly provides the Company with fraudulent information upon which the Company relies; and
2. such information materially affects the Covered Person's eligibility for enrollment or benefits under the Policy. In such instance, the Company shall send a written notice of termination or rescission to the Insured Person. It shall also refund any unearned premium which applies after the date of termination or rescission.

Fraudulent Use of Identification Card. A Covered Person's eligibility for coverage under the Policy shall immediately terminate if such Covered Person permits the use of his or her insurance identification card by any other person. In such instance, the Company shall mail a written notice of termination to the Covered Person. It shall also refund any unearned premium which applies after the date of termination.

Please Note: No coverage shall be in force and no benefit shall be payable for charges which are incurred after the date a Covered Person's coverage terminates for any reason under this Certificate, except as provided by any applicable continuation coverage which the Covered Person elects and submits premium in a timely manner.

Coverage Options Following Termination of Individual Coverage. Following termination of coverage, a Covered Person may be entitled to coverage under the employer group's primary Part D plan or an individual Medicare Part D plan.

Section Four - Decisions Regarding Benefits

- Appealing a Decision Relating to Benefits
- The Appeals Process
- Statement of ERISA Rights

I. Appealing a Decision Relating to Benefits

A Covered Person and the Company may not always agree that a Claim or request for Covered Services had been reviewed properly. When this happens, the Covered Person‘s first step should be to call the Company’s Customer Service Department. The Company’s Customer Service Department coordinator will assist the Covered Person and attempt to find a solution to the Covered Person’s problem or grievance.

If the Covered Person feels that his or her problem or grievance requires additional action, the Covered Person may also request a formal Appeal.

The Company’s appeals review procedures are designed to deliver a timely response and resolution to a Covered Person’s problem or grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the problem or grievance. The Covered Person may submit a formal appeal within 180 days of the receipt of an initial determination through the Company's Appeals Department. To initiate an appeal, call the Company’s Customer Service Department or write the Appeals Department at the address below:

UnitedHealthcare Insurance Company
Appeals Department
P.O. Box 6106, MS CA124-0197
Cypress, CA 90630-0016
1-888-556-6648

This written request will initiate the following Appeals Process, except in the case of “Urgent Requests” as discussed below. A Covered Person, or a representative appointed by a Covered Person including an Attorney, may submit written comments, documents, records and any other information relating to Your appeal regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to Your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

The Company will review Your appeal and if the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of Your appeal.

II. The Appeals Process

The Company will review Your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination not later than thirty (30) days of the Company's receipt of the appeal. For appeals involving the delay, denial or modification of health care services, the Company's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the Certificate that exclude that coverage.

Urgent Requests. Appeals involving an imminent and serious threat to Your health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to the Company's clinical review personnel. If Your case does not meet the criteria for an Urgent Request, it will be reviewed under the appeal process. If Your appeal requires urgent review, the Company will immediately inform You in writing of Your review status.

Independent Review. If You receive an adverse determination of an appeal to the Company, You may direct the Company to seek a review of that determination by an independent review organization. An adverse determination is a determination that services furnished or proposed to be furnished are not Medically Necessary. You are entitled to an immediate appeal to the independent review organization, without first following the Company's internal appeals process, if the situation involves a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted. Independent reviews will be conducted in accordance with applicable state law and will be made at no cost to You.

III. Statement of ERISA Rights

Contact Your Employer's Benefit Administrator to learn whether Your plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA). If You participate in an ERISA employee welfare benefit plan, ERISA provides You with certain rights and protections.

1. All benefit determination or Claim procedures are described for You in Your summary plan description.
2. If You receive an adverse benefit determination, a determination notice will be forwarded to You, electronically or in writing, within a reasonable time not to exceed ninety (90) days of the date the Claim is submitted.
3. You may appeal any adverse benefit determination. ERISA provides You with at least one hundred eighty (180) days from the day You receive notice of an adverse benefit determination to appeal it. You will be provided an opportunity to submit relevant information in support of Your appeal.
4. ERISA provides for up to two (2) mandatory appeal levels for any adverse determination. You have a right to bring a civil action on any adverse determination that You believe, after participating in the mandatory appeal process, was incorrectly made under Your plan.

5. ERISA provides that, in connection with any appeal of an adverse benefit determination, You have the right to request access to and receive a free copy of any and all documents, records, and other information, as follows:
   a. Relied on in making Your benefit determination;
   b. Submitted, considered, or generated in the course of making Your benefit determination;
   c. Which demonstrates compliance with administrative safeguards concerning consistent application of the plan document among similar claims, and
   d. Any plan Policy statement or guidance regarding Your diagnosis.
6. ERISA provides that most benefit appeal determination notices will be forwarded to You, in writing, within a reasonable period not to exceed sixty (60) days from the date of the plan's receipt of the benefit appeal request.
7. Your participation in a voluntary appeal level does not affect Your legal review rights, or any rights You have under Your plan. Any statute of limitations will be tolled during the time You participate in a voluntary review level.
8. You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor office and Your state insurance regulatory agency.

20

Section Five - Definitions

The Company is dedicated to making its services easily accessible and understandable. To help You understand the precise meanings of many terms used to explain Your benefits, We have provided the following definitions. These definitions apply to the capitalized terms used in Your Certificate, as well as the Schedule of Benefits.

30-Day Supply means, for most oral medication, the maximum amount (quantity) of medication that may be dispensed per single Copayment and/or Coinsurance amount at any one time during a 30-day period.

90-Day Supply means, for most oral medication, the maximum amount (quantity) of medication that may be dispensed per single mail service Copayment and/or Coinsurance amount at any one time during a 90-day period.

Administrator means an appropriately licensed organization with whom the Company has contracted to perform administration services. Applicable Administrators are identified under the Administrators section of the Certificate.

Brand Name Drug means a pharmaceutical product protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the Drug by other companies without consent of the innovator, as long as the patent remains in effect.

Certificate means this summary of the terms of Your Benefits. The Certificate is attached to and is part of the Policy issued to the Group Policyholder and is subject to the terms of the Policy.

Claim means notification in a form acceptable to the Company that a Covered Service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such Covered Service as required by the Company.

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) that regulate the conditions and manner in which an Employer must offer continuation of group health insurance to Covered Persons whose coverage would otherwise terminate under the terms of the Policy.

Coinsurance means that portion of the Covered Expense, which is not payable as a benefit due to the Percentage Payable being less than one hundred (100%). Coinsurance does not include any Deductibles or Copayments. Coinsurance does not include any amounts payable by the Covered Person because Prior Authorization was not obtained. Coinsurance does not include any amounts payable by the Covered Person, which are not considered as Covered Expense under the Policy.

Copayment means that portion of Covered Expenses which are the responsibility of the Covered Person and which are shown as Copayments on the Schedule of Benefits.

Covered Expense means an expense that:

1. is incurred for a Covered Service provided to a Covered Person; and
2. does not exceed the smallest of any Policy maximum that may apply to the Covered Expense.

Covered Person means the Insured Person or the eligible Dependent(s) of the Insured Person who are insured under the Policy.

Deductible means the amount of Covered Expense a Covered Person must pay before benefits become payable under the Policy. Until You satisfy the Deductible, You will pay 100% of the Company's contracted rate with the pharmacy for the medication and that amount will be applied toward Your Deductible.

Dependent means a person who is the Insured Person's Spouse who is not legally separated from the Insured Person and who is covered under a Medicare Part D plan issued by the Company.

Dependent Insurance means the group health insurance provided by the Policy for Dependent(s) of the Insured Person.

Drugs or Prescription Drugs mean those pharmaceutical substances required by law to be dispensed by prescription.

Effective Date means, with respect to any Covered Person, the date such Covered Person is first insured under the Policy.

Employer means the Group Policyholder approved by the Company for participation in the coverage provided by the Policy.

Generic Drug means a Drug that is designated as a Generic Drug according to Medispan, inclusive of single-source and multi-source generics.

Group Policyholder means the person, partnership, corporation or trust as shown on the Policy Information Page of the Policy.

Hospital means an acute care Facility operated pursuant to state laws and:

1. is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or by the Medicare program;
2. is primarily engaged in providing, for compensation from its patients, diagnostic and surgical facilities for the care and treatment of injured or sick individuals by or under the supervision of a staff of Physicians;
3. has 24-hour nursing services by registered nurses; and
4. is not primarily a place for rest or custodial care, or a nursing home, convalescent home or similar institution.

Insurance Month means that period of time:

1. beginning at 12:00 a.m. Standard Time at the Group Policyholder's principal location on the first day of any calendar month; and
2. ending at 11:59 p.m. on the last day of the same calendar month.

Insured Person means the Retiree for whom coverage is in effect as provided by the Policy.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the Treating Physician and by the Company's medical director to be all of the following:

1. A Health Intervention for the purpose of treating a medical condition;
2. The most appropriate supply or level of service, considering potential benefits and harms to the Covered Person;
3. Known to be Effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
4. If more than one Health Intervention meets the requirements of (1) through (3) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Covered Person.

A service or item will be covered under the Company health plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated, yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

- "Treating Physician" means the Physician who has personally evaluated the Covered Person.
- A "Health Intervention" is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat, or palliate) a medical condition or to maintain or restore functional ability. A "medical condition" is a disease, sickness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of

normal, age-appropriate human variation. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and the Covered Person's indications for which it is being applied.

- "Effective" means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- "Health outcomes" are outcomes that affect health status as measured by the length or quality (primary as perceived by the patient) of a person's life.
- "Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and the health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- A "new intervention" is one that is not yet in widespread use for the medical condition and Covered Person's indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

Medicare means Hospital Insurance Plan (Part A), Medical Insurance (Part B), and the supplementary Outpatient Prescription Drug Insurance Plan (Part D) provided under Title XVIII of the Social Security Act, as amended.

Non-Participating Pharmacy means a pharmacy that has not contracted with the Company.

Off-Label Drug means a Drug that is used for a purpose that is different from the use for which the Drug has been approved by the Food and Drug Administration (FDA). The Company excludes coverage for Off-Label Drugs, including Off-Label self-injectable Drugs, except as described in this Certificate. If an Off-Label Drug is prescribed for use, the Drug and its administration will be covered only if it satisfies the following criteria:

- The Drug is approved by the FDA for at least one indication;
- The Drug is prescribed by a provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
- The Drug is Medically Necessary to treat the condition;
- The Covered Person has failed, is intolerant of, or has contraindications to standard therapies;
- The Drug has been recognized for treatment of the indication for which the Drug is prescribed in a standard drug reference compendium approved by the Texas Commissioner of Insurance for this purpose, or substantially accepted by scientific studies published in any peer-reviewed medical literature.

Nothing in this section shall prohibit the Company from use of a formulary, or Copayment and/or Coinsurance.

Participating Pharmacy means a pharmacy that has contracted with the Company to provide outpatient Prescription Drugs to a Covered Person at negotiated costs.

Plan Year Deductible means the amount of Covered Expense shown on the Schedule of Benefits that a Covered Person is responsible for paying each Plan Year before benefits are payable under the Policy.

Plan Year means any consecutive twelve-month period beginning on the Effective Date shown in the Policy.

Percentage Payable means the benefits payable under the Policy which are a percentage of the Covered Expense in excess of all Deductibles and Copayments. The Percentage Payable for each type of Covered Service is set forth in the Schedule of Benefits.

Personal Insurance means the group Prescription Drug insurance provided by the Policy on Insured Persons.

Physician means a licensed doctor of allopathy or osteopathy who is practicing within the scope of his or her licensure, and any other practitioner of the healing arts who renders services within the scope of his or her licensure.

Policy means the Group Health Insurance Policy issued by the Company to the Group Policyholder.

Policy Anniversary means the annual date stated as the "Policy Anniversary" on the Policy Information Page of the Policy.

Policy Effective Date means the date stated as the "Policy Effective Date" on the Policy Information Page of the Policy.

Prescription Unit means the maximum amount (quantity) of medication that may be dispensed per single Copayment. For most oral medications, a Unit represents a 30-day supply or 90-day supply (through the mail service benefit) of medication. For other medications, a Unit represents a single container, inhaler unit, vial, package or course of therapy. The Unit will be tripled, e.g., 3 containers, 3 inhaler units, etc., if the medication is dispensed through the mail service benefit for a 90-day supply. For Drugs that could be habit-forming, a Unit may be set at a smaller quantity for the Covered Person's protection and safety.

Prior Authorization means getting approval in advance to obtain certain Drugs that may or may not be on the Company's formulary. Some Drugs are covered only if the Covered Person's Physician or other provider gets Prior Authorization from the Company. Covered Drugs that require Prior Authorization are marked in the formulary. If Prior Authorization is required, it must be obtained or the Drug might not be covered under the Policy.

Retiree means a former employee of the Employer who: (1) has met all the eligibility requirements established by the Employer for participation in the Employer's Retiree welfare benefit plan; (2) is eligible for, and enrolled in, Medicare Part D; and (3) is entitled to benefits under the Policy.

Self-Injectable means those Drugs which are either generally self-administered by Intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the subcutaneous route.

Spouse means a legally married spouse as recognized under federal law.

We, Our, Us and Company mean UnitedHealthcare Insurance Company.

You and Your mean the Insured Person.

26

Section Six - General Provisions

Certificate. Each Covered Person will receive individual Certificates. These Certificates summarize the benefits provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Clerical Error. Clerical error does not invalidate insurance otherwise validly in force, nor continue insurance otherwise validly terminated. Neither the passage of time nor the payment of premiums for a person who is not eligible for insurance under the terms of the Policy makes this insurance valid for such person. In this event, the Company's only liability is the proper refund of unearned premiums. If a premium adjustment requires the refund of unearned premium, the maximum refund is the six- (6) month period preceding the date the Company receives proof of the adjustment. The Company can request such information while the Policy is in force and for one (1) year after the Policy ends.

Conformity to State and Federal Law. The Company amends any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

Group Policyholder Not Our Agent. The Group Policyholder is not an agent of the Company.

Provider As Independent Agent. The Company does not undertake to directly furnish any health care service under the Policy. The obligations of the Company under the Policy are limited to the payment for health care service provided to Covered Persons by providers who are independent agents.

Outpatient Prescription Drug Records. The Company shall have access to outpatient Prescription Drug and treatment records of Covered Persons to determine benefits, process Claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a Claim based on lack of supporting outpatient Prescription Drug information or records.

Recovery of Payments. The Company reserves the right to deduct from any benefits properly payable under the Policy the amount of any payment which has been made:

1. in error;
2. pursuant to a misstatement contained in a Claim;

3. pursuant to a misstatement made to obtain coverage under the Policy within two (2) years after the date such coverage commences;
4. with respect to an ineligible person; or
5. pursuant to a Claim for which benefits are recoverable under any Policy or act of law provided for coverage for occupational injury or disease to the extent that such benefits are recoverable. This provision shall not be deemed to require the Company to pay benefits under the Policy in any such instance.

Such deduction may be made against any Claim for benefits under the Policy by a Covered Person if such payment is made with respect to such Covered Person.

Discharge of Liability. Any payment made in accordance with the provisions of the Policy shall fully discharge the liability of the Company to the extent of such payment.

Right to Receive Information. The Group Policyholder shall provide the Company with the information necessary to administer coverage under the Policy. Payroll and any other records of an Insured Person relating to coverage under the Policy shall be open for review by the Company at any reasonable time. The Company may request that information needed to compute the premium be furnished at least once each year.

Time Effective. Whenever an Effective Date of coverage or termination date of coverage is specified by the Policy, such commencement of coverage will be effective as of 12:00 a.m. of that date.

Waiver of Rights. The Company's failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect the Company’s right to enforce any other provision of the Policy.

28

Section Seven - Schedule of Benefits

Outpatient Prescription Drug Benefit

The Company will pay an outpatient Prescription Drug Benefit for Covered Expense incurred by a Covered Person for Covered Services described in this Certificate. The benefit will be subject to the Copayments and/or Coinsurance and Exclusions and Limitations described in this Certificate, and will not exceed any applicable maximum shown in this Schedule of Benefits.

This Schedule of Benefits focuses on what You pay for Your outpatient Prescription Drugs under this Policy. To keep things simple, We use the term "Drug" to mean any Prescription Drug, item or medication that is included under this Policy.

To understand the payment information We give You in this section, You need to know the basics of what Drugs are covered. Your Medicare Part D plan materials issued by the Company will provide You with information for prescription coverage under Your Part D plan. This Schedule of Benefits provides information for obtaining benefits under this outpatient Prescription Drug Policy.

This Policy covers amounts that are payable after the Medicare Part D plan issued by the Company has paid, and/or after any applicable discounts have been applied. Benefits will be paid as set forth below.

Drug Tiers

Every Drug on the Drug List is included in a tier as defined below. In general, the higher the tier number, the higher Your cost for the Drug. **Please refer to the cost share charts under the Drug Payment Stages in this Schedule of Benefits section to determine what Your out-of-pocket costs may be under this Policy.**

Tier 1 – includes all Generic Drugs and some Brand Name Drugs
Tier 2 – includes many common Brand Name Drugs
Tier 3 – includes non-preferred Brand Name Drugs
Tier 4 – includes unique or very high-cost Drugs

For the Catastrophic Coverage Stage, Tier 1 will include only Generic Drugs and Tier 2 will include only Brand Name Drugs.

Drug List

To find out which tier Your Drug is in, look it up in the Drug List. If You need a copy of the Drug List, You may access it by going online at www.UHCRetiree.com or request a paper copy by calling Customer Service Department at 1-888-556-6648.

We will generally cover a Drug on the Drug List as long as You follow the other coverage rules explained in this Schedule of Benefits and the Drug is Medically Necessary, meaning

reasonable and necessary, for treatment of Your illness or injury. It also needs to be an accepted treatment for Your medical condition.

The Drug List can change during the year

Most of the changes in Drug coverage happen at the beginning of each Plan Year. However, during the year, many kinds of changes may be made to the Drug List. For example:

- **Addition or removal of Drugs from the Drug List.** New Drugs become available, including new Generic Drugs. Perhaps the government has given approval to a new use for an existing Drug. Sometimes, a Drug gets recalled and We decide not to cover it, or We might remove a Drug from the list because it has been found to be ineffective.
- **A Drug is moved to a higher or lower tier.**
- **A Brand Name Drug is replaced with a Generic Drug.**

Do changes to Your Drug coverage affect You right away?

If any of the following types of changes affect a Drug You are taking, the change will not affect You until the next Plan Year if You stay in the Plan:

- If We move Your Drug into a higher tier.
- If We remove Your Drug from the Drug List, but not because of a sudden recall or because a new Generic Drug has replaced it.

If any of these changes happens for a Drug You are taking, then the change won't affect Your use or what You pay as Your share of the cost until the next Plan Year. Until that date, You won't see any increase in Your payments or any added restriction to Your use of the Drug. However, on the first day of the next Plan Year, the changes will affect You.

In some cases, You will be affected by the coverage change before the next Plan Year. In this case, You should work with Your doctor to switch to the Generic Drug or to a different Drug that We cover.

If a Drug is suddenly recalled because it's been found to be unsafe or for other reasons, the Drug will immediately be removed from the Drug List. Your doctor will know about this change, and can work with You to find another Drug for Your condition.

The Plan's Pharmacy Directory. In most situations You must use a Participating Pharmacy to get Your covered Drugs. A Participating Pharmacy is a pharmacy that has a contract with the Company to provide Your covered Drugs. The term "covered Drugs" means all of the Drugs that are covered by this Policy. The **Pharmacy Directory** has a list of Participating Pharmacies and it explains how You can use the mail order service. It also explains how You can get a long-term supply of a Drug (such as filling a prescription for a three month's supply). You can access the Pharmacy Directory online at www.UHCRetiree.com or request a paper copy by calling Customer Service at 1-888-556-6648.

30

Using Non-Participating Pharmacies. We generally cover drugs filled at a Non-Participating Pharmacy **only** when You are not able to use a Participating Pharmacy.

Note: If You use a Non-Participating Pharmacy, You may be responsible for paying the difference between what We would pay for a prescription filled at a Participating Pharmacy and what the Non-Participating Pharmacy charged for Your prescription.

Here are the circumstances when We would cover prescriptions filled at a Non-Participating Pharmacy:

- **Prescriptions for a medical emergency.** We will cover prescriptions that are filled at a Non-Participating Pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in the Drug List without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling.** If You take a prescription Drug on a regular basis and You are going on a trip, be sure to check your supply of the Drug before You leave. When possible, take along all the medication You will need. You may be able to order Your prescription Drugs ahead of time through Our Mail Service Pharmacy program or through other Participating Pharmacies. If You are traveling within the U.S. and become ill or run out of or lose Your prescription Drugs, We will cover prescriptions that are filled at a Non-Participating Pharmacy if You follow all other coverage rules**. In this situation, please check first with Customer Service to see if there is a Participating Pharmacy nearby.**

What is Your share of cost for Drugs covered under this plan?

The Copayment and/or Coinsurance for a covered Drug depends on:

1. Which Medicare Part D Drug Payment Stage You are in;
2. The tier for the Drug; and
3. Where You fill Your prescription; and
4. The “daily cost sharing rate” if You received less than a one month supply.

The “daily cost sharing rate” means the Copayment and/or Coinsurance amount applied to certain prescriptions filled under Your Part D coverage for less than a one month supply. This provides You, in consultation with Your Physician, the option of a shorter day supply of a new prescription without having to pay a full month’s Copayment and/or Coinsurance.

Drug Payment Stages

As shown below, there are various “Drug Payment Stages” for Your Prescription Drug coverage under Your Medicare Part D coverage. How much You pay under this Prescription Drug Policy for a Drug also may depend on which of these stages You are in at the time You get a prescription filled or refilled under Your Part D coverage.

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We keep track of the costs of Your Prescription Drugs and the payments You have made when You get Your prescriptions filled or refilled at the pharmacy. This way, We can tell You when You have moved from one Drug Payment Stage to the next. For each month in which You fill a prescription, You will receive an Explanation of Benefits in the mail indicating what Drug Payment Stage You are in.

For some Drugs, You can get a longer-term supply (also called an "extended supply") when You fill Your prescription. This can be up to a 90-day supply. The tables below show what You pay when You get a 30-day supply and a longer-term up to 90-day supply of a Drug.

Initial Coverage Level Stage (ICL): During the Initial Coverage Level Stage, Your Part D coverage plan pays its share of the cost of Your covered Prescription Drugs, and You pay Your share. Your share of the cost will vary depending on the Drug and where You fill Your prescription. You stay in this stage until Your Part D Drug payments for the year total the Medicare ICL for the Plan Year. At that time You enter the Coverage Gap Stage.

Your cost share during the Initial Coverage Level Stage of coverage is:

For Part D Drugs

	Participating Pharmacy	The Plan's Participating Pharmacy Mail Service Pharmacy Program
	(when You get a 30-day supply (or less) of a covered Drug)	(when You get a longer-term supply up to 90 days of a covered Drug)
Tier 1	$10 Copayment	$20 Copayment
Tier 2	$25 Copayment	$50 Copayment
Tier 3	$75 Copayment	$150 Copayment
Tier 4	$75 Copayment	$150 Copayment

Coverage Gap Stage: You stay in this stage until Your Part D payments for the year total the Medicare True Out of Pocket (TrOOP) amount for the current Plan Year. Refer to your Medicare Part D plan materials for information about the TrOOP amounts and requirements.

When You enter the Medicare Part D Coverage Gap, this Prescription Drug Policy will cover certain Drugs that are not being covered by Your Part D coverage, or a portion of the cost of certain Drugs that Your Part D coverage does still cover.

32

Your cost share during the Coverage Gap Stage of coverage is:

For Part D Drugs

	Participating Pharmacy	The Plan's Participating Pharmacy Mail Service Pharmacy Program
	(when You get a 30-day supply (or less) of a covered Drug)	(when You get a longer-term supply up to 90 days of a covered Drug)
Tier 1	$10 Copayment	$20 Copayment
Tier 2	$25 Copayment	$50 Copayment
Tier 3	$75 Copayment	$150 Copayment
Tier 4	$75 Copayment	$150 Copayment

Catastrophic Coverage Stage: Once You are in the Part D Catastrophic Coverage Stage, You will stay in this stage for the rest of the year. Once You have paid enough for Your Part D Drugs to move on to this last payment stage, **Your Part D plan will pay most of the cost** of Your Part D Drugs for the rest of the year.

Your cost share during the Catastrophic Coverage Stage of coverage is:

For Part D Drugs

	Participating Pharmacy	The Plan's Participating Pharmacy Mail Service Pharmacy Program
	(when You get a 30-day supply (or less) of a covered Drug)	(when You get a longer-term supply up to 90 days of a covered Drug)
Tier 1	$3.35 Copayment	$3.35 Copayment
Tier 2	$8.35 Copayment	$8.35 Copayment

NOTE: THIS CERTIFICATE CONSTITUTES ONLY A SUMMARY OF THE BENEFITS AVAILABLE UNDER THE EMPLOYER'S PLAN. THE POLICY BETWEEN THE COMPANY AND THE GROUP POLICYHOLDER MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE POLICY WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT UNITEDHEALTHCARE INSURANCE COMPANY AND YOUR EMPLOYER'S PERSONNEL OFFICE.

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UnitedHealthcare® RxSupplement™ is not a Medicare Part D prescription drug plan. This is an employer group retiree prescription drug plan. UnitedHealthcare RxSupplement group retiree prescription drug plans are underwritten by UnitedHealthcare® Insurance Company or, in New York, UnitedHealthcare Insurance Company of New York. These are private insurance companies not connected with or endorsed by the U.S. Government or the federal Medicare program. RxSupplement plans may not be available in all states. UnitedHealthcare is part of the UnitedHealth Group family of companies.

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FIRST SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT (Revision Date: January 1, 2018) UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (Amended and Restated Effective as of January 1, 2018)

General

This Summary of Material Modifications ("***SMM***") amends certain portions of the Summary Plan Description of the Group Health Benefit under the Anadarko Petroleum Corporation Retiree Health Benefits Plan (Amended and Restated Effective as of January 1, 2018), Revision Date: January 1, 2018 ("***Group SPD***"), and is effective as provided below. You should keep this SMM with your copy of the Group SPD which more fully describes the Plan.

Capitalized terms not defined herein shall have the meanings ascribed to them under the terms of the Group SPD. Any provisions of the Group SPD that are not specifically modified by this SMM have not been changed and thus remain in effect.

For purposes of clarification, each of the amendments set forth in this SMM are further subject to Article IX of the "Primary Document – Wrap SPD – Group Health Benefit under the APC Retiree Health Plan (2018)" of the Group SPD and Article V of the Wrap-Plan.

Change of Control Amendments

1. The Group SPD is amended, effective as of January 1, 2019, to provide that, upon the occurrence of a change of control, an Employee who is a party to a change of control agreement with the Plan Sponsor (or another Employer) ("**COC Agreement**") will be accredited with additional years of employment service for purposes of determining his eligibility as a "retiree" to participate in the group health benefit of the Plan, to the extent required by, and in accordance with, the applicable terms of the Employee's COC Agreement.

2. The Group SPD is further amended, effective as of January 1, 2019, to provide that, to the extent an Employee who is a party to a COC Agreement receives extended coverage under the Anadarko Petroleum Health Benefits Plan pursuant to his COC Agreement following his termination of employment with the Employer ("**Extended COC Coverage**"), such Employee will be provided a 31-day period immediately following the last day of his Extended COC Coverage in which to enroll himself and his Dependents in all of the Group Health Programs for which they are eligible.

Dental Benefit Changes

3. Effective as of January 1, 2019, the UnitedHealthcare Dental Benefits Program of the Group SPD is amended to provide for coverage of (a) implant-related dental procedures which are not accident-related services and are associated with hypodontia, oligondontia, or anodontia, and (b) treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (*i.e.*, extra) teeth, including when part of a congenital anomaly such as cleft lip or cleft palate, subject to an aggregate annual coverage maximum amount of $50,000.

Coverage of Gender Dysphoria Treatment

4. Effective as of January 1, 2019, the UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program, UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program, and UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program of the Group SPD are amended to provide medical services related to the treatment of gender dysphoria, as follows:

The United Health Care Programs ended Dec 31, 2020 and were replaced with the Aetna programs. See the Second SMM for more information.

Gender Dysphoria

Benefits are available for the treatment of gender dysphoria which is limited to the following services:

- Benefits for psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses, which are provided as described under *Mental Health Services* in this Section 6.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a Physician (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* of this Section 6.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described under Section 15, *Prescription Drug Products.*
- Puberty suppressing medication injected or implanted by a Physician in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for gender dysphoria, including the surgeries listed below:

  Male to Female:

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

  Female to Male:

  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)

- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

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

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

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

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

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

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization (as described in Section 4, *Personal Health Support and Prior Authorization*) as soon as the possibility of surgery arises.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

Gender Dysphoria services are subject to the following payment terms:

Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:	
	Designated and Network	**Non-Network**
Gender Dysphoria	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 Section 15, *Prescription Drug Products*.	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 Section 15, *Prescription Drug Products*.

Excluded from coverage are Cosmetic Procedures for Gender Dysphoria, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

New Wellness Programs

5. Effective as of November 1, 2018, the UnitedHealthcare POS Choice Plus Plan Medical Benefits Program, UnitedHealthcare PPO Options (Utah) Plan Medical Benefits Program, UnitedHealthcare Out of Area Options Plan Medical Benefits Program, UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program, UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program, and UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program of the SPD are each amended to provide the following new wellness programs:

The United Health Care Programs ended Dec 31, 2020 and were replaced with the Aetna programs. See the Second SMM for more information.

Quit For Life® Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the Claims Administrator at the number on the back of your ID card.

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no copayments, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit www.realappeal.com. When provided under the Group Health Benefit of the APC Retiree Health Benefits Plan, the Real Appeal program is available only for eligible retirees who have not reached Medicare eligibility due to age and their eligible family members.

***

Except as modified herein, you should refer to your copy of the Group SPD for any questions relating to the Group Health Benefit under the Anadarko Petroleum Corporation Retiree Health Benefits Plan.

SECOND SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN (Amended and Restated Effective as of January 1, 2018)

This Second Summary of Material Modifications ("***SMM***") amends certain portions of the Summary Plan Description of the Group Health Benefit ("***Group SPD***") under the Anadarko Petroleum Corporation Retiree Health Benefits Plan, Amended and Restated Effective as of January 1, 2018 ("***APC Retiree Health Plan***"), and is effective as provided below. You should keep this SMM with your copy of the Group SPD which more fully describes the Plan.

Capitalized terms not defined herein shall have the meanings ascribed to them under the terms of the Group SPD. Any provisions of the Group SPD that are not specifically modified by this SMM have not been changed and thus remain in effect.

For purposes of clarification, please note that each of the changes set forth in this SMM are subject to Article II and Article IX of the Wrap SPD – Group Health Benefit ("***Primary Document***") under the APC Retiree Health Plan of the Group SPD.

1. Effective 11:59 p.m. on December 31, 2020, the following Programs and the application of their corresponding Group Health Program Documents were terminated:

    a. Program 1 – "UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program (Pre-65 Program only)";
    b. Program 2 – "UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program (Pre-65 Program only)";
    c. Program 3 – "UnitedHealthcare HDHP Out of Area Options Plan Medical Benefits Program (Pre-65 Program only)"; and
    d. Program 4 – "UnitedHealthcare Dental Benefits Program (Post-65 Program and, for certain dependents only, a Pre-65 Program)".

2. Effective January 1, 2021, all references to the Anadarko Benefits Center in the Group SPD shall mean the OxyLink Employee Service Center, 4500 South 129th East Avenue, Tulsa, OK 74134-5801, 1-800-699-6903 (US), 1-918-610-1990 (Outside US), oxylink@oxy.com.

3. Effective January 1, 2021, the Group SPD was amended to replace pages 1 and 2 with the documents at Attachment A.

4. Effective January 1, 2021, Section 1.3 of the Primary Document was replaced entirely with the following:

    "**1.3 Benefits Committee** means the Occidental Petroleum Corporation Employee Benefits Committee, which is a committee of one or more Employees appointed by the Plan Sponsor to act as named fiduciary and Plan Administrator of

the Plan (including the Group Health Benefit). References herein to the Benefits Committee or Plan Administrator shall include, when appropriate, any Employee, Claims Administrator, or other person or entity who has been delegated the appropriate authority by the Benefits Committee as Plan Administrator in accordance with Section 10.4."

5. Effective 11:59 p.m. on December 31, 2020, the Primary Document was amended to remove Section 5.1(b).

6. Effective January 1, 2021, Article XIV of the Primary Document was replaced with the document at Attachment B.

7. Effective January 1, 2021, the Primary Document was amended to replace Appendices B, C, D, E, and G with the documents at Attachment C.

8. Effective January 1, 2021, the Group SPD was amended to add to the Group Health Benefit the following two Programs ("***New Programs***") with the corresponding Group Health Program Documents:

    a. **Oxy Retiree Medical Program for Anadarko Retirees** – The terms, conditions, and benefits of this Program are within the Group Health Program Document which is Attachment D to this SMM.

    b. **Oxy Retiree Dental Program for Anadarko Retirees** – The terms, conditions, and benefits of this Program are within the Group Health Program Document which is Attachment E to this SMM.

    The New Programs and their corresponding Group Health Program Documents are subject and subordinate to Article II of the Primary Document, whereby the Primary Document and Wrap-Plan shall control over any conflicting or inconsistent provisions of a Group Health Program Document. Under no circumstances shall the New Programs or this SMM change the eligibility requirements in Appendix F of the Primary Document. For purposes of clarity, eligibility to receive benefits from the New Programs of the Group Health Plan is determined solely by the terms of Appendix F to the Primary Document.

    The utilization by the APC Retiree Health Plan of the Group Health Program Documents for the New Programs shall have no effect upon the Occidental Petroleum Corporation Retiree Medical Plan, which is an independent plan distinct and separate from the APC Retiree Health Plan.

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Except as modified herein, you should refer to your copy of the Group SPD for any questions relating to the Group Health Benefit under the Anadarko Petroleum Corporation Retiree Health Benefits Plan.

SECOND SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

Attachment A

How to Use this Summary Plan Description of the Group Health Benefit under the APC Retiree Health Plan

The Anadarko Petroleum Corporation Retiree Health Benefits Plan ("***APC Retiree Health Plan***") offers group medical, dental and prescription drug coverage to eligible retirees and their dependents, as well as certain surviving dependents of deceased employees, under the portion of the APC Retiree Health Plan called the "Group Health Benefit". Coverage under the Group Health Benefit is provided through variety of "***Programs***", as listed at the bottom of this page, based on whether the covered person (a) has *not* yet attained Medicare-eligibility due to age ("***Pre-65 Programs***") or (b) has already attained Medicare-eligibility due to age ("***Post-65 Programs***").[1]

A Summary Plan Description of the Group Health Benefit ("***SPD***") has been prepared in order to summarize the provisions of the Group Health Benefit under the APC Retiree Health Plan. The SPD consists of five documents, which are all contained in this portable document format or "*PDF*." To move around in the document, please click on the "*Bookmarks*" tab which should be on the left side of the PDF.[2] The first document of the SPD is the *Primary Document – Wrap-SPD – Group Health Benefit under the APC Retiree Health Plan (2018)* ("***Primary Document***"). The Primary Document contains eligibility and enrollment provisions of the Plan and summarizes other Plan provisions and terms which are generally applicable to all Programs (except as otherwise noted). The remaining three documents, which are numbered 1 through 4 below (each a "***Program Document***"), include specific provisions applicable to each Program.

If you desire to know about the benefits and coverage terms under a particular Program, please reference both the Primary Document and the applicable Program Document. Please also see "*Article II – Interpretation*" of the Primary Document for a discussion of how the Primary Document and the Program Documents operate together and which prevails in the event of a conflict. As reflected in Appendix G of the Primary Document, the Programs and their related Program Documents are as follows:

Program	#	Program Document
Oxy Retiree Medical Program for Anadarko Retirees (*Pre-65 Program only*)	1	MEDICAL PLAN – Oxy Retiree Non-Medicare Eligible – Aetna Choice POS II Network 2019
Oxy Retiree Dental Program for Anadarko Retirees (*Pre-65 Program only*)	2	Retiree Dental Plan – Dental PPO/PDN with PPOII Network

Table Continues on the Next Page

[1] The Summary Plan Description of the Group Health Benefit is one of two components of the full Summary Plan Description of the APC Retiree Health Plan. Apart from the Group Health Benefit, other group health benefits are provided to eligible individuals under the Plan. Such benefits are described in a separate summary plan description document that constitutes the other component of the full Summary Plan Description of the Plan.

[2] If you cannot see the Bookmarks tab, please go to "View", select "Show/Hide", then select "Navigation Panels", then select "Bookmarks."

Program	#	Program Document
UnitedHealthcare Medicare Prescription Drug Program (*Post-65 Program only*)	3	UnitedHealthcare MedicareRx for Groups (PDP), Evidence of Coverage (2018), Group Number 00334
	4	UnitedHealthcare RxSupplement, Certificate of Coverage (2018), Group Number 00334

If you have any questions regarding the Group Health Benefit under the APC Retiree Health Plan, please call the OxyLink Employee Service Center at 800-699-6903 (US) or 918-610-1990 (Outside US).

SECOND SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

Attachment B

ARTICLE XIV

IMPORTANT ERISA INFORMATION

Name of Plan: Anadarko Petroleum Corporation Retiree Health Benefits Plan

Plan Sponsor's Name, Address and Telephone Number: Anadarko Petroleum Corporation, c/o Human Resources Department, Occidental Petroleum Corporation, 5 Greenway Plaza, Suite 110 Houston, Texas, 77046-0521, (713) 215-7000.

Plan Administrator's Name, Address and Telephone Number: Occidental Petroleum Corporation Employee Benefits Committee, c/o Human Resources Department, Occidental Petroleum Corporation, 5 Greenway Plaza, Suite 110 Houston, Texas, 77046-0521, (713) 215-7000.

Employer Identification Number: 76-0146568.

Plan Number: 504.

Type of Plan: The Plan is an "employee welfare benefit plan" subject to ERISA which provides, as the Group Health Benefit thereunder, (1) self-funded medical benefits, (2) self-funded prescription drug benefits, (3) fully-insured prescription drug benefits, and (4) self-funded dental benefits.

Type of Administration: The Group Health Benefit is administered by the Plan Administrator, with benefits being provided in accordance with the terms, limits and conditions of the Plan that are applicable to the Group Health Benefit. The Plan Administrator has engaged the Claims Administrator(s), as set forth in Appendix C, to determine eligibility for benefits, process claims and perform other administrative duties under the Group Health Benefit.

Agent for Service of Legal Process: Service for legal process related to the Plan may be made upon the Plan Administrator or claims administrators at the addresses listed above

Disclosure Administrator: OxyLink Employee Service Center, 4500 South 129th East Avenue, Tulsa, OK 74134-5801, 1-800-699-6903 (US), 1-918-610-1990 (Outside US), oxylink@oxy.com.

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month period beginning each January 1st and ending on December 31st.

Sources of Contributions: The adopting Employers and Participants pay the costs for coverage. The Plan Sponsor determines the portion of costs to be paid by the adopting Employers and the Participants.

SECOND SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

Attachment C

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX B

The terms and conditions of the following Group Health Programs which apply to retiree health coverage are incorporated, in their entirety, by reference into this SPD:

1. Pre-65 Group Health Programs. Available only to Participants who have not yet attained Medicare Eligibility Due to Age:

   - Oxy Retiree Medical Program for Anadarko Retirees; and
   - Oxy Retiree Dental Program for Anadarko Retirees.

2. Post-65 Group Health Programs. Available only to Participants who have attained Medicare Eligibility Due to Age:

   - UnitedHealthcare Dental Benefits Program; and
   - UnitedHealthcare Medicare Prescription Drug Program.

Retiree health coverage under the UnitedHealthcare POS Choice Plus Plan Medical Benefits Program, the UnitedHealthcare PPO Options (Utah) Plan Medical Benefits Program, and the UnitedHealthcare Out of Area Options Plan Medical Benefits Program terminated on December 31, 2015.

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX C

As of January 1, 2021, the following third-party entities serve as Claims Administrators and Claims Fiduciaries under the Group Health Benefit with respect to the following Group Health Programs:

Group Health Program		Claims Administrator / Claims Fiduciary
Oxy Retiree Medical Program for Anadarko Retirees	Medical Component	Aetna P.O. Box 14586 Lexington, KY 40512-4586 1-800-334-0299 (US) 817-417-2000, ext. 4154016 (Outside US) www.aetna.com
	Prescription Drug Component	Express Scripts, Inc. 1 Express Way St. Louis, MO 63121 1-800-551-7680 (US) 1-800-497-4681 (Outside US) www.express-scripts.com
Oxy Retiree Dental Program for Anadarko Retirees		Aetna P.O. Box 14094 Lexington, KY 40512-4094 1-800-334-0299 (US) www.aetna.com
UnitedHealthcare Medicare Prescription Drug Program		**Eligibility and Benefits Verification**: UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675 1-888-556-6648 www.uhcmedicarerxforgroups.com ***Payment of Claims***: OptumRx P.O. Box 29046 Hot Springs, AR 71903

As of January 1, 2021, the following third-party entities serve in the following positions under the Group Health Benefit:

Eligibility Administrator/ Certificate Administrator	**COBRA Administrator**
OxyLink Employee Service Center 4500 South 129th East Avenue Tulsa, OK 74134-5801 1-800-699-6903 (US) 1-918-610-1990 (Outside US) oxylink@oxy.com www.oxylink.oxy.com	OxyLink Employee Service Center 4500 South 129th East Avenue Tulsa, OK 74134-5801 1-800-699-6903 (US) 1-918-610-1990 (Outside US) oxylink@oxy.com www.oxylink.oxy.com PayFlex Phone: 844-PAYFLEX (844-729-3539) Outside U.S.: 402-345-0666 Fax: 888-238-3539 www.payflex.com

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX D

As of January 1, 2021, the following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information subject to HIPAA from the Group Health Benefit:

Employee/Position	Categories of PHI under the Plan to which Access is Needed and Conditions on Access
Vice President, Compensation & Benefits	PHI as needed to perform duties as Privacy Official and Complaint Official
All active employees of the HR Benefits Planning Department and the HR Systems & Data Admin of Human Resources ("**HR Departments**")	PHI as needed to perform administration of the Plan and assist Plan participants with questions
Systems Department employees who are responsible for maintenance of systems that may contain electronic PHI	PHI as needed to maintain and administer systems that may contain electronic PHI
Legal Counsel assigned to support the HR Departments Paralegals and administrative staff supporting Legal Counsel (above)	PHI as needed to advise and counsel on any claims or other Plan administrative issues that might arise relating to PHI
Vice President Human Resources	PHI as needed to perform executive functions associated with oversight of the Benefits Department and sponsorship of the Plan

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX E

Copies of the Group Health Programs' Medicare Part D Notice of Creditable (or Non-Creditable) Coverage may be accessed at www.oxylink.oxy.oxy under Plan Documents & Information > Required Notices > Medicare Creditable Drug Coverage Notices. These notices are incorporated herein.

SUMMARY PLAN DESCRIPTION OF THE
GROUP HEALTH BENEFIT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

APPENDIX G

The following Group Health Program Documents which are operative as of January 1, 2021 are attached hereto and incorporated, in their entirety, into this SPD by reference:

- Oxy Retiree Medical Program for Anadarko Retirees;
    - MEDICAL PLAN – Oxy Retiree Non-Medicare Eligible – Aetna Choice POS II Network 2019
- Oxy Retiree Dental Program for Anadarko Retirees;
    - Retiree Dental Plan – Dental PPO/PDN with PPOII Network
- UnitedHealthcare Medicare Prescription Drug Program:
    - UnitedHealthcare MedicareRx for Groups (PDP), Evidence of Coverage (2017), Group Number 00334; and
    - UnitedHealthcare RxSupplement, Certificate of Coverage (2017), Group Number 00334.

SECOND SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

Attachment D

NOTICE: This document is a Program Document for the Oxy Retiree Medical Program for Anadarko Retirees, which is part of the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Plan). Please see the Second Summary of Material Modification to the APC Retiree Plan for more information.

OXY Benefits

Summary Plan Description

MEDICAL PLAN

OXY RETIREE NON-MEDICARE ELIGIBLE

Aetna Choice POS II Network

2019

your health.
your life.
your future.

CONTENTS

Your Retiree Medical Plans

The Oxy Retiree Medical Program is comprised of two separate plans:

Oxy Non-Medicare-Eligible Plan *(includes retirees who are NOT eligible for the Oxy Medicare Advantage PPO Plan)* Described in this SPD	The medical option available is the Occidental Petroleum Corporation Retiree Medical Plan (i.e., Oxy Retiree Medical Plan, and, in some areas, regional HMO options). See **Medical Plans**. You are eligible for coverage under this Plan if you and your covered dependents: • Are NOT eligible for Medicare (or have been deemed not eligible for the Oxy Medicare Advantage PPO Plan) and • Meet the eligibility requirements outlined in this SPD. If you are eligible for Medicare, but an eligible dependent is not Medicare-eligible, the dependent who is not Medicare-eligible may be covered under this Plan.
Oxy Medicare-Eligible Plan Described in a separate SPD	The medical option available under this plan is the Oxy Medicare Advantage PPO Plan—also known as the Aetna Medicare℠ Plan (PPO) with extended service area (ESA). The plan also includes Medicare Part D expanded prescription drug coverage. You are eligible for coverage under this plan if, due to age or disability, you or any of your covered dependents: • Are eligible for Medicare, and • Meet the eligibility requirements outlined in the SPD for that plan.

The **Oxy Non-Medicare Eligible Plan** is described in this Summary Plan Description (SPD).

Oxy reserves the right, at any time or for any reason, to suspend, withdraw, amend, modify or terminate the Oxy Retiree Medical Plan and/or the Oxy Medicare Advantage PPO Plan (including the amount you must pay for any benefit), in whole or in part.

Medical Plans

The Retiree Medical Plans offer eligible participants the following medical options:

- **Oxy Retiree Medical Plan**—A Point of Service (POS) health plan that covers care received from network or non-network providers with no physician referral.
- **Regional HMO** *(in some areas)*—A Health Maintenance Organization (HMO) generally requires you to receive medical treatment or services from participating providers. Services received outside the network may not be covered except in the case of a medical emergency.

  If you retired after January 1, 2016, you must enroll in the Oxy Retiree Medical Plan option. If you retired prior to January 1, 2016, and are enrolled in a regional HMO option, you may continue participation in this coverage, as long as you remain in the regional coverage area and are not Medicare-eligible. If you later move out of the area, you must make a new medical coverage election within 31 days after your move.

All benefits, limits and exclusions for the HMO options are listed in their respective member brochures, contacts and certificates. Upon request, the OxyLink Employee Service Center will provide written materials that describe the benefits, including prescription drug benefits, coordination of benefits, claim and benefit payments and defined terms.

Medical Plan Eligibility

For updates to this information, go to OxyLink at **oxylink.oxy.com**

Who's Eligible	• All regular, full-time, non-represented employees who were regularly scheduled to work at least 30 hours per week and, effective March 1, 2018, part-time non-represented employees approved for the Phased Retirement Program who are: – At least age 55 with 10 or more years of regular, full-time service. – Enrolled in an Oxy medical plan for active employees the day before retirement, unless covered under another medical plan before retirement, then lost that coverage and you elect coverage under this Plan within 31 days of the event. – Not eligible to participate in the Oxy Medicare Advantage PPO Plan. – Not independently enrolled in an individual Medicare Part C or similar plan. • Represented employees are eligible if provided for in their collective bargaining agreement.
Eligible Dependents	Generally, your eligible dependents are your: • Legal spouse***** (unless legally separated); and • Children under age 26. Eligible dependent children, regardless of the child's student, employment or marital status or residence, include: – Your natural children; – Children legally adopted or placed for adoption with you; – Stepchildren and foster children; and – Other children whom you claim as dependents on your federal income tax return, for whom you and/or your spouse have primary legal custody, whom live with you in a regular parent-child relationship and for whom you can provide required documentation. • Disabled children age 26 or over (see **Dependent Eligibility** Section)

*****All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. Domestic partners may be eligible for the regional medical plans per state law.

About This SPD

This Summary Plan Description (SPD) summarizes your Occidental Petroleum Corporation Retiree Medical Plan, also known as the Oxy Retiree Medical Plan, the Plan or the Medical Plan. The Plan's complete provisions are contained in the Plan documents that legally govern the Plan's operation. The Plan documents include the official Plan text and other documents and reports that are maintained by the Plan. **If there is ever a conflict or difference between this SPD and the Plan documents and contracts, the official Plan documents and contracts will govern.**

This SPD reflects the provisions of the Plan documents in effect on January 1, 2019. These provisions may not apply to you if your employment ended before this date. Refer to future Summary of Material Modifications (SMMs) for any material changes to the Plan made after the date of this document.

Benefits at a Glance—Oxy Retiree Medical Plan

The chart below shows the deductibles, coinsurance and out-of-pocket maximums you pay under the Oxy Retiree Medical Plan. Network benefits are based on negotiated fees. Non-network benefits are based on the **recognized charges**. Network benefits apply to non-Medicare eligible participants and any Medicare-eligible participants covered under this Plan. **Non-network benefits apply only to non-Medicare eligible participants.** Since Medicare is primary for Medicare-eligible participants who are eligible for this Plan, the lower non-network coinsurance levels **will not apply** if you use a provider that does not participate in Aetna's network and you are **not subject to** precertification requirements. Allowed charges are limited to the Medicare-approved amount for any Medicare-eligible participants in this Plan. Refer to the Medicare section for further details.

More coverage details for specific services and supplies are included in **Covered Medical Expenses**.

All covered expenses are subject to the annual deductible until it is met unless otherwise noted.

AETNA RETIREE MEDICAL PLAN		
Medical Network	Aetna Choice® POS II Open Access **www.aetna.com** **800-334-0299**	
ANNUAL DEDUCTIBLE*	**YOU PAY**	
	NETWORK	**NON-NETWORK**
• Individual	$400	$800
• Family	$800	$1,600
	Individual deductible also applies. Applies to medical expenses only. Some retirees may have a higher deductible based on when they retired and when they became Medicare-eligible. See the **Deductible** section for more information.	
OUT-OF-POCKET (OOP) MAXIMUM*	**YOU PAY**	
	NETWORK	**NON-NETWORK**
• Individual	$2,500	$5,000
• Family	$4,500	$9,000
When your share of covered expenses (including the deductible) reaches the OOP limit, covered expenses for the remainder of the calendar year are paid at 100%.	Individual OOP maximum also applies. Excludes prescriptions.	
LIFETIME MAXIMUM		
	Unlimited	
REQUIREMENTS		
Inpatient Care Precertification (non-Medicare participants only)	• All inpatient care must be precertified. • In most cases, network providers will handle precertification. • If you use non-network providers, it is your responsibility to obtain precertification to avoid a noncompliance penalty of up to **$500.**	

*Charges, whether for network or non-network care, will count toward meeting your deductibles and benefit maximums, unless stated otherwise.

PREVENTIVE CARE	PLAN PAYS	
	NETWORK	NON-NETWORK
See Preventive Care for more information: • Routine physicals (adult and child) • Flu shots • Mammography • PSA test • Cervical cancer screening and exam • Colorectal cancer screening	100% covered, **no** deductible	70%
OFFICE VISITS		
Primary Care Physician	80%	70%
Specialist	80%	70%
TELADOC		
24/7 Telemedicine Services Register at Teladoc.com/Aetna, download the app from your mobile device app store or call 855-Teledoc (835-2362).	See a doctor, 24/7, without having to go to a doctor's office. You have access to private online video or phone sessions with a board-certified doctor. Teladoc doctors treat non-emergency health conditions, including: • Cold and flu • Allergies • Sinus problems • Sore throat • Respiratory infection • Skin problems They can also send prescriptions to your pharmacy. Your cost is $40 per session until you've met your deductible. Then, the Plan pays 80% and you pay 20% ($8) per visit.	
DIAGNOSTIC PROCEDURES		
Outpatient Diagnostic X-rays, Lab and Testing	80%	70%
Outpatient Complex Imaging	80%	70%
EMERGENCY CARE		
Emergency Admissions Must be certified within 48 hours of admission	90%	90%
Urgent Care	80%	70%
Ambulance	80%	80%
Non-Emergency Use of Emergency Room	Not covered	Not covered
HOSPITAL/SURGICAL CENTER		
Inpatient Requires precertification	90%	70%
Outpatient Surgery	90%	70%

VISION CARE	PLAN PAYS	
	NETWORK	NON-NETWORK
Routine Eye Exam One per calendar year	100% covered, **no** deductible	70%
Materials	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
Inpatient Facility Requires precertification	90%	70%
Outpatient Facility	90%	70%
Outpatient Office Visit	80%	70%
OTHER MEDICAL SERVICES		
Skilled Nursing Facility Up to 120 days per calendar year	90%	70%
Home Health Care Up to 120 visits combined with private duty nursing per calendar year	80%	70%
Hospice Care	90%	70%
Short Term Rehabilitation Physical, occupational, speech and cognitive therapy	80%	70%
Acupuncture Therapy Maximum 26 visits per year	80%	70%
Chiropractic Care Maximum 26 visits per year	80%	70%
Durable Medical Equipment One for similar purpose	80%	70%
Surgery Not Billed by Physician, Lab, Ambulance	80%	70%
Hearing Aids Maximum benefit of $2,500 every 3 years	80%	70%
Infertility $20,000 lifetime benefit	80%	70%

PRESCRIPTION DRUG NETWORK BENEFITS	AETNA RETIREE MEDICAL PLAN
Prescription Drug Network	Express Scripts, Inc. (ESI)
Annual Deductible	None
Out-of-Pocket (OOP) Drug Limit	Using lowest-cost option, separate annual OOP drug limit is $1,500 per person.
Lifetime Maximum	Infertility prescription drug benefit has a maximum $10,000 lifetime benefit
Brand Name Drugs	If a generic drug is available, you pay the generic copay or coinsurance plus the difference in price between the brand name and the generic drug. The additional cost for the brand name drug is not applied to your prescription annual out-of-pocket cost.
	YOU PAY*
Retail Pharmacy up to a 30-day supply	
• Generic	$10 copay
• Preferred brand	25% ($10 min/$50 max)
• Non-preferred brand	25% ($25 min/$100 max)
• Maintenance Medication	**Initial fill plus 2 refills; then a penalty applies for additional fills at a retail pharmacy. Consider the mail order pharmacy for maintenance medications to avoid the penalty.**
Mail Order Pharmacy up to a 90-day supply	
• Generic	$20 copay
• Preferred brand	25% ($20 min/$100 max)
• Non-preferred brand	25% ($50 min/$200 max)

*Certain preventive drugs are covered at 100% ($0 copay). For more information, contact ESI at **800-551-7680** or OxyLink at **800-699-6903** or email oxylink@oxy.com to request a list of these preventive drugs.

Managing Your Benefits

For Plan information and forms, go to **oxylink.oxy.com**. Your providers' customer service representatives can help answer your benefit questions. In addition, your provider websites offer access to information about your benefits and tools to help you manage your health and benefits. All you need to do is complete a simple registration process.

BENEFIT CONTACTS	
OxyLink Employee Service Center 4500 South 129th East Avenue Tulsa, OK 74134-5801	For questions about retiree medical eligibility or other Oxy Retiree Medical Plans: • Call **800-699-6903.** Outside the U.S.: **918-610-1990** Monday through Friday (except holidays) 8 a.m. to 4:30 p.m. CT • Email questions to **oxylink@oxy.com** • Visit the website: **oxylink.oxy.com**
Aetna P.O. Box 14586 Lexington, KY 40512-4586	For questions about the medical option: • Aetna: **800-334-0299.** Outside the U.S.: **817-417-2000**, ext. 4154016; or • **Aetna.com**: Through the member website, you can: – Order a new ID card or print a temporary card – View benefits and check status of claims – Find a doctor, specialist, **hospital** or urgent care facility – Use the cost estimator to compare cost estimates in advance – Use personal health record to monitor and manage your health
Express Scripts, Inc. 1 Express Way St. Louis, MO 63121	For questions about the prescription drug program: • Express Scripts: **800-551-7680.** Outside U.S.: **800-497-4681** • **Express-scripts.com**: Through the online services, you can: – Compare brand name and generic drug prices – Order a new ID card or print a temporary card – Obtain order forms, claim forms and envelopes – Request renewals or refills of mail-order prescriptions – Check the status of Express Scripts mail orders – Check and pay mail-order account balances
PayFlex Retiree Billing Unit P.O. Box 953374 St. Louis, MO 63195-3374	For questions about billing: • PayFlex: **888-678-7835** Monday through Friday, 8 a.m. – 7 p.m. CT (except holidays) • **Payflex.com**

Provider ID Cards

You will receive medical and prescription drug ID cards when you enroll for medical coverage. Be sure to keep your ID cards handy and show them whenever you receive care or fill a retail prescription. The cards may include phone numbers you may need to contact the provider's Member Services. You may also use a digital ID card via the Aetna or Express Scripts mobile app or you may print temporary ID cards from the Aetna website at **www.aetna.com** or the Express Scripts website at **www.express-scripts.com**.

Eligibility and Enrollment

Your Eligibility

Generally, you and your covered dependents on record at the time of your Oxy retirement date are eligible to participate if you:

- Were a regular, full-time employee of Occidental Petroleum Corporation (OPC) or an affiliated company (Oxy) or, effective March 1, 2018, a part-time non-represented employee approved for the Phased Retirement Program, on a U.S. dollar payroll (temporary employees and interns are not eligible to participate) and:
  - Were designated as eligible to participate by your employer or through your collective bargaining agreement and did not participate in a similar type of employer-sponsored plan.
  - Were at least age 55 with 10 or more years of regular, full-time Oxy service when you left Oxy employment (other rules may apply to collective bargaining groups, grandfathered groups or sold or closed locations).

  You were considered a full-time employee if you were regularly scheduled to work at least 30 hours per week. For this purpose, "affiliated company" means any company in which 80 percent or more of the equity interest is owned by Occidental Petroleum Corporation.
- Are not eligible for retiree coverage under another group medical plan as a result of credit for Oxy service.
- Were enrolled in an Oxy Medical Plan, including regionally available options, e.g., a Health Maintenance Organization (HMO) option, the day before your retirement, except as described below:
  - If you were covered under your spouse's medical plan or any other medical plan immediately before retirement from Oxy, you are eligible for coverage under this Retiree Medical Plan when you retire or later if you lose coverage under the other plan, as long as you elect coverage within 31 days of the event. Proof of prior medical coverage or loss of creditable coverage is required.

If you were part of a collective bargaining group, your eligibility to participate is generally described above.

You are not eligible to participate in the Plan if:

- You are independently enrolled in an individual Medicare Part C (i.e., Medicare Advantage) or similar plan; or
- You are eligible to participate in the Oxy Medicare Advantage PPO Plan (the Aetna Medicare Advantage PPO Plan).

Service credit for prior employer service following a merger, acquisition or joint venture may have been granted as part of the transaction. Credit while on Long-Term Disability may apply. Contact OxyLink Employee Service Center for more information.

You may not be covered as both a retiree and a dependent.

Special retiree medical eligibility provisions will apply if you receive severance benefits under Option A of Oxy's **Notice and Severance Pay Plan**, or similar arrangement with Oxy that provides for such eligibility.

Part-Time Work and the Oxy Retiree Medical Plan

If you lose eligibility under an Oxy medical plan for active employees as a result of a reduction in work hours (i.e., you are regularly scheduled to work fewer than 30 hours per week), and you meet the eligibility requirements for retiree coverage (generally age 55 with 10 or more years of service), you may enroll in the Oxy Retiree Medical Plan. You will also continue to accrue age and service credits toward your retiree medical contribution multiple during such reduced work schedule.

Special Provisions Under the Notice and Severance Pay Plan

Special eligibility provisions apply if you elect and receive benefits under Option A of Oxy's Notice and Severance Pay Plan or enter into a similar arrangement with Oxy that provides for such eligibility. If you were part of a collective bargaining group, this section only applies if your negotiated bargaining agreement specifically provided for your participation in the Notice and Severance Pay Plan.

Your eligibility for retiree medical coverage will be determined based on your age and years of service as if you continued to be an employee throughout your severance or the medical coverage period specified in a similar arrangement with Oxy (each referred to as "Medical Coverage Period"). Retiree medical coverage will be provided if, on the last day of your Medical Coverage Period, you:

- Have at least 30 years of eligible service,
- Are at least age 50 and have at least 5 years of eligible service with combined age and service of 65 years or more, or
- Otherwise satisfy the eligibility requirements under the medical plan.

To determine your eligibility for such future coverage, calculate your combined age and service by adding your years and months of age and eligible service as of the last day of your Medical Coverage Period, counting any partial month of age or service as a whole month. If you became an Oxy employee due to Oxy's purchase, merger or transfer of any unit, operation or business and, as a result, your eligibility for retiree coverage under the Oxy Retiree Medical Plan is subject to a required minimum number of service years directly with Oxy, you must meet such minimum by the end of your Medical Coverage Period to qualify for such future coverage when you reach age 55.

Contributions for retiree medical coverage are normally a multiple (1x to 4x) of the retiree base rate established for the Plan year. This base rate is associated with your coverage level and a combination of your age and service. However, if you elect Option A under the Notice and Severance Pay Plan and you are eligible for retiree medical coverage at the end of your severance period, your contributions will be calculated using a combined age and service of at least 80 years, which qualifies you for the lowest multiple (1x) under the Plan. Refer to the **Paying for Coverage** section for details.

Enrollment If Receiving Benefits Under the Notice and Severance Pay Plan

If you are under age 55 at the end of your Medical Coverage Period, you must contact OxyLink within 31 days of the date you turn age 55 to enroll. If you enroll at age 55, proof of loss of other coverage is not required, and coverage will be effective the first of the month following or coincident with attainment of age 55.

If you do not enroll at age 55 because you have other coverage, you may later enroll in retiree medical coverage if you lose that other coverage. However, you must enroll within 31 days of loss of coverage and proof of loss of coverage may be required.

Dependent Eligibility

Generally, your legal spouse (unless legally separated), your children under age 26, and your disabled children may qualify as eligible dependents under the Plan.

Your Spouse

Your eligible spouse is your spouse to whom you are legally married. All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. This includes a spouse through common law marriage in applicable states. This does not include a spouse from whom you are legally separated.

Your Children

Your eligible children may include your:

- Natural children;
- Children legally adopted or placed for adoption with you;
- Stepchildren;
- Foster children; and
- Other children who you claim as dependents on your federal income tax return (e.g., grandchildren), for whom you and/or your spouse have primary legal custody and who live with you in a regular parent/child relationship.

Unless otherwise noted in a specific coverage section, your children must be under the age of 26 to be eligible for coverage under the Plan regardless of their marital, student, financial or residency status. However, a child who has reached the upper age limit (age 26) and who is mentally or physically incapable of self-sustaining employment may continue to be eligible (see **Disabled Dependent Children** for more details).

Qualified Medical Child Support Order

If, because of a divorce or legal separation, your children are not eligible for Plan coverage, it may be possible to obtain coverage through a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree or order issued by a court of competent jurisdiction, or other court or administrative order, requiring you to provide health care benefits for a child. You will be notified if any of your children are affected by a QMCSO. If so, the **Plan Administrator** will provide information to the child, custodial parent or legal guardian on how to obtain benefits and submit claims. The claims administrator will pay eligible claims to the child or the child's custodial parent or legal guardian, except to the extent paid directly to a service provider on behalf of the child.

You may ask the OxyLink Employee Service Center for a free copy of the procedures governing QMCSOs.

Disabled Dependent Children

If you have a disabled child, the child's coverage may be continued past the Plan's limiting age for dependents. Your child is considered to be disabled if he or she:

- Is unable to earn a living because of a mental or physical disability that starts before the Plan's age limit; and
- Depends mainly on you for support and maintenance.

You must provide proof of your child's disability to the claims administrator no later than 31 days after your child reaches the dependent age limit for review and determination of eligibility of continuation of coverage. The claims administrator may continue to ask you for proof that the child continues to meet conditions of incapacity and dependency.

The child's coverage will end on the first to occur of the following:

- Your child is no longer disabled;
- You fail to provide proof that the disability continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

Dependent Coverage After Your Death

If you die while you are covered as a retiree under this Plan, your spouse may elect to continue his or her coverage and coverage for your eligible dependents as of your date of death by paying the appropriate amount of retiree contributions, if any, as described under **Paying for Coverage**. If you had not elected retiree coverage for yourself and/or your dependents under this Plan, your surviving spouse may elect to enroll for coverage for his or herself and your dependents within 31 days of loss of other coverage. Proof of loss of coverage may be required.

Coverage for your dependents may continue until an event occurs as described in the section entitled **When Coverage Ends**.

Enrollment

You and/or your surviving spouse must complete and return an enrollment form (or waiver) for retiree medical coverage no later than 31 days after your retirement date. You may waive coverage, but if you do, you may not reenroll for coverage under the Oxy Retiree Medical Plan, with the following exception:

If you or your spouse (or a surviving spouse) currently have other coverage and lose eligibility for that coverage, you or your spouse may reenroll in the Oxy Retiree Medical Plan within 31 days of loss of coverage. Proof of loss of coverage may be required.

You may elect not to cover your spouse if he or she is covered under another group plan. You may not be covered as both a retiree and a dependent spouse under Oxy Retiree Medical Plan. If you and your spouse work for or are retired from Oxy, only one of you may cover your children as dependents. If your spouse has dependents as an Oxy employee and later leaves Oxy for any reason, you may enroll yourself and your dependents within 31 days of the loss of coverage.

When you enroll for coverage you will elect one of the following coverage levels:

- Retiree Only
- Retiree + One Dependent
- Family (retiree plus two or more dependents)

Adding or Dropping Dependents

If you marry after your Oxy retirement date, your new spouse will be eligible for coverage under this Plan. You must enroll your new spouse within 31 days of his or her first date of eligibility (the date of marriage), or if later, within 31 days of loss of other coverage.

After your retirement date, you may add a new non-spousal dependent for coverage under this Plan only by paying the full coverage cost (including company cost) in effect at the time you add your dependent. The cost is subject to change each year as Oxy's Retiree Medical Plan costs increase, as described under **Your Share of Medical Service Cost**. You must enroll your new dependent within 31 days of his or her first date of eligibility (or within 31 days of a court-issued QMCSO), or if later, within 31 days of loss of other coverage.

Dependents who are no longer eligible for coverage are not automatically dropped from coverage. You must remove them from the Plan. If you don't advise the Plan that a dependent is no longer eligible for coverage, the Plan may stop the dependent's coverage retroactive to the date the dependent became ineligible and you will **not** be refunded any premiums you paid for the ineligible dependent. You are required to repay the total cost of claims paid by the Plan for the ineligible dependent dating back to the original enrollment and/or termination of coverage date. The dependent is not eligible for COBRA coverage if his or her eligibility ends due to lack of (or insufficient) documentation for proof of eligibility.

To change your dependents, contact the OxyLink Employee Service Center.

Paying for Coverage

If you are a retiree or LTD Plan beneficiary who became Medicare-eligible before January 1, 2000, you and your covered dependent(s) are not currently required to pay contributions to participate in the Oxy Retiree Medical Plan; however, a correspondingly higher deductible may apply.

If you are a retiree who retired or became eligible for Medicare on or after January 1, 2000, the contributions for you and/or your Medicare-eligible dependents are a multiple of the Oxy retiree base rate, as shown below.

IF YOUR COMBINED AGE AND YEARS OF SERVICE ON YOUR OXY RETIREMENT DATE* IS:	YOUR MONTHLY CONTRIBUTION IS THE FOLLOWING MULTIPLE OF THE RETIREE BASE RATE FOR THE LEVEL OF COVERAGE YOU ELECT:	
	MEDICARE-ELIGIBLE	NON-MEDICARE ELIGIBLE
65 to 69	2 times	4 times
70 to 74	2 times	3 times
75 to 79	2 times	2 times
80 or more	1 times	1 times

*Your retirement date is the first of the month following your termination date.

The amount of your contribution is based on:

- Your combined age and years of service,
- The date you become eligible for Medicare,
- Your elected level of coverage (i.e., Retiree Only, Retiree + One Dependent or Family), and
- The Medicare status of you and your covered dependents

Your combined age and service will be calculated by adding together your years and months of age and service as of your retirement date, which is the first of the month following your termination date. A partial month of age or service will be considered a full month for purposes of this calculation.

The retiree base rate for coverage is established each year. It is typically announced in the 4th quarter of each year in a retiree newsletter, which is also posted online at **oxylink.oxy.com** > Plan Documents and Information > Newsletters.

For 2019, the retiree base rate is $150 per month for all participants covered under this Plan.

For example, a retiree with a combined age and service of 73 years would pay three times the base rate for retiree and spouse coverage of $900 per month ($150 base rate x 2 individuals x 3).

Contributions are billed monthly by PayFlex. Once your retirement is processed you will receive detailed information from PayFlex with the available payment options.

Additionally, if you are eligible for Medicare you must pay any applicable premiums for Medicare Part A and B (including any late enrollment penalties for Part B or Part D) directly to the Center for Medicare and Medicaid Services (CMS).

Dependent Contributions After Your Death

If you die while you are covered as a retiree under the Oxy Retiree Medical Plan, your spouse, if eligible (see **Death** for more details), may elect to continue his or her coverage and coverage for your eligible dependents as of your date of death by paying the appropriate amount of retiree contributions, as shown on the previous chart.

When Coverage Ends

This section explains how and why coverage may be terminated, and how you and your covered dependents may be able to continue coverage after it ends.

When Your Coverage Ends

Your coverage under the Plan ends on the first to occur of the following events:

- The Plan is discontinued;
- You voluntarily stop your coverage;
- The coverage described in this SPD is terminated under the group contract;
- You are no longer eligible, as defined in **Your Eligibility**;
- You fail to make any required contribution; or
- You become eligible for the Medicare Advantage PPO Plan

The Plan coverage stops on the last day of the month in which you lose eligibility. You may have a right to continue your coverage as described in **Continuation of Coverage**. You may not convert your group health care coverage to an individual policy when you leave Oxy.

When Dependent Coverage Ends

Your dependent's eligibility for coverage will end on the earliest of the following events:

- Dependent coverage is terminated under the Plan;
- A dependent becomes covered as an employee;
- A dependent no longer meets the Plan's definition of a dependent;
- Your coverage terminates;
- Your death, if there is no surviving spouse;
- Your surviving spouse waives coverage, remarries or dies (This would result in any covered dependent children losing coverage. However, dependent children have the right to continue coverage under COBRA); or
- Dependent becomes eligible for the Oxy Medicare Advantage PPO Plan.

The Plan coverage stops on the last day of the month in which your dependent loses eligibility. You must notify the OxyLink Employee Service Center within 31 days of your dependent's change in eligibility status. Any applicable contribution change will take effect on the first of the month following the event. There will be no refund of contributions unless it is due to an Oxy administration error.

Your dependents may have a right to continue their coverage. See **Continuation of Coverage** or contact the OxyLink Employee Service Center for more information.

Death

If you die and are eligible for retiree medical coverage as described in the **Eligibility and Enrollment** section, your spouse may elect to continue his or her coverage and coverage for your covered dependents under this retiree Plan. If retiree medical coverage is elected, your spouse must pay the applicable retiree contribution. If dependent coverage (including spouse) is elected, coverage will continue for your dependents until the earliest occurrence of one of the following events:

- Dependent's coverage ends under the Plan;
- Dependent is or becomes covered as an employee;
- Failure to meet the requirements for dependent coverage;
- Spouse is or becomes eligible for coverage under another group plan;*
- Failure to pay any required contributions; or
- Your surviving spouse elects to waive coverage, remarries or dies.

Coverage is not available for only dependent children. If you die without a surviving spouse or if your spouse does not have coverage or it ends, dependent children have a right to **continue coverage** under COBRA.

Medicare

Medicare is a federal health insurance program, which provides health care services under the Original (Traditional) Medicare Plan (Part A and Part B) or in some areas, a Medicare Advantage Plan. Generally, you are eligible to receive benefits from Medicare when you reach age 65. Medicare is also available if you have been entitled to Social Security disability benefits for two years (waived if you have amyotrophic lateral sclerosis) or if you have end-stage renal disease (kidney failure).

Medicare includes the following parts:

- *Part A Hospital Insurance* – Hospital coverage automatically provided at **no cost** when you become Medicare-eligible.
- *Part B Medical Insurance* – Physician and outpatient services coverage automatically provided if you are receiving your Social Security benefits. Otherwise, it requires you enroll. **You pay** a monthly premium for this coverage and you can opt out.
- *Part C Medicare Advantage Plans* – Include Health Maintenance Organization plans, Preferred Provider Organization plans, Private Fee for Service plans and Special Needs plans. Generally, you must be enrolled in Parts A and B to enroll in this coverage. Some plans also include Part D.
- *Part D Prescription Drug Plan* – Outpatient prescription drug coverage. You must be enrolled in Parts A and B to enroll in this coverage. **You pay** a monthly premium for this coverage.

When you and/or your dependents become Medicare-eligible, Medicare becomes effective the first of the month in which you or your dependent turns age 65, or otherwise becomes Medicare-eligible. At that time, coverage for most Medicare-eligible participants will be provided under the Oxy Medicare Advantage PPO Plan (see separate Oxy Medicare Advantage PPO Plan SPD). However, if you become Medicare-eligible but are deemed not eligible for the Oxy Medicare Advantage PPO Plan, you will remain in this Oxy Retiree Medical Plan and Medicare will generally be the primary insurance coverage and payer of your medical claims with this Plan as the secondary payer of your medical claims.

*If your spouse subsequently loses eligibility under the other plan, he or she may reenroll in the Medical Plan within 31 days of the loss of coverage. Proof of loss of eligibility may be required.

Important: Oxy Medicare Advantage PPO Plan Participation

If you are a retiree who is Medicare-eligible, you live in the United States and are otherwise eligible for Medicare, your coverage will be provided under the Oxy Medicare Advantage PPO Plan ***not*** under this Oxy Retiree Medical Plan. For additional information on benefits that are provided under the Oxy Medicare Advantage PPO Plan, refer to the separate SPD for that plan.

How to Apply for Medicare

To apply for Medicare, you should contact Social Security by telephone at **800-772-1213**. In most cases, the entire application process can be handled by telephone, online and/or through the mail.

Even if you fail to enroll in Parts A and B of Medicare, the Oxy Retiree Medical Plan benefit will be reduced by what Medicare would have paid. Therefore, you are encouraged to enroll in both Medicare Parts A and B to ensure maximum benefit coverage.

Medicare Part D

Those covered by Parts A or Part B can enroll in Medicare Part D, which helps pay for insurance coverage for outpatient prescription drugs. In some cases, a Medicare Part D plan may provide a better benefit than the prescription drug coverage provided under this Plan. You can, but do not have to, enroll in Medicare Part D because the Oxy Retiree Medical Plan is considered “creditable,” that is, the Plan provides coverage that is expected to be as good as or better than the lowest level of drug coverage authorized under a Medicare Part D plan.

If you decide to enroll in a Part D plan, use your Part D coverage to obtain your prescription drug benefits since the Plan is not eligible to receive the federal subsidy for your drug costs if you are enrolled in Medicare Part D. This will ultimately impact the Plan’s ability to control costs and, therefore, your contributions.

If you are enrolled in the Oxy Retiree Medical Plan and decide to enroll in a Medicare Part D plan at a later date, you may do so without incurring a late enrollment penalty provided the Plan is still considered creditable.

You can access detailed information regarding the Medicare program online at **Medicare.gov** or contact Medicare at 800-MEDICARE (800-633-4227).

Integration with Medicare

Benefits under the Oxy Retiree Medical Plan are integrated with Medicare to provide the same overall level of benefits for Medicare-eligible participants as for those participants who are not Medicare-eligible. This section describes how Medicare benefits are integrated with the Oxy Retiree Medical Plan.

If you are a retiree or a dependent of a retiree and you are eligible for Medicare and not deemed eligible for the Oxy Medicare Advantage PPO Plan, you will remain in this Plan. Plan benefits generally will be offset by benefits payable by Medicare. This approach calculates the amount you would have received under the Oxy Retiree Medical Plan as if you were not eligible for Medicare, subtracts the amount payable by Medicare and reimburses the difference. **Even if you fail to enroll in Parts A and B of Medicare, the Oxy Retiree Medical Plan benefit will be reduced by what Medicare would have paid.** Therefore, it is important to enroll in both Medicare Parts A and B to ensure maximum benefit coverage. As the secondary payer, the Plan will apply (deduct) what Medicare Part B paid or would have paid when processing your claims (this means if you do not enroll in Part B, the Plan will still deduct what Medicare Part B would have paid if you were enrolled). Refer to the **COB with Medicare** section for more information.

Important Information

For non-prescription expenses, in most cases Medicare and the Oxy Retiree Medical Plan provide similar benefits and coverage levels. Since Medicare is considered primary and pays first, there is often no benefit payable by the Oxy Retiree Medical Plan for Parts A and B expenses. Most benefits payable by the Oxy Retiree Medical Plan are for prescription expenses.

To simplify claim processing you can enroll in the Medicare Direct Program described in the **Medicare Direct Program** section. If you live outside the United States, the Oxy Retiree Medical Plan will be integrated in a similar manner with the social insurance plans of the country in which the individual is eligible for benefits.

If you have group coverage in addition to Medicare and the Oxy Retiree Medical Plan, refer to the **Coordination of Benefits (COB)** section for more information.

Integration of benefits with Medicare does not apply to any private individual medical coverage a participant may have.

Medicare-Approved Amount and Medicare Assignment

The *Medicare-approved amount* is the maximum amount that Medicare will recognize for a particular service or procedure. It is often less than the actual charge, unless the provider accepts *Medicare assignment*. Medicare assignment is when a provider (physician, hospital, lab, etc.) will agree to accept the Medicare-approved amount as full and final settlement for the services. If the medical provider does not accept Medicare assignment, you and/or the Plan are responsible for any charges up to 15% over the Medicare-approved amount.

When providers agree to a Medicare assignment, they may not charge more than the Medicare-approved amount for services rendered. Under Medicare Part B, Medicare pays 80% of the Medicare-approved amount, after the Medicare deductible has been met. You or the Oxy Retiree Medical Plan are responsible for paying the balance of the Medicare-approved amount. There is no legal obligation for you or the Plan to pay the provider for charges above the Medicare-approved amount.

Effective January 1, 1993, physicians who do not accept Medicare assignment are limited by law to charge no more than 15% above the Medicare-approved amount for services rendered.

Important

Aetna Network provisions do not apply to Medicare-eligible participants because Medicare is your primary coverage.

Aetna Medical Option

This section describes how the Medical Plan works and how to make the most of your coverage. You will find information about choosing a physician and sharing the cost of your care, as well as details about certain important Plan rules and requirements.

Aetna Medical Plan Providers

Under the Aetna Basic option, you have the freedom to choose your doctor or health care facility when you need medical care. Your network is the Aetna Choice® POS II network.

Network Provisions for Non-Medicare Eligible Participants

This section describes how network provisions apply to non-Medicare eligible participants.

Using Network and Non-Network Providers for Non-Medicare Eligible Participants

When you need care, you can select a provider that belongs to the network (a network provider) or one that does not belong to the network (a non-network provider). The network providers represent a wide range of services from basic, routine care (general practitioners, pediatricians, internists, OB/GYNs), to specialty care (cardiologists, endocrinologists, urologists) and health care facilities (hospitals, skilled nursing facilities).

If you receive care from a network provider, your covered benefits are calculated using Aetna's negotiated fees. Aetna's negotiated fees do not apply to care that is not covered under the Plan.

When you use a non-network provider, your benefits are determined using the **recognized charge**. If the non-network provider's charge is more than the recognized charge (as defined by Aetna), **you pay the difference**. This excess amount will not apply toward your deductible or out-of-pocket maximum.

Aetna Provider Network

To participate in Aetna's network, a provider must meet certain standards in a process called credentialing, which looks at factors such as education and licensing.

To find a network provider in your area:

- ***Use the provider search at*** **www.aetna.com.** Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you are willing to travel. When you are asked to select a plan category, choose *Aetna Open Access® Plans*, then select *Aetna Choice® POS II (Open Access).* You can search the online directory for a specific provider or all providers in a given ZIP code and/or travel distance. You can also get information about a provider's practice, such as address, phone numbers and access for the disabled.
- ***Call or email Aetna Member Services.*** A representative can help you find a network provider in your area. The Aetna Member Services toll-free number is shown on your ID card. You also may email Aetna Member Services from Aetna's secure member website. Just go to **www.aetna.com** and select "Member Log In."

Primary Care Physician (PCP)

You may decide to choose a primary care physician (PCP) for routine care such as health screenings and care for everyday health problems. A PCP can be a general practitioner, family practitioner, internist, pediatrician or an OB/GYN. You can choose a different PCP for each member of the family, and you can change your PCP at any time.

You are not required to choose a PCP; however, you are encouraged to develop a relationship with a primary doctor.

- Your PCP or other primary doctor is your personal health care manager. He or she gets to know your personal health history and health care needs, maintains all of your records and can recommend a specialist when you need care that he or she cannot provide.
- Your network provider takes care of precertification. This is an approval process that is required for certain types of care. **If you receive care from a non-network provider, it is your responsibility** to ensure that any required precertification is obtained.

Specialists

Specialists are doctors such as oncologists, cardiologists, chiropractors, neurologists or podiatrists. When you need specialty care, you can make an appointment directly with any licensed specialist. *No referral is required.* Remember, you will pay less out of your own pocket when you use a network provider. You can find a network specialist the same way you find a PCP. If you decide to choose a PCP, he or she can help you find the right specialist.

Out-of-Area Benefits

The Aetna Choice® POS II network is not available in a few geographical areas. If you or a covered dependent lives outside of a network area, your benefits will be administered as though you live within a network area (i.e., network coinsurance levels will apply), except allowed charges will be limited to the recognized charge.

When you need care, choose any licensed provider. You may need to pay for your care at the time you receive it and then file a claim for reimbursement, or your provider may submit the claim for you and bill you for the balance after the claim is processed. All benefits are based on the recognized charge for a given service or supply. If you are charged more than the recognized charge, you must pay the difference, which does not apply to your deductible or out-of-pocket limit.

Your Share of Medical Service Cost

You share in the cost of your care by making monthly contributions, if applicable, for the cost of coverage and paying deductibles and coinsurance. These terms are explained below and specific deductibles and coinsurance percentages are shown in the chart in the **Benefits at a Glance.** In line with Oxy's cost-sharing philosophy and as a means of encouraging participants to use their Medical Plan benefits wisely, contributions, annual deductibles and coinsurance will increase as the annual Medical Plan costs increase over time.

Deductible

	AETNA RETIREE MEDICAL PLAN
Individual Deductible	The individual deductible is the part of the network and non-network covered expenses you pay each year before the Plan starts to pay benefits. Network expenses count toward the non-network deductible and vice versa. Prescription drug expenses do not count toward your medical deductible. Once you meet the individual deductible, the Plan starts to pay benefits. Each January 1, you start over with a new deductible.
Family Deductible	Once the total of covered expenses applied toward the individual deductibles for you and any covered dependents reaches the family deductible, you and your dependents will all be considered to have met the family deductible, and the Plan will pay benefits for you and your covered dependents.

The annual deductible for you and your dependents is based on your retirement date and when you become eligible for Medicare:

- Retirees who retired and were Medicare-eligible on or after January 1, 2000 will have deductibles as shown in the **Benefits at a Glance**.
- Retirees who retired after January 1, 1984, and were Medicare-eligible before January 1, 2000, currently do not pay monthly contributions for medical coverage. Instead, the deductible represents a combination of the deductible plus the annualized contribution. In 2019, this annual deductible for network services is $2,200 per individual ($400 plus the $150 retiree base rate times 12 months) with a maximum $4,400 per family. The 2019 non-network deductible for this group will be $2,600 per person and $5,200 for the family maximum.
- Certain Oxy retirees who retired before January 1, 1984 have an annual deductible for network services of $150 per person, with a maximum family deductible of $450.

Coinsurance

Once you meet the deductible, the Plan pays part of your covered expense and you pay the rest. The part you pay is called your coinsurance.

Out-of-Pocket Maximum

AETNA RETIREE MEDICAL PLAN	
Out-of-Pocket Maximum	The Plan puts a limit on the dollar amount you pay for covered network and non-network expenses out of your own pocket—called the out-of-pocket maximum. • Your out-of-pocket maximum is based on whether you receive network or non-network care. • **Once your share of covered expenses (including the deductible) reaches the individual out-of-pocket maximum, the Plan pays 100% of covered expenses for the rest of the calendar year.** Each January 1, you start over with a new out-of-pocket maximum**.** There is a separate individual out-of-pocket maximum for prescription drugs as described in *Prescription Drug Benefits*. • Your Medical Plan contributions and any precertification penalties as well as the prescription drug out-of-pocket limit do not apply toward the medical out-of-pocket maximum.
Family Out-of-Pocket Maximum	Once the total of amounts applied toward the individual out-of-pocket maximums for you and your covered dependents reaches the family out-of-pocket maximum, the Plan pays 100% of covered expenses for all covered family members for the rest of the calendar year.

You may access information about your current deductible and maximum benefits at OxyLink Online at **oxylink.oxy.com**.

Negotiated Fees vs. Recognized Charges

When you receive care from a network provider, your covered benefits are based on Aetna's negotiated fees. These are the fees that network providers agree to charge Aetna members for their services. Aetna's negotiated fees do not apply to care that is not covered under the Plan.

When you receive care from a non-network provider, your benefits are based on the recognized charge for a service or supply (as determined by Aetna). The recognized charge is the usual and recognized charge for health care services in a given geographic area. If a non-network provider charges you more than the recognized charge, **you must pay the difference**. This excess amount will not apply toward your deductible or out-of-pocket maximum.

For prescription drugs, if you purchase prescriptions from an Express Scripts network retail or mail order pharmacy, your copay and coinsurance amount is based on Express Scripts discounted pricing. Reimbursement for prescriptions obtained through a non-network pharmacy is described in Prescription Drug Benefits.

Precertification for Non-Medicare Eligible Participants

To receive certain benefits from the Plan, non-Medicare eligible participants must follow the precertification rules described in this section. (Precertification does not apply to Medicare-eligible participants.)

Understanding Precertification

Certain services such as inpatient stays, certain tests, procedures and outpatient surgery require precertification by Aetna. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the Plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to precertify services provided by a network provider. Network providers obtain necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services.

When you go to a non-network provider, it is **your responsibility** to obtain precertification from Aetna for any services or supplies on the precertification list on the next page. If you do not precertify, your benefits may be reduced, or the Plan may not pay any benefits.

Important

This section contains important information on the precertification process and any impact it may have on your coverage.

Precertification requirements do not apply to Medicare-eligible participants because Medicare is their primary coverage.

Precertification Process

Before being hospitalized or receiving certain other medical services or supplies, you must follow certain precertification procedures.

You, a member of your family, a hospital staff member, or the attending physician must notify Aetna to precertify the admission or medical services and expenses before receiving any of the services or supplies that require precertification, within the specified timeframes listed below. If you are using a network provider, generally, he or she is responsible for precertification.

To obtain precertification, you, your physician or the facility must call Aetna at the telephone number listed on your ID card. This call must be made as follows:

SERVICE	PRECERTIFY
For non-emergency admissions	At least five days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition	Before the outpatient care, treatment or procedure if possible, or as soon as reasonably possible.
For an emergency admission	Within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission	Before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness or an injury.
For outpatient non-emergency medical services requiring precertification	At least five days before the outpatient care is provided or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your physician of the precertification decision. If your precertified expenses are approved, the approval is good for 60 days as long as you remain enrolled in the Plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision as described in **Claims and Appeals Procedures: When You Disagree with a Claim Decision**.

Services and Supplies to Precertify

Precertification is required for the following types of inpatient and outpatient care medical expenses:

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a residential treatment facility for treatment of mental disorders and substance abuse
- Partial hospitalization programs for mental disorders and substance abuse
- Home health care
- Private duty nursing care
- Intensive outpatient programs for mental disorders and substance abuse
- Applied behavioral analysis therapy
- Neuropsychological testing
- Outpatient detoxification
- Psychiatric home care services
- Psychological testing

If You Fail to Precertify

A precertification penalty of $500, or the cost of the treatment, if less, will be applied to the benefits paid if you do not obtain a required precertification before incurring medical expenses. You are responsible for obtaining the necessary precertification from Aetna before receiving services from a non-network provider. Your provider may precertify your treatment for you; however, you should verify with Aetna before the procedure that the provider has obtained precertification from Aetna.

If your treatment requires precertification and it isn't obtained, Aetna will reduce the amount paid toward your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

Here's how your benefits are affected if the necessary precertification is not obtained.

IF PRECERTIFICATION IS:	THEN THE EXPENSES ARE:
Requested and approved by Aetna.	Covered.
Requested and denied.	Not covered; may be appealed.
Not requested, but would have been covered if requested.	Covered after a precertification penalty is applied.
Not requested, would not have been covered if requested.	Not covered; may be appealed.

Remember, any additional out-of-pocket expenses incurred because your precertification requirement was not met will ***not count*** toward your deductible, coinsurance or out-of-pocket maximum.

The Plan pays benefits for covered medical expenses only. If a service or supply you receive while confined as an inpatient is not covered by the Plan, benefits will not be paid for it—whether or not your inpatient confinement has been precertified.

Covered Medical Expenses

This section describes the services and supplies covered under the Aetna Retiree Medical Plan. If you are not eligible for Medicare, unless otherwise noted in **Benefits at a Glance**, network charges are covered at 90% or 80% and non-network charges are covered at 70%. If you are Medicare-eligible, Medicare is your primary coverage and the Plan integrates benefits as described under **Integration with Medicare**. The deductible applies unless otherwise noted.

Although a service may be listed as a covered benefit, it will not be covered unless it is medically necessary for the diagnosis or treatment of your illness or injury. Also, regardless of whether you use a network or non-network provider, in most cases the Plan does not cover treatments, procedures or tests that are considered experimental or investigational as described in **What the Medical Plan Does Not Cover**. To find out if a service is considered experimental or investigational, you may contact Aetna Member Services or refer to Aetna's Clinical Policy Bulletins available online at **www.aetna.com.**

Acupuncture

The Plan covers up to 26 visits per calendar year for acupuncture therapy.

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your physician, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure and
- To alleviate chronic pain or to treat:
  - Postoperative and chemotherapy-induced nausea and vomiting
  - Nausea of pregnancy
  - Postoperative dental pain
  - Temporomandibular disorders (TMD)
  - Migraine headache
  - Pain from osteoarthritis of the knee or hip (adjunctive therapy).

Ambulance Services

Ground Ambulance

The Plan covers charges for transportation:

- To the first hospital where treatment is given in a medical emergency;
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition (limited to 100 miles); and
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available;
- Your condition is unstable and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital (the two conditions above must be met).

Ambulance Services Limitations

The Plan does not cover charges incurred to transport you:

- If an ambulance service is not required by your physical condition;
- If the type of ambulance service provided is not required for your physical condition;
- By any form of transportation other than a professional ambulance service; or
- By fixed wing air ambulance from a non-network provider.

Clinical Trials

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures under an approved clinical trial only when you have cancer or a terminal illness, and *all* of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on published, peer-reviewed scientific evidence, that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets all of these criteria.

An “approved clinical trial” is a clinical trial that meets these criteria:

- The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs

Covered expenses include charges made by a provider for “routine patient costs” furnished in connection with your participation in an approved clinical trial for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Clinical Trials Limitations

The Plan does not cover:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies).

Dental Care

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a physician, a dentist or hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues as follows:

- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) for surgery needed to:
  - Treat a fracture, dislocation or wound;
  - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues;

  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth; or
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition natural teeth damaged, lost or removed; or other body tissues of the mouth fractured or cut due to injury. Any such teeth must have been free from decay or in good repair and be firmly attached to the jaw bone at the time of the injury. Treatment must be completed in the calendar year of or calendar year following the accident.
- If crowns, dentures, bridges or in-mouth appliances are installed due to injury, covered expenses only include charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Jaw Joint Disorders

The Plan also covers charges for the following services and supplies for treatment of a jaw joint disorder if they are the result of a disease:

- Diagnosis;
- Non-surgical treatment (including appliance therapy and adjustments to a maximum of six months per lifetime);
- Surgery to alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement; and
- Hospital services and supplies.

If treatment is for an injury, the treatment must be done in the calendar year of the accident that caused the injury or in the next calendar year.

Diagnostic and Preoperative Testing

Outpatient Complex Imaging Expenses

The Plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- Computerized axial tomography (CAT or CT) scans;
- Magnetic resonance imaging (MRI);
- Positron emission tomography (PET) scans; and
- Any other outpatient diagnostic imaging service costing over $500.

The Plan **does not** cover diagnostic complex imaging expenses under this part of the Plan if such imaging expenses are covered under any other part of the Plan.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.

Coverage for certain services including, but not limited to, multiple x-rays performed on the same day may be limited or reduced.

Outpatient Preoperative Testing

Before a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a hospital; and
- Not repeated in or by the hospital or surgery center where the surgery will be performed.

Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

The Plan **does not** cover diagnostic complex imaging expenses under this part of the Plan if such imaging expenses are covered under any other part of the Plan. If your tests indicate that surgery should not be performed because of your physical condition, the Plan will pay for the tests, however surgery will not be covered.

Durable Medical Equipment

The Plan covers durable medical equipment (such as wheelchairs, walkers, crutches) as follows:

- Rental of durable medical equipment. Instead of rental, the Plan may cover the initial purchase of this equipment if Aetna is shown that long-term use of it is planned and that it either cannot be rented or would cost less to purchase than to rent;
- Repair of purchased durable medical equipment; and
- Replacement of purchased durable medical equipment if Aetna is shown that it is needed because of a change in the person's physical condition, or if it is likely to cost less to purchase a replacement than to repair existing equipment or rent similar equipment.

Emergency and Urgent Care

Emergency Medical Conditions

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physician services;
- Hospital nursing staff services; and
- Radiologist and pathologist services.

You should contact your physician after receiving treatment for an emergency medical condition.

Important

With the exception of urgent care, if you visit a hospital emergency room for a non-emergency condition, the Plan will not cover your expenses. No other Plan benefits will pay for non-emergency care in the emergency room.

Urgent Conditions

Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition.

Urgent care coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- Physician services;
- Nursing staff services; and
- Radiologist and pathologist services.

You should contact your physician after receiving treatment for an urgent condition.

Family Planning

For females with reproductive capacity, the Plan pays those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist in either a group or individual setting.

Covered expenses include charges made by a physician for:

- Services and supplies needed to administer or remove a covered contraceptive prescription drug or device;
- Female injectable contraceptives that are generic prescription drugs;
- Female contraceptives devices that are generic devices and brand name devices;
- Female voluntary sterilization, including charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants;
- Male voluntary sterilization; and
- Voluntary termination of pregnancy.

Pregnancy Coverage

The Plan pays benefits for pregnancy-related expenses on the same basis as it would for a disease. For inpatient care of a mother and newborn child, benefits will be payable for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

Precertification is not required for the first 48 hours of hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits must be precertified. You, your doctor or other health care provider can request precertification by calling the number on your ID card.

To be covered, expenses must be incurred while covered by the Plan. Any pregnancy benefits payable by a previous group medical coverage will be subtracted from benefits payable under the Plan.

Infertility Coverage

The Plan covers services to diagnose and treat an underlying medical condition that causes infertility when provided by or under the direction of a physician.

The Plan covers treatments for infertility up to a lifetime maximum of $20,000 (network and non-network combined limit) for medical related services. The services must be preauthorized by calling the National Infertility Unit at **800-575-5999** before the initiation of hormone treatment services. Failure to obtain preauthorization of services will result in a denial of benefits.

The following procedures are covered:

- Artificial insemination cycles (including intrauterine insemination) stimulated with ovulatory stimulants (e.g. Clomid) or aromatase inhibitors (e.g. Letrozole) or completed without stimulation medications.
- Advanced reproductive technologies (ART) such as: in-vitro fertilization (IVF), frozen embryo transfer (FET), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), and intracytoplasmic sperm injection (ICSI). Call the National Infertility Unit at **800-575-5999** before treatment begins to confirm coverage.

Infertility medications necessary for the provision above, including parenteral injection and oral ovulation induction drugs will be subject to a $10,000 lifetime pharmacy limit.

All frozen embryos stored after a completed cycle with ovarian stimulation must be used before coverage availability for another ovarian stimulation cycle. Embryo transfer guidelines should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate.

The following services, expenses and fees are not covered:

- Donor-related for donated oocytes or sperm, including medical and travel expenses; agency, lab and donor fees; psychological screening; FDA testing for the donor and partner; genetics screening; and all medications for the donor;
- IUI cycle stimulated with gonadotropins or menotropins;
- Fallopian tube ligations and vasectomy reversals;
- Surrogacy and associated fees;
- Experimental or investigational medical and surgical procedures;
- Services not medically appropriate per Aetna’s Clinical Policy Bulletin for Infertility Coverage; and
- Non-participating provider services, unless authorized by the NIU.

Hearing Aids

Hearing aids will be covered up to $2,500 every 3 years.

Eligible health services include hearing care that includes prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

- Any wearable non-disposable instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments, or accessories

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist or otologist.
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam.
- Any other related services necessary to access, select and adjust or fit a hearing aid.

Special coverage options after your Plan coverage ends

Continuation of coverage for other reasons
To request an extension of coverage, just call the toll-free Member Services number on your ID card.

How can you extend coverage for hearing services and supplies when coverage ends?
If your coverage ends while you are not totally disabled, your Plan will cover hearing services and supplies within 30 days after your coverage ends if:

- The prescription for the hearing aid is written in the 30 days before your coverage ended.
- The hearing aid is ordered during the 30 days before the date coverage ends.

Home Health Care

Covered expenses include charges for home health care services when ordered by a physician as part of a home health care plan, provided you are:

- Transitioning from a hospital or other inpatient facility, and the services are in lieu of a continued inpatient stay; or
- Homebound because of illness or injury.

Covered expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a hospital or skilled nursing facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services if these services are provided within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services by a qualified social worker, when provided in conjunction with skilled nursing care.
- Skilled behavioral health care services provided in the home by a behavioral health provider when ordered by a physician and directly related to an active treatment plan of care established by the physician as long as:

- The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications;
- The services are in lieu of a continued confinement in a hospital or residential treatment facility, or receiving outpatient services outside of the home;
- The services provided are not primarily for comfort, convenience or custodial in nature;
- The services are intermittent or hourly in nature; and
- The services are not for applied behavioral analysis.

Benefits for home health care visits are payable up to the home health care plan maximum. **In calculating the calendar year maximum visits, each four-hour visit by a nurse or therapist is one visit, and each behavioral health provider visit of up to one hour is one visit.** This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for home health care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent on others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Unless specified above, **not covered** under this benefit are charges for:

- Services or supplies that are not a part of the home health care plan;
- Services of a person who usually lives with you, or who is a member of your or your spouse's family;
- Services of a certified or licensed social worker;
- Services for infusion therapy;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
- Services that are custodial care.

Important

The Plan does **not** cover custodial care, even if care is provided by a nursing professional, and a family member or other caretakers cannot provide the necessary care.

Home health care needs to be precertified by Aetna. See **Precertification** for details.

Home health care plan maximum is 120 visits per calendar year (combination of network and non-network). See this *Home Health Care* section for definition of what constitutes a **visit**.

Hospice Care

The Plan covers hospice care that is provided as part of a hospice care program for a person with a prognosis of 12 months or less to live. The Plan covers charges made by a hospice facility, hospital or skilled nursing facility on its own behalf for:

- Inpatient care—Room and board charges, up to the semi-private room rate and other services and supplies provided to a person while a full-time inpatient for pain control, and other acute and chronic symptom management.
- Outpatient care—Those services and supplies furnished to a person while not confined as a full-time inpatient.

The Plan covers outpatient charges made by a hospice care agency for:

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day;
- Medical social services under a physician's direction. These include:
  - Assessment of the person's social, emotional and medical needs, and the home and family situation;
  - Identifying community resources available to the person; and
  - Helping the person make use of these resources;
- Psychological and dietary counseling;
- Consultation or case management services provided by a physician;
- Physical and occupational therapy;
- Part-time or intermittent home health aide services for up to eight hours in any one day. These services consist mainly of caring for the person;
- Medical supplies; and
- Drugs and medicines prescribed by a physician.

Charges made by a physician for consulting or case management services and charges made by a physical or occupational therapist are also covered if:

- The provider is not an employee of a hospice care agency; and
- A hospice care agency is still responsible for the person's care.

As part of hospice care coverage, the Plan covers home health care agency expenses for:

- Physical and occupational therapy;
- Part-time or intermittent home health aide services for up to eight hours in any one day, which consist mainly of caring for the person;
- Medical supplies;
- Drugs and medicines prescribed by a physician; and
- Psychological and dietary counseling.

The Plan's hospice care benefit *does not* include coverage for:

- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling, including estate planning and the drafting of a will; and
- Homemaker or caretaker services. These are services not entirely related to the care of a person and include sitter or companion services for the person who is ill or other family members; transportation; housecleaning and home maintenance.

Important

Inpatient hospice care and home health care must be precertified by Aetna. See **Precertification** for details.

Hospital Services

Inpatient Hospital Expenses*

The Plan covers charges made by a hospital for room and board, and other hospital services and supplies for a person confined as an inpatient. Room and board charges are covered up to the hospital's semi-private rate.

Room and board charges include:

- Services of the hospital's nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

The Plan also pays for other services and supplies provided during an inpatient stay such as:

- Ambulance services;
- Physician and surgeon services;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products, but not the cost of the blood or blood products;
- Radiation therapy;
- Speech therapy, physical therapy and occupational therapy;
- Oxygen and oxygen therapy;
- Radiological services, laboratory testing and diagnostic services;
- Medications and intravenous (IV) preparations; and
- Discharge planning.

Important

Hospital admissions need to be precertified by Aetna. See **Precertification** for details.

Outpatient Hospital Expenses

The Plan covers charges made by a hospital for hospital services and supplies provided to a person who is not confined as an inpatient. Charges include:

- Professional fees; and
- Services and supplies furnished by the hospital on the day of a treatment, procedure or test.

* To receive network benefits for certain transplant procedures and related services, you must participate in the National Medical Excellence Program. See **Special Programs** for more information.

Mental Disorders and Substance Abuse Treatment

Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

In addition to meeting all other conditions for coverage, the treatment plan must:

- Be written and prescribed and supervised by a behavioral health provider;
- Include follow-up treatment; and
- Be for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

- **Inpatient treatment:** Covered expenses include room and board charges at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.
- **Partial confinement treatment:** Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
- **Outpatient treatment:** Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The Plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Outpatient mental health treatment also includes:
  - Electro-convulsive therapy (ECT); and
  - Substance use disorder injectables.

Substance Abuse

Covered expenses include charges made for the treatment of substance abuse by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider; and
- The program of therapy includes either:
  - A follow-up program directed by a behavioral health provider on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse.

Important

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See **What the Medical Plan Does Not Cover** for more information.

Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. See **Precertification** for details.

The Plan covers:

- **Inpatient Treatment:** Covered expenses include room and board charges at the semi-private room rate, and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent. Coverage includes treatment in a hospital-when the hospital does not have a separate treatment facility section-for the medical complications of substance abuse. Medical complications include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- **Partial Confinement Treatment:** Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance abuse. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
- **Outpatient Treatment:** Outpatient treatment includes charges for treatment of substance abuse received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The Plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Obesity Treatment

Covered expenses include one morbid obesity surgical procedure within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned. Covered expenses also include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of morbid obesity for the following outpatient weight management services:

- An initial medical history and physical exam; and
- Diagnostic tests given or ordered during the first exam.

Physician Services

Physician Visits

Covered expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay, or in an outpatient facility. Covered expenses also include:

- Allergy testing, treatment and injections; and
- Charges made by the physician for supplies, radiological services, x-rays and tests provided by the physician.

Surgery

Covered expenses include charges made by a physician for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another physician to obtain a second opinion before the surgery.

Coverage for certain services including, but not limited to, secondary and/or multiple surgeries and assistant surgeon charges may be limited or reduced.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Preventive Care

In compliance with health care reform, the Plan covers certain preventive services such as routine well woman, well man and well child exams that are submitted and billed by your provider as preventive care at 100% coverage with no deductible. The list of services is normally updated annually, so you should contact Aetna to determine if a service is considered preventive or to request a current list of covered preventive care services.

If an exam or service is given to diagnose or treat an illness or injury, it is not considered a physical exam or routine screening, so the exam and/or service ***would not*** be processed under preventive care. It would be processed as a regular medical claim subject to deductible and coinsurance.

Routine Physical Exams

Covered expenses include charges made by your primary care physician (PCP) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human immune deficiency virus (HIV) infections.
    - Screening for gestational diabetes for women.
    - High-risk human papillomavirus (HPV) DNA testing for women age 30 and older.
  - X-rays, lab and other tests given in connection with the exam.
  - For covered newborns, an initial hospital checkup.

Unless specified above, *not covered* under this benefit are charges for:

- Services covered to any extent under any other part of the Plan;
- Services for diagnosis or treatment of a suspected or identified illness or injury;
- Exams during your stay for medical care;
- Services not given by a physician or under his or her direction; or
- Psychiatric, psychological, personality or emotional testing or exams.

Immunizations

Covered expenses include charges made by your physician or a facility that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for:

- Immunizations for infectious diseases; and
- Materials for administration of immunizations.

The Plan does not cover charges incurred for immunizations that are not considered preventive care such as those required due to your employment or travel.

Well Woman Preventive Visits

Covered expenses include charges made by your physician, obstetrician or gynecologist for:

- A routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury; and
- Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. Covered expenses include charges made by a physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, the Plan will not cover charges for:

- Services covered to any extent under any other part of this Plan;
- Services for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Routine Screenings for Cancer

Covered expenses include, but are not limited to, charges incurred for routine cancer screenings as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) test;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE);
- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense); and
- Lung cancer screening.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, this preventive care benefit does not cover charges incurred for services that are covered to any extent under any other part of this Plan.

Screening and Counseling Services

Covered expenses include charges made by your PCP in an individual or group setting for the following:

- **Obesity and/or Healthy Diet:** Screening and counseling services to aid in weight reduction due to obesity. Coverage is limited to 26 network and 10 non-network visits; however, of these only 26 visits will be allowed under the Plan for healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. Each session of up to 60 minutes is equal to one visit. Coverage includes:
  - Preventive counseling visits and/or risk factor reduction intervention;
  - Nutrition counseling; and
  - Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.
- **Misuse of Alcohol and/or Drugs:** Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment. Coverage is limited to five visits. Each session of up to 60 minutes is equal to one visit.
- **Use of Tobacco Products:** Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage is limited to eight visits. Each session of up to 60 minutes is equal to one visit. Coverage includes, to aid in the cessation of the use of tobacco products:
  - Preventive counseling visits;
  - Treatment visits; and
  - Class visits.
- **Sexually Transmitted Infections:** Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections. Coverage is limited to two visits. Each session of up to 30 minutes is equal to one visit.
- **Genetic Risks for Breast and Ovarian Cancer:** Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

Prenatal Care

Coverage for prenatal care is limited to pregnancy-related physician office visits, including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check and fundal height).

Unless otherwise specified, the Plan does not cover charges for:

- Services that are covered to any extent under any other part of this Plan; and
- Pregnancy expenses (other than prenatal care as described above).

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breastfeeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breastfeeding by a certified lactation support provider. Covered services include:

- **Lactation Support and Lactation Counseling Services:** Covered expense when provided in either a group or individual setting. Benefits for lactation counseling services are limited to six network visits in 12 months. Additional or non-network visits are covered as physician office visits.
- **Breastfeeding Durable Medical Equipment:** Coverage includes the rental or purchase of breastfeeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows:
  - Breast pump: Covered expenses include the following:
    - The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.
    - The purchase of:
      - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
      - A manual breast pump. A purchase will be covered once per pregnancy.

      If an electric breast pump was purchased within the previous three-year period, the purchase of another breast pump will not be covered until a three-year period has elapsed from the last purchase.
  - Breast pump supplies: Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

  Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Aetna reserves the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item that can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Vision Care Services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The Plan covers charges for one routine eye exam in any calendar year.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device. The Plan covers the first prosthesis for an internal body part or organ or external body part that you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of illness, injury or congenital defect as described in the list of covered devices below:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;

- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made and fitted for you.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition, or normal growth or wear and tear;
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The Plan will *not cover* expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the shoes are the first pair of corrective shoes for a child up to age two, or if an orthopedic shoe is an integral part of a covered leg brace;
- Trusses, corsets and other support items; or
- Any item listed in **What the Medical Plan Does Not Cover**.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a physician, hospital or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part;
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18;
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided the reconstructive surgery occurs no more than 24 months after the original injury. Note: Injuries that occur as a result of medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected; and
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when the defect results in:
  - Severe facial disfigurement; or
  - Significant functional impairment and the surgery is needed to improve function.

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Sexual Health

The Plan covers charges for any treatment, drug, service or supply related to changing sex or sexual characteristics.

Short-Term Rehabilitation Therapy Services

Covered expenses include charges for short-term therapy services when prescribed by a physician as described below. The services must be performed by a:

- Licensed or certified physical, occupational or speech therapist;
- Hospital, skilled nursing facility or hospice facility;
- Behavioral health provider for autism spectrum disorder; or
- Physician.

Charges for the following short-term rehabilitation expenses are covered:

Autism Spectrum Disorder Benefits

Covered expenses for autism spectrum disorder (as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association) include charges made for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy) of autism spectrum disorder when ordered by a physician, licensed psychologist, or licensed clinical social worker, as part of a treatment plan, when the covered child is diagnosed with autism spectrum disorder.

Cardiac and Pulmonary Rehabilitation Benefits

Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The Plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of a reversible pulmonary disease state. This course of treatment is limited to a maximum of 36 hours or a six-week period.

Therapy

The Plan covers outpatient cognitive therapy, physical therapy, occupational therapy and speech therapy rehabilitation. Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient hospital and skilled nursing facility benefits provision in this SPD:

- **Applied behavioral analysis (ABA) therapy** for individuals diagnosed with an Autism Spectrum Disorder. Specific criteria must be met to be eligible for this benefit. Treatment is based on medical necessity and requires precertification. This program also requires ongoing reviews for continuation of therapy.
- **Cognitive therapy** associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- **Occupational therapy** (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.

- **Physical therapy** is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- **Speech therapy** is covered for non-chronic conditions and acute illnesses and injuries if expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

Coverage for physical, occupational and speech therapy is also available for the treatment of developmental delays (as an exception to the non-chronic condition criteria described in the bullets above).

A visit consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period. The therapy should follow a specific treatment plan that details the treatment, specifies frequency and duration, and provides for ongoing reviews; and is renewed only if continued therapy is appropriate.

Unless specifically covered above, *not covered* under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include pervasive development disorders, Down syndrome and cerebral palsy, as they are considered both developmental and/or chronic in nature. This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of autism spectrum disorders;
- Any services that are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;
- Services not performed by a physician or under the direct supervision of a physician;
- Treatment covered as part of the spinal manipulation treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a physician or physical, occupational or speech therapist who resides in your home or who is a member of your or your spouse's family; or
- Special education to instruct a person whose speech has been lost or impaired to function without that ability, including lessons in sign language.

Skilled Nursing Care

The Plan covers charges by an R.N., L.P.N., or nursing agency for outpatient skilled nursing care. This is care by a visiting R.N. or L.P.N. to perform specific skilled nursing tasks.

Covered expenses also include private duty nursing provided by a R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a calendar year in excess of the Private Duty Nursing Care maximum shifts. Each period of private duty nursing of up to eight hours is considered one private duty nursing shift.

Limitations

Unless specified above, the Plan does not cover charges for:

- Nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a hospital or health care facility.
- A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

Skilled Nursing Facility Care

The Plan covers charges made by a skilled nursing facility for the services and supplies listed below. These must be provided to a person while confined to convalescent care from an illness or injury.

- Room and board, including charges for services (such as general nursing care) made in connection with room occupancy. Any charge for room and board in a private room that exceeds the hospital's semi-private room rate is *not* covered;
- Use of special treatment rooms;
- X-ray and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy; and
- Other medical services provided by a skilled nursing facility. This does not include private or special nursing, physician services, drugs, biologicals, solutions, dressings, casts and other supplies.

Skilled nursing facility care *does not* include charges for treatment of:

- Drug addiction;
- Chronic brain syndrome;
- Alcoholism;
- Mental retardation; and
- Any other mental disorder.

Important

Admission to a skilled nursing facility must be precertified by Aetna. See **Precertification** for details.

The Plan pays for a maximum of 120 days for skilled nursing services per calendar year, combined for network and non-network care.

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a hospital; or
- A physician in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto the Aetna member website at **www.aetna.com** or calling the number on the back of your ID card.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for inpatient infusion therapy is provided under inpatient hospital and skilled nursing facility. Benefits payable for infusion therapy will not count toward any applicable home health care maximums.

Spinal Manipulation Benefit

The Plan covers expenses for chiropractic therapy services such as manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine. Benefits are paid for up to 26 visits per calendar year.

The maximum does not apply to expenses incurred:

- While the person is a full-time inpatient in a hospital;
- For treatment of scoliosis;
- For fracture care; or
- For surgery, including pre- and post-surgical care provided or ordered by the operating physician.

Special Programs

As participants in the Plan, you and your covered family members can take advantage of the special care programs described in this section.

24/7 Telemedicine Services

Teladoc gives you access 24/7 to a U.S. board-certified doctor for non-emergency medical conditions through the convenience of phone, video or mobile app visits. Set up your account by visiting Teladoc.com/Aetna, download the app from your mobile store or call 1-855-Teladoc (835-2362). You will need to provide a medical history and request a consult. You pay the applicable cost up front.

Transplants—National Medical Excellence Program®

The National Medical Excellence (NME) Program® helps you and covered family members receive care from nationally recognized doctors and facilities specializing in solid organ and bone marrow transplants and certain other specialized care.

Transplant Services

Eligible health services include organ transplant services provided by a physician and hospital.
Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-cell receptor therapy for FDA-approved treatments

Network of transplant specialist facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need, or
- A Non-IOE facility.

Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

The National Medical Excellence (NME) Program® will coordinate all solid organ, bone marrow and CAR-T and T-cell therapy services, and other specialized care you need.

Many pre- and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the covered service is not directly related to your transplant.

Important

To ensure coverage, all transplant procedures need to be precertified by Aetna. See **Precertification** for details.

Expenses Not Covered

Unless specified above, *not covered* under this benefit are charges incurred for:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Network of Transplant Specialist Facilities

If you are a participant in the Institutes of Excellence™ (IOE) program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits may vary if an IOE facility or non-IOE or non-network provider is used. The network level of benefits is paid only for a treatment received at a facility designated by the Plan as an IOE for the type of transplant being performed. Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as non-network services and supplies, even if the facility is a network facility or IOE for other types of services. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

You can obtain a list of IOE facilities on the provider search (**www.aetna.com**) or by contacting Aetna Member Services at **800-334-0299.**

Travel and Lodging

When significant travel is required to use an IOE facility, you may be eligible for travel and lodging allowances according to Aetna's standard internal policies and procedures.

Other Health Management Programs

Special programs are available to provide you with education, guidance and tools to better handle certain conditions and health care events. Discount programs are also available to give you access to savings on weight management, fitness, vision and hearing products and services, and alternative therapies.

For more details, log on to the member website at **aetna.com** and select *Health Programs* for links to health management and family health program information and resources.

In Touch Care

When you're facing a chronic or acute health challenge, Aetna In Touch Care, a voluntary, confidential program, provides the resources you need, when you need them at no cost to you.

One-on-One Nurse Support

For urgent circumstances, an In Touch Care nurse provides one-on-one phone support for you and your family. The nurse can help you:

- Customize action plans that fit your life;
- Navigate the health care system;
- Coordinate your care; and
- Prepare for a hospital stay or plan for recovery.

Virtual Care

For less urgent, less immediate health needs, use online tools to help you:

- Track your health progress through an online health assessment, or track your health statistics and physical activity;
- Choose from several online coaching programs that provide customized tools and guidance; and
- Call an In Touch Care nurse if you need extra help along the way.

Aetna may contact you directly to notify you about this program. You can also learn more at **aetna.com**.

Compassionate Care℠ Program

The Aetna **Compassionate Care Program** can help you and your family when facing the advanced stages of an illness. You may have questions and difficult decisions to make. You don't have to do it alone. Nurse case managers and helpful resources are here to help. Call the Member Services toll-free phone number on your Aetna ID card to talk with a nurse case manager about the program.

Beginning Right℠ Maternity Program

This program helps pregnant women stay well and deliver healthier babies. The program provides:

- Educational materials about prenatal care, labor and delivery, postpartum depression and breastfeeding;
- Coordination of maternity care by trained obstetrical nurses;
- Access to a personalized smoking cessation program designed specifically for pregnant women;
- Specialized information for dad or partner;
- Preterm labor education; and
- Access to breastfeeding support services.

Under the program, your pregnancy care is coordinated by your OB/GYN doctor and Aetna case managers.

Another important feature, the *Pregnancy Risk Assessment*, is a survey that identifies women who may need more specialized prenatal and/or postnatal care due to their medical history or present health status. The program assists women at risk and their physicians in coordinating any specialty care that may be medically necessary.

If you are eligible for this program, an Aetna nurse will call to get you started or you can also call **800-334-0299** to participate.

Informed Health® Line

You and your family have around-the-clock access to an Aetna team of nurses experienced in providing information on a variety of health topics. Aetna's Informed Health® Line (IHL) nurses help you communicate more effectively with your physicians and provide you with information about:

- Health issues;
- Medical procedures; and
- Treatment options.

To reach the Informed Health® Line day or night, call **800-556-1555,** which is also listed on your Aetna ID card. You may also access the member website to review comprehensive and unbiased evidence-based information for help in making decisions about your health.

What the Medical Plan Does Not Cover

Not every medical service or supply is covered by the Plan, even if prescribed, recommended or approved by your physician or dentist. The Plan covers only those services and supplies that are medically necessary and included in **Covered Medical Expenses**. Charges made for the following are not covered except to the extent listed under *Covered Medical Expenses.*

This section contains a general list of charges *not covered* under the medical portion of the Aetna medical options. Excluded charges are not used when calculating benefits and do not count toward your deductible, coinsurance or out-of-pocket maximum.

Any Plan exclusions will not apply to the extent that coverage of the charges is required under any law that applies to the coverage. Also, the law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

General Exclusions

The Plan *does not* cover:

- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies that are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under **Continuation of Coverage**.
- Care, treatment, services or supplies not prescribed, recommended or approved by a physician or dentist.
- Services of a resident physician or intern rendered in that capacity.
- Charges made only because you have health coverage.
- Charges you are not legally obligated to pay.
- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member.
- Charges not recognized by the claims administrator.
- Charges for a service or supply furnished by a non-network provider in excess of the recognized charge.
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the Plan.

- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
- Charges in excess of the negotiated fee for a given service or supply given by a network provider.
- Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by Aetna when required. This exclusion does not apply in a medical emergency or in an urgent care situation.
- Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, Workers' Compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Behavioral Health Services

The Plan *does not* cover charges for:

- Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse is specifically provided in **Covered Medical Expenses**;
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field;
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine use or nicotine use;
- Treatment of antisocial personality disorder;
- Counseling services and treatment for marriage, religious, family, career, social adjustment, pastoral or financial counselor, except as specifically provided in **Covered Medical Expenses**;
- Wilderness treatment programs (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting; or
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or to medical treatment of the mentally retarded in accordance with the benefits provided in **Covered Medical Expenses**.

Cosmetic Services and Plastic Surgery

The Plan *does not* cover charges for any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons, including:

- Face lifts; body lifts; tummy tucks; liposuctions; removal of excess skin; removal or reduction of non-malignant moles, blemishes or varicose veins; cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants), except removal of an implant will be covered when medically necessary;

- Removal of tattoos (except for tattoos applied to assist in covered medical treatments such as markers for radiation therapy);
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct gynecomastia;
- Breast augmentation; and
- Otoplasty.

Custodial Care and Maintenance Care

The Plan *does not* cover charges for custodial care or maintenance care, as defined, without regard to who prescribes, recommends or performs these services.

Educational Services

The Plan *does not* cover charges for:

- Any services or supplies related to education, training or retraining services or testing, including special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities; minimal brain dysfunction; developmental, learning and communication disorders; behavioral disorders (including pervasive developmental disorders); training or cognitive rehabilitation; regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Experimental or Investigational

The Plan *does not* cover charges for experimental or investigational drugs, devices, treatment or procedures except as described in **Covered Medical Expenses**.

Facility Charges

The Plan *does not cover* facility charges for care services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums; or
- Infirmaries at schools, colleges, or camps.

Home and Mobility

The Plan *does not* cover charges for any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;

- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Motor Vehicle Accidents

The Plan *does not* cover charges incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.

Other Services and Supplies

The Plan also *does not* cover:

- Annual or other charges to be in a physician's practice;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practice;
- Charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD;
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity and urine auto-injections;
- Non-emergency charges incurred outside of the United States if you traveled to such location to obtain prescription drugs or supplies, even if otherwise covered under the Plan. This also includes prescription drugs or supplies if:
  - Such prescription drugs or supplies are unavailable or illegal in the United States; or
  - The purchase of such prescription drugs or supplies outside the United States is considered illegal;
- Charges for the LEAP, TEACCH, Denver and Rutgers programs;
- Dental services (except as provided in Dental Care) for any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
  - Services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
  - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
  - Non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

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

- Disposable outpatient supplies, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses and other devices not intended for reuse by another patient, except as specifically provided as covered;
- Drugs, medications and supplies that are excluded under the Oxy Retiree Medical Plan option, however, may be covered under **Prescription Drug Benefits**:
  - Over-the-counter drugs, biological or chemical preparations, and supplies that may be obtained without a prescription including vitamins;
  - Any services related to the dispensing, injection or application of a drug;
  - Any prescription drug purchased illegally outside the United States, even if otherwise covered under this Plan within the United States;
  - Immunizations related to work;
  - Needles, syringes and other injectable aids, except as covered for diabetic supplies;
  - Drugs related to the treatment of non-covered expenses;
  - Performance enhancing steroids;
  - Injectable drugs if an alternative oral drug is available;
  - Outpatient prescription drugs;
  - Self-injectable prescription drugs and medications;
  - Any prescription drugs, injectibles, or medications or supplies provided by the customer or through a third-party vendor contract with the customer; and
  - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in **Skilled Nursing Care**;
- Personal comfort or convenience items: any service or supply primarily for your convenience and personal comfort or that of a third party, including telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy;
- Expenses for preparing or copying medical reports, itemized bills or claim forms; mailing and/or shipping and handling; broken or cancelled appointments; sales tax; or interest charges;
- Travel expenses of a physician or covered person, except as specified in **Special Programs**;
- Food items, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if they are the sole source of nutrition (this exclusion does not apply to specialized medical foods delivered parenterally);
- Foot care except as provided in **Covered Medical Expenses** and any services, supplies or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
  - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
  - Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury;
- Hospital, inpatient or residential cognitive therapy, or educational therapy or retraining unless part of a neurological rehabilitation program for an acute organic brain condition;

- Treatment for developmental deficits, learning disability, pervasive development disorders and chronic organic brain syndrome; except as specifically provided in **Short-Term Rehabilitation Therapy Services**;
- Non-medical services in the treatment of mental disability (except initial diagnosis);
- Services and supplies provided for personal comfort or convenience, or for the convenience of any other person, including a provider;
- Drugs, medicines or supplies while not confined as an inpatient that do not require a physician's prescription;
- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the **Preventive Care**; however, the prescription drug benefits cover certain prescribed smoking cessation products;
- Performance, athletic performance or lifestyle enhancement drugs or supplies;
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services or supplies is provided for in this SPD;
- Dental procedures, except the procedures described in **Covered Medical Expenses**;
- Durable medical equipment charges for more than one item for the same or similar purposes;
- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered;
- Court ordered services, including those required as a condition of parole or release;
- Any health exams required:
  - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - By any law of a government;
  - For securing insurance, school admissions, or professional or other licenses;
  - To travel; and
  - To attend a school, camp, or sporting event or participate in a sport or other recreational activity;
- Any special medical reports not directly related to treatment except when provided as part of a covered service;
- Any growth/height treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth;
- Hearing:
  - Any hearing service or supply that does not meet professionally accepted standards; and
  - Hearing exams given during a stay in a hospital or other facility; and
  - Any tests, appliances and devices for the improvement of hearing, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech except to the extent coverage for such tests, appliances and devices is provided for in this SPD;
- Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries;

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities);
- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in **Covered Medical Expenses**;
- Payment for that portion of the charge for which Medicare or another party is the primary payer; or
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law), including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public hospital or other facility is required to provide; or
  - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Other Therapies and Tests

The Plan *does not* cover charges for any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy; and
- Thermograms and thermography.

The Plan *does not* cover charges for therapies for the treatment of congenital defects amenable to surgical repair (such as cleft lip/palate), except as specifically provided in **Covered Medical Expenses**.

Reproductive and Sexual Health

The Plan *does not* cover charges for:

- Contraception, except as specifically described in **Family Planning.** Not covered supplies include over-the-counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.
- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.
- Infertility: Except as specifically described in **Covered Medical Expenses**

Vision and Speech

The Plan *does not* cover charges for:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision services or supplies that do not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Contact lenses evaluation and fitting exam;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost, stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction; and
- Speech therapy for treatment of delays in speech development, except as specifically provided in **Covered Medical Expenses**.

Weight Management

Except as provided in **Obesity Treatment**, the Plan *does not* cover charges for treatments, prescription drugs, services, or supplies intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions.

Requesting Medical Benefits

In general, if you use a network provider, the provider will submit the claim for you. You must submit the claim if you use a non-network provider within 90 days after the date you incur a covered expense. If, through no fault of your own, you are unable to meet this deadline, your claim will still be accepted if you file as soon as possible. However, if a claim is filed more than two years after the 90-day deadline, it will not be covered unless you are legally incapacitated.

Filing Medical Claims

Claim forms are available on:

- OxyLink Online at **oxylink.oxy.com**
- **Aetna.com** or by calling Aetna Member Services at **800-334-0299**

The claim form contains instructions on how and when to file a claim, as well as the address to which you should send your completed form. When filing a claim for benefits, you must provide:

- Names and addresses of physicians or providers;
- The dates on which expenses are incurred; and
- Copies of all bills and receipts.

Claims should be submitted to:

Aetna Life Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079
Fax: **859-455-8650**

You should always submit claims to the primary plan first. When filing a claim for **coordination of benefits**, you must submit the explanation of benefits (EOB) statement received from the primary plan and all associated bills to the secondary plan.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative—a person you authorize, in writing, to act on your behalf. You need to tell Aetna if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling Aetna that you are allowing someone to appeal for you. You can get this form by contacting Aetna. You can use an authorized representative at any level of appeal. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Important

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures. See **When You Disagree with a Claim Decision** for more information about appeals.

Payment of Medical Benefits

Generally, benefits will be paid after services are rendered and as soon as Aetna receives the necessary proof to support the claim. Aetna will pay any benefits directly to you unless you or the provider tells Aetna to make benefits payable to the provider when the claim is filed.

Prescription Drug Benefits

Prescription drug coverage is provided through Express Scripts, Inc. (Express Scripts) for the Aetna Retiree Medical Plan.

This benefit has two components that covers outpatient prescription drugs prescribed by a physician to treat an illness or injury:

- The retail pharmacy benefit is designed to meet your short-term prescription drug needs of up to 30 days.
- The mail order pharmacy is designed for a longer-term prescription.

The amount you pay for your prescription depends on whether it is a generic, preferred or non-preferred brand name drug. Refer to the **Benefits at a Glance** chart for prescription drug **copay** and **coinsurance** information.

For mail-order and retail prescriptions, if a generic equivalent drug is available and you or your doctor select a preferred or non-preferred brand name drug, the Plan will only pay up to what it would have paid for the generic. You will be responsible for the balance, and the coinsurance and out-of-pocket maximums do not apply.

Retail Pharmacy

You should use a participating retail pharmacy for your short-term prescriptions (up to a 30-day supply). For maintenance prescription drugs, you can obtain your initial prescription plus two refills at a participating retail pharmacy and then a penalty will apply for any additional retail fills—see **Mail Order Pharmacy** for obtaining maintenance drugs. When you show your Express Scripts ID card to the pharmacist, you pay your retail copay or coinsurance plus any cost difference between brand and generic drugs for each prescription at the time of purchase.

To find a participating retail pharmacy near you:

- Log on to **express-scripts.com** and under Manage Prescriptions, select Locate a Pharmacy.
- Ask your retail pharmacy whether it participates in the Express Scripts network.

If you use a non-participating retail pharmacy, you must pay the entire non-discounted cost of the prescription and then submit a reimbursement claim form to Express Scripts. You will be reimbursed for the amount the covered medication would have cost at a participating retail pharmacy less the appropriate coinsurance.

For claims: Return the completed form and receipts to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

You may also fax your claim form to: **608-741-5475**.

Mail Order Pharmacy

If you take maintenance prescription drugs or other medications for long-term treatment, you may order up to a 90-day supply through the Express Scripts mail-order drug service. Mail order can also be used to fill non-urgent, short-term prescriptions. The retail pharmacy coinsurance will apply to mail order prescriptions of 30 days or less.

Typically, the mail-order service provides significant cost savings on medications that are dispensed by Express Scripts.

To order by mail, send your original prescription, completed order form and payment of the applicable copay or coinsurance amount to Express Scripts. If you choose not to provide debit or credit card information and prefer to pay by check, you can estimate your copay or coinsurance by contacting Express Scripts. Order forms are available on **oxylink.oxy.com, express-scripts.com**, or by contacting Express Scripts Member Services. Mail your order forms to:

Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

You may also have your doctor fax your prescriptions. Ask your doctor to call **800-551-7680** for faxing instructions.

Refills can be ordered by mail, online at **express-scripts.com**, or by phone any time day or night. Refills are usually delivered within three to five days after the order is received.

Specialty Pharmacy

Specialty medications include many high-cost drugs that treat complex, chronic diseases such as hemophilia and rheumatoid arthritis, and may be given orally, by injection in your doctor's office, or as a self-administered injectable. Certain specialty drugs are only covered when ordered through the Express Scripts Specialty Pharmacy, Accredo, which provides enhanced clinical benefits as well as cost benefits to you and the Plan.

A staff of Accredo pharmacists and nurses specially trained in these specific conditions are available 24 hours a day, seven days a week, to help ensure that the drugs and dosing you receive are clinically appropriate. Additional benefits include real-time safety checks to help prevent drug interactions, as well as ancillary supplies and equipment such as syringes and sharps containers.

Drugs within certain specialty drug categories will not be covered if obtained from an outpatient clinic, home infusion company, doctor's office, or from another pharmacy and submitted as a medical claim to Aetna.

EXAMPLES OF SPECIALTY DRUG CATEGORIES	SPECIALTY DRUG EXAMPLES
Self-administered drugs	Growth hormones
Anemia	Procrit, aranesp
Rare disease	Immune Globulin
Administered injectable	Synagis
Administered infused	Remicade, orencia

Precertification

The Plan requires precertification (prior authorization) for certain drugs and has certain coverage limits. For example, prescription drugs used for cosmetic purposes (e.g., Botox, Retin-A) may not be covered for a specific use, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period (e.g., Imitrex). Another example includes growth hormones.

If you submit a prescription for a drug that requires prior authorization or has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the Express Scripts mail order pharmacy, your doctor will be contacted directly.

When a prior authorization or a coverage limit is triggered, more information is needed to determine whether your use of the medication meets the Plan's coverage conditions.

Express Scripts will notify you and your doctor in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Step Therapy

Express Scripts' step therapy program is also a form of precertification under which certain drugs are covered by the Plan only after one or more other "prerequisite" (clinically appropriate and/or cost-effective alternative) drugs are tried first. Your doctor may also contact Express Scripts to request coverage of a prerequisite drug without a trial.

If the drug that you are prescribed requires step therapy, you should arrange for your doctor to call the number shown on your Express Scripts ID card to begin the certification process. Benefits may not be payable unless the required procedures are followed and certification approved.

Coordination of Pharmacy Benefits

Express Scripts does not coordinate benefits. If your dependent's primary coverage is provided by another plan and the Oxy Retiree Medical Plan is secondary, you should submit prescription drug claims to Aetna for secondary benefits. Secondary benefits are provided by the Plan and will be subject to the medical deductible and 80% coinsurance. See **Coordination of Benefits (COB)** for more information.

Covered Prescription Drug Benefits

The prescription drug benefit covers:

- Federal legend drugs—drugs that require a label stating: "Caution: Federal law prohibits dispensing without a prescription" (Age restrictions apply to coverage for certain prescription drugs.);
- Compound medications if they are medically necessary, not experimental or investigative, do not contain any excluded ingredients, and determined by Express Scripts to be reasonably priced (This list may be obtained from Express Scripts.);
- Any other drug which, under applicable state law, may be dispensed only upon a physician's written prescription;
- Insulin;
- Needles and syringes;
- Over-the-counter (OTC) diabetic supplies (except Glucowatch products and insulin pumps);
- Oral, transdermal, intravaginal and injectable contraceptives;
- Infertility prescription drugs up to a $10,000 lifetime maximum benefit;
- Legend contraceptive devices;
- Legend prenatal vitamins for females only;
- Legend pediatric fluoride vitamin drops up to a 50-day supply; and
- Legend smoking deterrents.

What the Prescription Drug Benefit Does Not Cover

The prescription drug benefit *does not* cover the following prescription drug expenses:

- Any drug that does not, by federal law, require a prescription, such as an over-the-counter (OTC) drug or drugs with an equivalent OTC product, even when a prescription is written for it; however, some OTC preventive medications will be covered if obtained with a prescription;
- Compound medications that are experimental or investigative or contain an excluded ingredient;
- Therapeutic devices and appliances;
- Any drug entirely consumed when and where it is prescribed;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any refill of a drug dispensed more than one year after prescribed, or as permitted by law where the drug is dispensed;
- Drugs labeled "Caution-Limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs to treat impotency or sexual dysfunction;
- Drugs whose sole purpose is to stimulate or promote hair growth (e.g., Rogaine, Propecia);
- Drugs prescribed for cosmetic purposes (e.g., Renova, Vaniqa, Botox, Solage);
- Allergy sera;
- Immunization agents;
- Biologicals, blood and blood plasma;
- Performance, athletic performance or lifestyle enhancement drugs or supplies;
- Fertility agents once the $10,000 lifetime maximum benefit has been exhausted; or
- Nutritional supplements, appetite suppressants and antiobesity preparations.

Information for Medicare-Eligible Participants who are not deemed eligible for the Medicare Advantage PPO Plan

In some cases, a Medicare Part D plan may provide a better benefit than this Plan. You can, but do not have to, enroll in Medicare Part D because the Oxy Plan is considered "creditable." That is, the Oxy Retiree Medical Plan provides coverage that is expected to be as good as or better than the lowest level of drug coverage authorized under a Medicare Part D plan.

If you decide to enroll in a Part D plan, please use your Part D coverage to obtain your prescription drug benefits since the Plan is not eligible to receive the federal subsidy for your drug costs if you are enrolled in Medicare Part D. This will ultimately impact the Plan's ability to control costs and, therefore, your contributions.

If you are enrolled in the Oxy Retiree Medical Plan and decide to enroll in a Medicare Part D plan at a later date, you may do so without incurring a late enrollment penalty provided the Plan is considered creditable.

Coordination of Benefits (COB)

When you and your eligible dependents are covered by more than one health plan (e.g., medical, dental, vision), your benefits are coordinated with benefits from your other coverage to prevent duplicate payments for the same services.

The Plan coordinates coverage with any of the following plans:

- Group insurance;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- No-fault auto insurance required by law and provided on other than a group basis;
- Other governmental benefits other than Medicare; and
- Any other type of coverage for groups, including plans that are insured and those that are not.

This feature can result in your receiving greater benefits from this Plan in combination with another plan and Medicare than you would have received if you were covered only by Medicare and this Plan. This is likely whenever this Plan is third in line to pay, after another plan and Medicare.

If the plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, medical coverage will be coordinated with other medical plans, and dental coverage will be coordinated with other dental plans.

This Plan always pays secondary to:

- Any medical payment, personal insurance plan or no-fault coverage under any automobile policy available to you; and
- Any plan or program that is required by law.

All covered persons should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

How COB Works

When you have a claim for expenses that is covered by two or more plans, one plan—known as the primary plan—pays benefits first. The other plan, the secondary plan, adjusts payments so the total benefit paid does not exceed 100% of the total **allowable expense**.

When the Oxy Plan is **primary,** it pays the allowable amount for the treatment you received.

When the Oxy Plan is **secondary,** it pays the amount necessary so the total amount you receive from the Oxy Plan and the other plans combined is not greater than the amount you would have received under the Oxy Plan alone (100% of the total allowable expense under the Oxy Plan). In determining that amount, the Plan calculates the benefits it would have paid in the absence of other coverage. Then the Plan applies that amount to any allowable expense under the Plan that was unpaid by the primary plan. The amount will be reduced so that when combined, the total benefits paid by all plans for the claim do not exceed 100% of the total allowable expense. In addition, as the secondary plan, the Plan will credit to its deductible any amounts that would have been credited in the absence of other coverage.

Order of Benefit Determination

In general, the rules used to determine which plan pays benefits first are:

- The plan with no coordination provision is primary. (Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide non-network benefits.)
- The plan that covers the person other than as a dependent pays before the plan that covers that person as a dependent. (If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent [e.g., a retired employee], then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.)
- For a dependent child who has coverage under both parents' plans (when the parents are married or living together), the plan that covers the parent with the earlier birth date (month and day) in the year is primary (no matter what the year). If the month and day of birth of both parents is the same, then the plan that has covered the parent for a longer time pays first. If the other plan has a rule based on gender of the parent, the rule in the other plan determines order of payment.
- For dependent children whose parents are legally separated or divorced, plan payments are determined in this order:
  - If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expense of the child, the order of benefit determination rules specified in the bullet above will apply (earlier birth date rule).
  - If there is a court decree (Qualified Medical Child Support Order, or QMCSO) for the child, the plan that covers the child as a dependent of the parent who is responsible pays before any other plan that covers the child as a dependent child. If the parent with responsibility has no health coverage but his or her spouse does, the plan of that parent's spouse is the primary plan.
  - If there is no QMCSO:
    - The plan of the custodial parent (the parent awarded custody by a court decree or, if there is no court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation);
    - The plan (if any) of the spouse of the custodial parent;
    - The plan of the parent not having custody; and then
    - The spouse's plan of the parent not having custody.

  A dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as outlined above as if the individuals were the parents.
- The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) pays before the plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, then this rule is ignored.
- If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, then this rule is ignored.
- The plan that has covered the person as an employee, member or subscriber for a longer time pays before the plan that has covered the person a shorter time.
- When the rules above do not apply, the allowable expenses are shared equally between the plans. In addition, the Plan will not pay more than it would have paid had it been primary.

COB with Medicare

Once you become **Medicare-eligible**, how your health care claims are processed will change. If it's determined you are not eligible to participate in the Oxy Medicare Advantage PPO Plan and you are eligible to remain in the Oxy Retiree Medical Plan, Medicare will provide your primary coverage and be the primary payer for your health care expenses effective the first of the month you become eligible for Medicare. The Oxy Retiree Medical Plan will generally be the secondary payer. When processing claims for each Medicare-eligible participant, the Oxy Retiree Medical Plan will reduce its payment by the amount Medicare paid—or would have paid if you were enrolled in Medicare Parts A and B. **This means Medicare benefits will be taken into account for any participant while he or she is eligible for Medicare, whether or not you choose to enroll in Medicare Part A and/or Part B.**

A person is eligible for Medicare if he or she is:

- Covered under it;
- Not covered under Medicare because he or she:
  - Refused it;
  - Dropped it; or
  - Failed to make proper request for it.

These are the changes:

- For Medicare Part A inpatient hospital expenses, all health care expenses covered under the Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of the Plan are figured.
- For all other covered expenses, the total amount of regular benefits under all health care expense benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, the Plan will pay the difference. Otherwise, the Plan will pay no benefits.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under the Plan in the order received by the claims administrator. If two or more charges are received at the same time, the largest will be applied first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating other plan benefits with those under the Plan will be applied after the Plan's benefits have been figured under the above rules.

For more information on Medicare, visit **medicare.gov**.

Right to Receive and Release Necessary Information

The claims administrators may receive or release, from any other organization or person, any information necessary to decide whether coordination applies and to determine benefits payable under the Plan. This may be done without your consent. Any person claiming benefits under the Plan is required to give information necessary to coordinate benefits.

Facility of Payment

Any payment made under another plan may include an amount that should have been paid under the Plan. If it does, the claims administrator may pay that amount to the organization that made that payment. That amount is then to be treated as though it were paid under the Oxy Plan. The claims administrator will not have to pay that amount again. The term *payment made* means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the claims administrator pays more than should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

Claims and Appeals Procedures

This section explains the rules and provisions that affect claim denial and appeals of benefits.

The Plan Administrator is responsible for claims and appeals procedures. However, the Plan Administrator has delegated authority to handle claims and appeals to the claims administrators. See **Administrative Information** for contact information.

Filing an Initial Claim

The claims administrator has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. The claims administrator may not abuse its discretionary authority by acting arbitrarily and capriciously.

When you file a claim, the claims administrator reviews the claim and makes a decision to either approve or deny the claim. The claims administrator has the full discretionary authority to:

- Interpret the provisions of the Plan—such interpretation will be final and conclusive on all persons;
- Determine eligibility for benefits;
- Provide participants with a reasonable notification of their benefits available under the Plan; and
- Approve reimbursement requests and authorize the payment of benefits.

If your benefit claim is denied, in whole or in part, you will receive notification by mail or electronically from the claims administrator within the time frames noted in the following table. The notice provides important information to assist you in making an appeal of the denied claim (or adverse benefit determination), if you wish to do so. Refer to **When You Disagree with a Claim Decision** for more information about appeals.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative (that is, a person you authorize in writing to act on your behalf, including your provider). The Plan will also recognize as your authorized representative:

- A court order giving a person (an authorized representative) authority to make the appeal on your behalf by providing written consent to Aetna; and
- In the case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting Aetna. You can use an authorized representative at any level of appeal.

Adverse Benefit Determination

An adverse benefit determination is a denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a service, supply or benefit. It may be based on:

- Your eligibility for coverage;
- Plan limits or exclusions;
- The results of any utilization review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not medically necessary.

Time Frames for Claim Processing

TYPE OF CLAIM	CLAIMS ADMINISTRATOR RESPONSE TIME	EXTENSION
Urgent care claim (including urgent care that is concurrent care involving the extension of a course of treatment or number of treatments); a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; • Subject you to severe pain that cannot be adequately managed without the requested care or treatment; or • In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.	As soon as possible, taking into account the medical demands, but no later than 72 hours (24 hours for a concurrent care claim extension if the claim is at least 24 hours before the expiration of the prescribed course of treatment or number of treatments) after the Plan receives your claim. If you fail to provide sufficient information with the claim to determine whether, or to what extent, benefits are payable from the Plan, you are notified no later than 24 hours after the Plan receives your claim about the specific information you need to submit. You will have at least 48 hours to provide this information. You will be notified of the claim decision as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period during which you may provide the specified information.	NA
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow you to appeal	NA

TYPE OF CLAIM	CLAIMS ADMINISTRATOR RESPONSE TIME	EXTENSION
Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of receiving care (**precertification**).	Within a reasonable time, but no later than 15 days after the Plan receives your claim.	These time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification
Post-service claims: a claim for care or treatment that has been rendered.	Within a reasonable time, but no later than 30 days after the Plan receives your claim.	

Medicare Direct Program

The Medicare Direct Program is a computerized claim-paying service that automatically forwards information directly from Medicare to Aetna about your medical claims paid under Medicare Part B. The Medicare Direct Program does not apply to claims paid under Medicare Part A.

If you participate in the program, you can easily and conveniently coordinate your Medicare payments with the Medical Plan. Any of your medical claims paid under Medicare Part B are forwarded directly to Aetna, who is then able to process your claim without you having to mail the claim or the Explanation of Medicare Benefits (EOMB) to Aetna. This service is free of charge and offers you less paperwork, faster turnaround time on your claim, and reduced postage costs.

Eligibility

Retirees are eligible to participate in the Medicare Direct Program if:

- Medicare is your primary coverage;
- You are enrolled in Medicare Part B;
- You are covered by the Medical Plan;
- Your only two sources of medical coverage are Medicare and the Oxy Retiree Medical Plan; and
- You have received medical care in a Medicare Direct-participating state.

Dependents are also eligible if they meet the above criteria and have Medicare and the Medical Plan as their only two sources of medical coverage. Your dependents may participate in Medicare Direct even if you choose not to enroll. Surviving spouses of deceased retirees also are eligible to participate in Medicare Direct if they meet the requirements as outlined above.

How to Enroll

To enroll in the Medicare Direct Program, you may complete a Medicare Direct form, available by contacting Aetna Member Services at 800-334-0299. If your spouse is not eligible for Medicare Direct when you enroll, you can request a new form for your spouse to complete when he/she becomes eligible for Medicare Part B. If you meet the eligibility rules above, Medicare Direct will begin six to eight weeks after you sign up.

Terminating Participation

You can terminate your participation at any time by calling Aetna Member Services or writing to:

Aetna, Inc. – Medicare Direct
151 Farmington Avenue
Hartford CT 06156-5605

Claim Denial

If your claim is denied, in whole or in part, you will receive a notice by mail or electronically that contains all of the following:

- A reference to the specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- If an internal rule, guideline, protocol or other similar criterion was relied on to determine a claim, you will receive either a copy of the actual rule, guideline, protocol or other criterion, or a statement that the rule, guideline, protocol or other criterion was used and how you can request a copy free of charge. If the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment for the determination based on the Plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request;
- A description of any additional material or information needed to perfect the claim and an explanation of why it's necessary;
- An explanation of the Plan's claim review procedures, applicable time limits and your rights to bring a civil action under ERISA section 502(a) following any denial on review; and
- An explanation of the expedited claim review procedure for an urgent care claim. In the case of an urgent care claim, the Plan may notify you by phone or fax and follow up with a notice by mail or electronically no later than three days after the notification.

If your Medical Plan or Prescription Drug Program claim is denied, in whole or in part, your notice will also include:

- Information to confirm the identity of the claim, including the date of service, provider's name and claim amount.
- A statement describing the availability of, on request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The denial code, its meaning and a description of any standard used in denying the claim.
- Details about any available internal appeals and external review processes, including information about how to initiate an appeal.
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process.

The following special rules apply to any disability claim only if the Plan Administrator determines you are disabled for purposes of such benefit. If your disability claim is denied, in whole or in part, your notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented to the Plan Administrator by health care professionals treating the you and vocational professionals who evaluated you, (2) the views of medical or vocational experts obtained by the Plan Administrator, without regarding to whether the advice was relied upon in making the benefit determination, and (3) a disability determination made by the Social Security Administration;
- If the claim denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your circumstances, or a statement that such an explanation will be provided free of charge upon request;
- The internal rules, guidelines, protocols, standards or other similar criteria relied upon in denying the claim, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

When You Disagree with a Claim Decision

Appeal Process

Requests for appeal submitted verbally for urgent care claims or in writing for all claims must be made within 180 days from the receipt of the notice of an adverse benefit determination to the claims administrator. However, appeals of adverse benefit determinations involving urgent care may be made to Aetna Member Services at **800-334-0299**.

Your appeal should include:

- Your name;
- Your employer's name;
- A copy of the notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Written requests for claim appeals may be sent to:

CLAIMS ADMINISTRATOR	APPEALS ADDRESS
Aetna	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512
Express Scripts, Inc.	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St Louis, MO 63166-6588 Fax: **877- 852-4070**

The Plan provides either one or two levels of appeal depending on the type of coverage. If you have two levels of appeal and you are dissatisfied with the outcome of your level one appeal, you can request a level two appeal, to be filed no later than 60 days following receipt of the level one notice of adverse benefit determination (90 days for non-urgent prescription drug claims). Appeals are reviewed by personnel not involved in making the adverse benefit determination (except for concurrent care claim reduction or termination). The following chart summarizes how appeals are handled for different types of claims.

TYPE OF APPEAL	LEVEL ONE APPEAL RESPONSE	LEVEL TWO APPEAL RESPONSE
Urgent care medical claims (including urgent care that is concurrent care)	36 hours	36 hours
Concurrent care claim reduction or termination	With enough advance notice to allow you to appeal	NA
Pre-service claim	15 calendar days	15 calendar days
Post-service claims	30 calendar days (15 days for provider submitted prescription drug claims)	30 calendar days (15 days for provider submitted prescription drug claims)

External Review for Medical Claims

The claims administrator may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with the claims administrator's decision. An external review is a review by an independent clinical reviewer, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, you must meet the following requirements:

- You have received notice of the denial of a claim by the claims administrator;
- Your claim was denied because the claims administrator determined the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from the claims administrator will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form. You will not be charged for an external review.

You must submit the Request for External Review Form to the claims administrator within 123 calendar days (4 months) of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

The claims administrator will contact the External Review Organization and they will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information you send with the Request for External Review Form, and will follow the claims administrator's contractual documents and Plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 45 calendar days of the claims administrator's receipt of your request form and all necessary information. A quicker review is possible if your clinical reviewer certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within three to five calendar days after the claims administrator receives the request.

The claims administrator, Oxy and the Plan will abide by the decision of the External Review Organization, except where the claims administrator can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending to the claims administrator the information you wish to be reviewed by the External Review Organization. The claims administrator is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about the claims administrator's external review process, call the customer service telephone number shown on your ID card.

Appealing a Denied Disability Claim

The following special rules apply to the appeal of a denied disability claim only if the Plan Administrator determines you are disabled for purposes of such benefit. You are entitled, upon request, to review and receive a free copy of any Plan policy statement or guideline that relates to the denied benefit, even if the policy statement or guideline was not relied on in denying the claim.

When the Plan Administrator reviews a denied disability claim on appeal, the following additional requirements apply:

- The review will not give deference to the claim denial and will not be made by the person who made the original claim denial, or a subordinate of that person.
- In deciding an appeal of any disability claim denial that is based in any way on a medical judgment, the Plan Administrator must get advice from a health care professional who has training and experience in the area of medicine.
- Upon request, you will be provided the names of any medical or vocational experts who were consulted in connection with your disability claim denial, even if the advice was not relied upon in making the denial.
- The health care professional consulted by the Plan Administrator cannot be a person who was consulted by the Plan Administrator in connection with the claim denial (or a subordinate of the person who was consulted in the original claim).
- The Plan Administrator must disclose, free of charge, any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan Administrator in connection with the disability claim, and any new or additional rationale upon which such adverse benefit determination may be based. The Plan Administrator will disclose this information to you before the Plan Administrator issues an adverse benefit determination and will give you a reasonable opportunity to respond prior to that date.

If any part of your disability claim is denied on appeal, the Plan Administrator's denial shall also set forth:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented to the Plan Administrator by health care professionals treating the you and vocational professionals who evaluated you, (2) the views of medical or vocational experts obtained by the Plan Administrator, without regarding to whether the advice was relied upon in making the benefit determination, and (3) a disability determination made by the Social Security Administration;
- If the claim denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your circumstances, or a statement that such an explanation will be provided free of charge upon request;
- The internal rules, guidelines, protocols, standards or other similar criteria relied upon in denying the claim, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- Any applicable contractual limitations period that applies to the claimant's right to bring suit under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires.

Assignment of Coverage

Your benefit under the Plan belongs to you and generally may not be sold, assigned, transferred, pledged or garnished under most circumstances. The Plan Administrator may accept elections or make payments to someone who is legally authorized to conduct your affairs. This may be a relative, a court-appointed guardian or some other person.

Medical, prescription, dental and vision benefits provided under the Plan may not be assigned, transferred or in any way made over to another party by you or your dependents. Nothing in the Plan will be construed to make the Plan or Oxy liable to any third party to whom you or your dependents may be liable for medical, prescription, dental or vision care treatment or services. If any person attempts to take any action contrary to this assignment prohibition, such action shall be void and Oxy and the Plan Administrator may disregard such action, will not be bound by it in any manner and will suffer no liability for any such disregard.

In addition, the Plan is required to comply with federal laws, such as IRS tax levies and court-issued Qualified Domestic Relations Orders (QDROs). The Plan Administrator will hold or pay your benefit as it finds appropriate in case of your bankruptcy or other assignment of your benefits under the Plan whether voluntary or involuntary.

However, the Plan may make payments to physicians, other health care professionals or institutions who provide health care services or supplies to participants in the normal course of administration of the Plan. Payments to a state providing Medicaid benefits in accordance with ERISA Section 609 are allowed. Similarly, Oxy's subrogation and reimbursement rights are not limited by this provision.

A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Recovery of Overpayment

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The claims administrator has the right to:

- Reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the Plan; or
- Reduce any future benefit payment to the network provider by the amount of the overpayment.

These future payments may involve the Plan or other health plans that are administered by the Plan's third-party administrator— Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they receive, and then credits the recovered amount to the plan that overpaid the network provider. Payments to network providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

These rights do not affect any other right of overpayment recovery the claims administrator may have.

Incorrect Information, Fraud, Concealment or Error

The Plan has the right to seek repayment by whatever means permitted by law if due to an error (whether human or systems) or incorrect information (whether provided by fraud, misrepresentation or concealment):

- You or your dependents are provided coverage under the Plan;
- Continuation coverage is provided;
- Claims are paid;
- Liability for failure to enroll, provide continuation coverage, pay benefits or terminating coverage arises; or
- An overpayment or erroneous payment is made.

Likewise, a human or systems error will not deprive you or your dependents of coverage or impact the payment of benefits under the Plan to which you or your dependents are otherwise entitled.

Except as otherwise required by law, if you or your dependents fail to provide requested information, make a false statement, or furnish fraudulent or incorrect information, the Plan reserves the right to terminate your and your dependents' coverage under the Plan either retroactively or prospectively, seek repayment for any payments made on your or your dependents' behalf, and refuse to offer continuation coverage.

Legal Action

You must exhaust all appeal levels and procedures before you initiate any litigation, arbitration or administrative proceeding regarding an alleged breach of the contract terms by the claims administrator or any matter within the scope of the appeals procedure.

If your claim for benefits is not approved in whole or in part, and you disagree with the outcome, you have the right to bring a civil action when **all available levels of reviews, including all appeal processes, have been completed.**

In addition, no legal action can be brought after the later of (i) 180 days after receiving a response to your appeal of an adverse benefit determination or (ii) two years after the earliest date services or benefits were sought.

Unclaimed Funds

In the event any reimbursement check issued under a program funded using Oxy's general assets remains uncashed after a period of time determined by the Plan Administrator, the check will be voided, and the funds returned applied to payment of current benefits under the applicable program. If you or your dependent subsequently request repayment, the Plan Administrator will make payment pursuant to the terms and conditions of the program in effect at the time the original claim was presented.

Subrogation and Right of Recovery Provision

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first-party insurance coverage).

Your health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interests are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have to recover the benefits paid by the Plan. Immediately on paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery you have against any responsible party with respect to any payment made by the responsible party to you due to your illness or injury to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment from any responsible party or insurance coverage as a result of an illness or injury, the Plan has the right to recover from, and be reimbursed by, you for all amounts the Plan has paid and will pay as a result of that illness or injury, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or on your behalf to any provider) from the Plan, you agree that if you receive any payment as a result of an illness or injury, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness or injury for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan or Oxy.

Assignment for Subrogation

To secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to you or on your behalf to any provider) from the Plan, you acknowledge that the Plan's recovery rights are a first-priority claim against all responsible parties and are to be repaid to the Plan before you receive any recovery for your damages. The Plan is entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery to you that is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence. The Plan's reimbursement will not be limited or reduced because any responsible party is liable only in part, its resources are limited or you have not been fully compensated. Any portion of the recovery used to pay fees and costs including attorneys' fees will not be allocated against the Plan's recovery (i.e., the "common fund doctrine").

Cooperation

You shall fully cooperate with the Plan's efforts to recover its benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to a party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to illness or injury sustained by you. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain before receipt of such recovery funds or within five days if no notice was given before receipt. Further, you and your agents agree to provide notice before any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in:

- The denial of any future benefit payments or claim until the Plan is reimbursed in full;
- Termination of your health benefits; or
- The institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery before fully satisfying the health Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the illness or injury to identify any responsible party. The Plan reserves the right to notify a responsible party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act (HIPAA), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator for the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. The Plan Administrator may in its sole and absolute discretion waive or modify any of the subrogation and right of recovery provisions whenever it deems appropriate under the facts and circumstances of a particular case.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents have the right to continue group health plan coverage if it ends for the reasons under **Qualifying Events**. If you pay the required premiums, you and your eligible dependents may continue participation in the Plan option in which you or your dependents are enrolled at the time of your qualifying event.

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through:

- The Health Insurance Marketplace;
- Medicaid; or
- Other group health plan coverage options (such as a spouse's plan). You must enroll through a special enrollment period, generally within 30 days of losing coverage.

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

Qualifying Events

You and your qualified beneficiaries have a right to choose COBRA coverage if coverage is lost because of any of these qualifying events:

COVERAGE IS LOST BECAUSE…	CAN CONTINUE COVERAGE …	FOR UP TO…	TAKE ACTION
• You die • You become entitled to benefits under Medicare	• Your spouse • Your dependent children	36 months	You and your qualified beneficiaries are notified of the right to continue coverage. To continue coverage, enroll within 60 days of the later of the COBRA notification date or the date regular benefits end.
• Your surviving spouse dies	• Your dependent children	36 months	
• You divorce, legally separate or your marriage is annulled	• Your ex-spouse • Your dependent children	36 months	You or your qualified beneficiaries must notify the OxyLink Employee Service Center within 60 days of the event by the approved method, or your dependents lose their right to COBRA coverage. After receiving notice of the qualifying event from you, your qualified beneficiaries are notified of their right to continue coverage. To continue coverage, enroll within 60 days of the later of the COBRA notification date or the date regular benefits end.
• Your dependent child is no longer eligible for coverage under the Plan (for example, your child reaches the age limit)	• Your dependent child	36 months	

Qualified Beneficiary

A qualified beneficiary under COBRA includes you, your covered spouse and your covered dependent children at the time a coverage-ending event occurs. If you or your spouse gives birth to or adopts a child after the qualifying COBRA event, the child is also a qualified beneficiary. If you marry while continuing coverage under COBRA, your new spouse and any other dependents you add to your family are also considered qualified beneficiaries. You must enroll new beneficiaries in the Plan within 31 days of the event.

Disability Extension

An 11-month extension of coverage may be available for all qualified beneficiaries if one of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability must start before the 60th day of COBRA coverage and last until the end of the 18-month period of COBRA coverage. To qualify for this disability extension, you must notify the COBRA administrator (PayFlex) and provide a copy of the SSA determination within 60 days after the date of the SSA disability determination and before the end of the original 18-month COBRA period. Notify the COBRA administrator within 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Second Qualifying Event

An extension of coverage is available to spouses and dependent children if a second qualifying event occurs during the first 18- or 29-month continuation period. You must notify the COBRA administrator (PayFlex) in writing within 60 days after a secondary qualifying event if you want to extend your COBRA coverage. COBRA coverage will not last beyond 36 months from the date of the original qualifying event.

Enrolling in COBRA Coverage

COBRA coverage is provided under the same plan option in which you are enrolled at the time of the qualifying event. When plan coverage changes, it also changes for COBRA coverage.

Each qualified beneficiary has an independent right to elect COBRA coverage. You can elect coverage for your spouse. You or your spouse can elect coverage for your children. You elect coverage by enrolling within 60 days from the date of the qualifying event—or the date you receive the form, if later.

You must pay your premiums for the first month of continuation coverage within 45 days of the date you elect COBRA. Make all future payments on the first day of each month (subject to a 30-day grace period) while coverage continues.

If you do not pay your premium within the initial 45-day period (30 days of the due date for future payments), your coverage will end retroactive to the last day for which timely payment was made. You will lose all continuation rights under the Plan.

Cost of COBRA Coverage

Your cost for COBRA coverage is the full cost of coverage to the Plan—that is, the amount you pay for coverage plus the company's contribution to the cost—with a 2% administrative fee added. You pay 150% of the full premium cost for the additional 11 months of disability coverage.

Your cost will change if the cost of group coverage for the company's retirees changes. You pay the cost of COBRA coverage with after-tax dollars.

When COBRA Coverage Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period;
- Failure to pay required premiums;
- Coverage under another group plan that does not restrict coverage for preexisting conditions;
- Oxy no longer offers a group health plan;
- A qualified beneficiary is on extended coverage for up to 29 months due to disability and a final determination is made that the beneficiary is no longer disabled; or
- Your dependents die.

When you or a family member on COBRA becomes enrolled in Medicare, continued Plan coverage is secondary to Medicare.

Contact and Address Information

To protect your family's rights, you should keep the Plan informed in writing of any changes in your address and any changes in your marital status. You should also keep a copy, for your records, of any notices you provide. You may provide such notices to the OxyLink Employee Service Center via electronic mail to **oxylink@oxy.com** or mail to:

4500 South 129th East Avenue
Tulsa, Oklahoma 74134-5801

Plan materials are available on **oxylink.oxy.com** or contact the OxyLink Employee Service Center at **800-699-6903.**

If you have questions about COBRA, contact the OxyLink Employee Service Center. For more information about your rights under **ERISA**, including COBRA, HIPAA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at **dol.gov/ebsa** or call their toll-free number at **888-444-3272**. For more information about health insurance options available through a Health Insurance Marketplace, visit **healthcare.gov**.

Additional Information

Administrative Information

Outlined below is some additional information about the Plan and those who have assumed responsibility for its operation.

Plan Name	Occidental Petroleum Corporation Retiree Medical Plan, also known as the Plan.
Plan Sponsor's Employer Identification Number	95-4035997
Plan Number	651
Plan Year Ends	December 31
Plan Administrative Services	Administrative services contracts with Aetna Life Insurance Company and Express Scripts, Inc.
Plan Administrator	Occidental Petroleum Corporation Employee Benefits Committee 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
Claims Administrators	**For Aetna:** Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 **For Express Scripts, Inc.:** Express Scripts, Inc. 1 Express Way St. Louis, MO 63121
Plan Sponsor	Occidental Petroleum Corporation 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
Named Fiduciary	• Aetna Life Insurance Company for Aetna medical claims • Express Scripts, Inc. for prescription drug claims
Plan Type	An ERISA welfare plan
Address for Legal Process	Service for legal process related to the Plan may be made upon the Plan Administrator or claims administrators at the addresses listed above.
Funding	The medical benefits are not insured with Aetna or Express Scripts, Inc. They are paid from participant contributions and OPC's general assets.

Plan Continuation

Oxy expects and intends to continue the Plan but does not guarantee any specific level of benefits or the continuation of any benefits during any periods of active employment, inactive employment, disability or retirement. Benefits are provided solely at Oxy's discretion. Oxy reserves the right, at any time or for any reason, through an action of the Executive Vice President of Human Resources of Occidental Petroleum Corporation or the successor to that position, to suspend, withdraw, amend, modify or terminate the Plan (including altering the amount you must pay for any benefit), in whole or in part. In the case of material changes in this description of the Plan, such action will be evidenced by a written announcement to affected individuals.

Discretionary Authority

The Plan sponsor has designated two Named Fiduciaries under the Plan, who together have complete authority to review all denied claims for benefits under the Plan. The Plan Administrator has discretionary authority to determine who is eligible for coverage under the Plan and the claims administrators have discretionary authority to determine eligibility for benefits under the Plan. In exercising its fiduciary responsibilities, each Named Fiduciary shall have discretionary authority to determine whether and to what extent covered Plan participants are eligible for benefits, and to construe disputed or doubtful Plan terms. A Named Fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

The Plan Administrator is responsible for making reports and disclosures required by applicable laws and regulations.

Plan Documents

This benefit plan description summarizes the main features of the Plan, and is not intended to amend, modify or expand the Plan provisions. In all cases, the provisions of the Plan document and any applicable contracts control the administration and operation of the Plan. If a conflict exists between a statement in this summary and the provisions of the Plan document or any applicable contracts, the Plan document will govern. You may request a copy of all the Plan documents by writing to the Plan Administrator at the address shown in **Additional Information**. Copies of requested documents will be furnished within 30 days at a reasonable charge.

No Implied Promises

By adopting and maintaining the Occidental Petroleum Corporation Retiree Medical Plans for certain eligible participants, Oxy has not entered into an employment contract with any employee. Nothing contained in the Plan documents or in this summary gives any employee the right to be employed by Oxy or to interfere with Oxy's right to discharge any employee at any time. Similarly, the Plan does not give Oxy the right to require any employee to remain employed by Oxy or to interfere with the employee's right to terminate employment with Oxy at any time.

Oral representations or promises will not be binding on the Plan. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan document will always govern.

Multiple Employers and Misstatement of Fact

You cannot be covered under the Plan multiple times because you are connected with more than one employer.

If there is a misstatement of fact that affects your coverage under the Plan, the true facts will be investigated to determine the coverage that applies.

Outcome of Covered Services and Supplies

The claims administrators and Oxy are not responsible for, and they do not make any guarantees concerning, the outcome of the covered services and supplies you receive.

Additional Provisions

The following additional provisions apply to your coverage:

- This SPD applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- This document describes the main features of the Plan. If you have any questions about the terms of the Plan or about the proper payment of benefits, contact your employer or Aetna.
- Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan participants with access to Sutter's services on a network basis.

Financial Sanctions Exclusions

If any benefit provided by this Plan violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this Plan at any given time or times will not constitute a waiver of Aetna's right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this Plan.

Rescission of Coverage

Your coverage may be rescinded if you or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal appeal with Aetna and/or the right to a third-party review conducted by an independent external review organization if your coverage under this SPD is rescinded retroactive to its effective date.

Required Notices

Federal law affects how certain health conditions are covered. Your rights under these laws are described below.

The Newborns' and Mothers' Health Protection Act

The Plan provides minimum hospital stay benefits for the mother and newborn of 48 hours following a normal delivery or 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that the Plan may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, precertification may be required for more than 48 or 96 hours of confinement.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires that the following procedures be covered for a person who receives benefits for a medically necessary mastectomy and who elects to have reconstructive surgery after the mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the Plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Health Insurance Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. The Marketplace will also direct you to Medicaid and Medicare if you are eligible. Open enrollment for health insurance coverage through the Marketplace generally begins in the fall for coverage as early as January 1.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you may be eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and instead may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a medical plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you will lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution was well as your employee contribution to employer-offered coverages often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please Contact OxyLink at 800-699-6903 or check your summary plan description on OxyLink Online at **oxylink.oxy.com**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

This information is numbered to correspond to the Marketplace application.

3. Employer name: Occidental Petroleum Corporation
4. Employer Identification Number (EIN): 95-4035997
5. Employer address: 5 Greenway Plaza, Suite 110
6. Employer phone number: 1-713-215-7000
7. City: Houston
8. State: Texas
9. Zip code: 77046

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

- □ All employees.
- ✓ Some employees. Eligible employees are: regular, full-time hourly or salaried non-represented employees regularly scheduled to work at least 30 hours per week.

With respect to dependents:

- ✓ We do offer coverage. Eligible dependents are: Your Spouse, your domestic partner and his or her dependent children up to age 26, and your dependent children up to age 26.
- □ We do not offer coverage.

- ✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, healthcare.gov will guide you through the process.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage under this Plan, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **NOT** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** (1-877-543-7669) or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Plan, the company must allow you to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in the Plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA** (1-866-444-3272).

If you live in one of the following states, you may be eligible for assistance paying your Plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility:

STATE	CONTACT INFORMATION
ALABAMA—Medicaid	Website: www.myalhipp.com Phone: 1-855-692-5447
ALASKA—Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
FLORIDA—Medicaid	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA—Medicaid	Website: www.medicaid.georgia.gov – Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA—Medicaid	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA—Medicaid	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS—Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY—Medicaid	Website: http://chfs.ky.gov Phone: 1-800-635-2570
LOUISIANA—Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
MAINE—Medicaid	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS—Medicaid and CHIP	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
MINNESOTA—Medicaid	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670
MISSOURI—Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA—Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

STATE	CONTACT INFORMATION
NEBRASKA—Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA—Medicaid	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE—Medicaid	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-800-852-3345 ext. 5218 or 603-271-5218
NEW JERSEY—Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK—Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA—Medicaid	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA—Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA—Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON—Medicaid and CHIP	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA—Medicaid	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND—Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA—Medicaid	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA—Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS—Medicaid	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH—Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT—Medicaid	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

STATE	CONTACT INFORMATION
VIRGINIA—Medicaid and CHIP	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON—Medicaid	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA—Medicaid	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN—Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING—Medicaid	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (1-866-444-3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice About Your Prescription Drug Coverage and Medicare

Please read the Creditable Coverage notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Occidental Petroleum Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Oxy has determined that the prescription drug coverage offered by the Occidental Petroleum Corporation Retiree Medical Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7 (provided you have been deemed not eligible to participate in the Oxy Medicare Advantage PPO Plan). However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to enroll in a Medicare prescription drug plan (provided you have been deemed not eligible to participate in the Oxy Medicare Advantage PPO Plan) and drop your prescription drug coverage through the Occidental Petroleum Corporation Retiree Medical Plan, be aware that you and your dependents may not be able to get this coverage back. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans available in your area beginning this fall. Your current coverage through the Occidental Petroleum Corporation Retiree Medical Plan pays for other health and wellness expenses in addition to prescription drugs.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Occidental Petroleum Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About this Notice or Your Current Prescription Drug Coverage…

Contact OxyLink at 800-699-6903. Note: You'll receive the Creditable Coverage notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Occidental Petroleum Corporation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **800-MEDICARE** (800-633-4227). TTY users should call 877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **800-772-1213** (TTY 800-325-0778).

Privacy Notice for Health Plans

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires the Plan to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you when you enrolled and is available through OxyLink Online at **oxylink.oxy.com**.

The Plan and Oxy will not use or further disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, you may call the OxyLink Employee Service Center at **800-699-6903,** go to **oxylink.oxy.com** and select *Required Notices,* then print the *HIPAA Privacy Notice.* If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, contact the OxyLink Employee Service Center.

Nondiscrimination Notice—It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, our medical providers offer free aids and services. For people whose primary language isn't English, our medical providers offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your medical (Aetna or Anthem BlueCross BlueShield) and/or prescription drug (Express Scripts/Medco) ID card(s). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance.

You can file a complaint with the Health and Welfare Team, Occidental Petroleum Corporation, 4500 S. 129th East Avenue, Tulsa, OK 74134-5801, 800-699-6903, fax: **800-610-1944**, oxylink@oxy.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling **800-368-1019** (TDD: 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

ملحوظة: إذا كنت تتحدث اذكر تتوافر المساعدة اللغوية بالمجان لك تصل برقم اتصل بـ Aetna 800-334-0299-1 Express Scripts 855-547-8390-1

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759 1089 TDD.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759 1089 TDD.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD まで、お電話にてご連絡ください。

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

ध्यान दें: यदद आप ह दिी बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD पर कॉल करें।

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

ໂປດຊາບ: ຖ້າ ທ່ານ ເວົ້າພາສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫ ຼືອ ດ້ານພາສາ, ໂດຍ ບໍ່ ເສັ ຽ ຄ່າ, ແມ່ ນ ພ້ ອມ ໃຫ້ ທ່ ານ. ໂທ Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی رایگان به صورت شما ارائه می شود. با Aetna (800) 334 0299, تماس بگیرید. Express Scripts (800) 551-7680

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as follows:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

You have the right to continue medical, dental and vision coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Help with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance with obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Glossary

Following are definitions of the terms and phrases used throughout this document:

Aetna—Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

Affiliate—Any business entity that is more than 80% owned, directly or indirectly by OPC, or is in an affiliated service group with OPC, as defined under the Code.

Allowable expense for coordination of benefits (COB)—A health care service or expense, including coinsurance and copays and without reduction of any applicable deductible, that is covered at least in part by any of the health plans covering the person. When a health plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the health plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the health plans provides coverage for a private room.
- If a person is covered by two or more health plans that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
- If a person is covered by two or more health plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
- The amount a benefit is reduced or not reimbursed by the primary health plan because a covered person does not comply with the health plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.
- If all health plans are high deductible health plans and the person intends to contribute to an HSA, the deductible for the primary high deductible health plan is not an allowable expense, except for any health expense not subject to the deductible per the Code.

If a person is covered by one health plan that computes its benefit payments on the basis of reasonable or recognized charges and another health plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements will be the allowable expense for all the health plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered an allowable expense and a benefit paid.

Behavioral health provider—A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Code—The Internal Revenue Code of 1986, as amended.

Coinsurance—The portion of your covered expenses that you pay.

Copay—A flat dollar amount you pay before receiving services. Copays apply before the deductible amount and apply to the out-of-pocket maximum limit.

Cosmetic—Services or supplies that alter, improve or enhance appearance.

Covered Expenses—Medical, dental, vision or hearing services and supplies shown as covered under this Plan.

Custodial care—Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including Room and Board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Day care treatment—A partial confinement treatment program to provide treatment for you during the day. The hospital, psychiatric hospital or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible—The part of your covered expenses you pay before the Plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the *Benefits at a Glance* on page 3 and the *Deductible* section on page 18.

Dentist—A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Dental Emergency—Any dental condition that:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Dependent—Generally, your:

- Legal spouse (unless legally separated), and
- Children under age 26, and your disabled children may qualify as eligible dependents under the Plan.

Your eligible spouse is your spouse to whom you are legally married. All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. This includes a spouse through common law marriage in applicable states. This does not include a spouse from whom you are legally separated.

Your eligible children may include your:

- Natural children;
- Children legally adopted or placed for adoption with you;
- Stepchildren;
- Foster children; and
- Other children who you claim as dependents on your federal income tax return (e.g., grandchildren), for whom you and/or your spouse have primary legal custody and who live with you in a regular parent/child relationship.

Unless otherwise noted in a specific coverage section, your children must be under the age of 26 to be eligible for coverage under the Plan regardless of their marital, student, financial or residency status. However, a child who has reached the upper age limit (age 26) and who is mentally or physically incapable of self-sustaining employment may continue to be eligible.

A dependent also includes a child for whom health care coverage is required through **Qualified Medical Child** Support Order (QMCSO). A QMCSO is any judgment, decree or order issued by a court of competent jurisdiction, or other court or administrative order, requiring you to provide health care benefits for a child.

If you have a disabled child, the child's coverage may be continued past the Plan's limiting age for dependents. Your child is considered to be disabled if he or she:

- Is unable to earn a living because of a mental or physical disability that starts before the Plan's age limit; and
- Depends mainly on you for support and maintenance.

You must provide proof of your child's disability to the claims administrator no later than 31 days after your child reaches the dependent age limit for review and determination of eligibility of continuation of coverage. The claims administrator may continue to ask you for proof that the child continues to meet conditions of incapacity and dependency.

The child's coverage will end on the first to occur of the following:

- Your child is no longer disabled;
- You fail to provide proof that the disability continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

Detoxification—The process determined by a physician by which an alcohol- or drug-intoxicated person or an alcohol- or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs.

The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory—A listing of all network providers serving the class of employees to which you belong. The contractholder will give you a copy of this directory. Network provider information is also available through Aetna's online provider directory, DocFind®.

Durable medical and surgical equipment (DME)—Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Emergency admission—A hospital admission where the physician admits the person to the hospital right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- That requires confinement right away as a full-time inpatient; and
- For which, if immediate inpatient care were not given, could (as determined by Aetna), reasonably be expected to result in:
  - Placing the person's health in serious jeopardy;
  - Serious impairment to bodily function;
  - Serious dysfunction of a body part or organ; or
  - Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency care—The treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency condition—A recent and severe medical condition—including but not limited to severe pain—that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Some examples of emergency conditions include:

- Serious injury, severe pain or infection;
- Poisoning;
- Uncontrollable bleeding;
- Sudden change of vision;
- Chest pain;
- Sudden weakness or trouble talking;
- Major burns;
- Spinal injury;
- Difficulty breathing; and
- Broken bones.

ERISA—The Employee Retirement Income Security Act of 1974, as amended.

Experimental and investigational—A drug, device, a procedure or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved;
- Approval required by the FDA has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes;
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or investigational, or for research purposes.

Home health care agency—An agency that:

- Mainly provides skilled nursing and other therapeutic services;
- Is associated with a professional group (of at least one physician and one R.N.) which makes policy;
- Has full-time supervision by a physician or an R.N.;
- Keeps complete medical records on each person;
- Has an administrator; and
- Meets licensing standards.

Home health care plan—A plan that provides for care and treatment in a person's home. It must be:

- Prescribed in writing by the attending physician; and
- An alternative to confinement in a hospital or skilled nursing facility.

Homebound—Means you are confined to your place of residence:

- Due to an illness or injury that makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered to be homebound include (but are not limited to):

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Hospice care—Care provided to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice care agency—An agency or organization that:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - Skilled nursing services;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - Physician services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for terminally ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least one physician, one R.N. and one licensed or certified social worker employed by the agency.
- Establishes policies about how hospice care is provided.
- Assesses the patient's medical and social needs.
- Develops a hospice care program to meet those needs.

- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice care facility—A facility, or distinct part of one, which:

- Mainly provides inpatient hospice care to terminally ill persons;
- Charges patients for its services;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Keeps a medical record on each patient;
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility;
- Is run by a staff of physicians. At least one staff physician must be on call at all times;
- Provides 24-hour-a-day nursing services under the direction of an R.N.; and
- Has a full-time administrator.

Hospice care program—A written plan of hospice care that:

- Is established by and reviewed from time to time by the person's attending physician and appropriate hospice care agency personnel.
- Is designed to provide palliative (pain relief) and supportive care to terminally ill people and supportive care to their families.
- Includes an assessment of the person's medical and social needs, and a description of the care to be given to meet those needs.

Hospital—An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of physicians;
- Provides 24-hour-a-day R.N. service;
- Charges patients for its services; and
- Is operating in accordance with the laws of the jurisdiction in which it is located; or
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent nursing home or any institution or part of one that is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

Illness—A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury—An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.

Such occurrence, act or event must be definite as to time and place.

Institutes of Excellence (IOE)— A hospital or other facility that has contracted with Aetna to give services or supplies to an IOE patient in connection with specific transplants, procedures at a negotiated charge. A facility is an IOE facility only for those types of transplants, procedures for which it has signed a contract.

Jaw joint disorder—

- A temporomandibular joint (TMJ) dysfunction or any alike disorder of the jaw joint;
- A myofacial pain dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L.P.N.—A licensed practical nurse.

Lifetime Maximum—This is the most the Plan will pay for covered expenses incurred by any one covered person in their lifetime.

Maintenance care—Care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically necessary—Health care, dental or vision services, and supplies or prescription drugs that a physician, other health care provider, dental provider or vision provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, other health care or dental provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians, dentists or vision providers practicing in relevant clinical areas and any other relevant factors.

Mental disorder—An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a mental disorder under the Plan:

- Anorexia/Bulimia Nervosa
- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Pervasive Mental Developmental Disorder (including Autism)
- Psychotic Disorders/Delusional Disorder
- Schizo-affective Disorder
- Schizophrenia

Morbid obesity—This means a Body Mass Index (BMI) that is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

Negotiated fee (charge or rate)—The maximum charge a network provider has agreed to make for any service or supply for the purpose of benefits under the Plan.

Network provider—A health care provider who belongs to the claims administrator’s network and has contracted to furnish services or supplies for a negotiated charge.

Network services or supplies—Health care service or supply that is furnished by a network provider.

Night care treatment—A partial confinement treatment program provided when you need to be confined during the night. A room charge is made by the hospital, psychiatric hospital or residential treatment facility. Such treatment must be available at least:

- Eight hours in a row a night; and
- Five nights a week.

Non-network care—A health care service or supply provided by a non-network provider (one who does not belong to the claims administrator’s network).

Non-network provider—A health care provider who does not belong to the claims administrator's network and has not contracted with the claims administrator to furnish services or supplies at a negotiated fee.

Occupational Injury or Occupational Illness—An injury or illness that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an injury or illness.

OPC—Occidental Petroleum Corporation, a Delaware corporation.

Occurrence—This means a period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or injury.

Orthodontic treatment—Any medical or dental service or supply that is furnished to prevent or diagnose or correct a misalignment (whether or not for the purpose of relieving pain):

- Of the teeth;
- Of the bite; or
- Of the jaws or jaw joint relationship.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; and
- A surgical procedure to correct malocclusion.

Oxy—Occidental Petroleum Corporation or an affiliated company.

Partial confinement treatment—A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or mental disorders. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital or residential treatment facility on less than a full-time inpatient basis;
- It is in accord with accepted medical practice for the condition of the person;
- It does not require full-time confinement; and
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.

Day care treatment and night care treatment are considered partial confinement treatment.

Physician—A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services that are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services that are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- Is not you or related to you.

Plan—The Occidental Petroleum Corporation Retiree Medical Plan. Unless the context otherwise requires in this SPD, the Plan means the retiree medical benefits described here.

Plan Administrator—Occidental Petroleum Corporation Employee Benefits Committee.

Precertification—A review of inpatient admissions and other care to determine whether the requested care is covered under your Plan. This review should take place before the admission and before the care is provided and is only required for non-Medicare eligible participants.

Prescription—A drug, biological, or compounded prescription drug by a prescriber. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug—A drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary care physician (PCP)—A network provider who is:

- Chosen by a covered person from the list of PCPs in the provider directory or in the online provider search;
- Responsible for a person's ongoing health care; and
- Shown on Aetna's records as the person's PCP.

Psychiatric hospital—An institution that meets all of the following requirements:

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

Psychiatric physician—A physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or mental disorders.

R.N.—A registered nurse.

Recognized charge—The amount of a non-network provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

If your ID card displays the National Advantage Program (NAP) logo, your cost may be lower when you get care from a NAP provider. Through NAP, the recognized charge is determined as follows:

- If your service was received from a NAP provider, a pre-negotiated charge will be paid. NAP providers are non-network providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP providers are not network providers.
- If your service was not received from a NAP provider, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the recognized charge for specific services or supplies will be the non-network Plan rate, calculated in accordance with the following:

Service or Supply	Non-Network Plan Rate
Professional services	An amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.
Inpatient and outpatient charges of hospitals	**FCR** rate
Inpatient and outpatient charges of facilities other than hospitals	**FCR** rate
Prescription drugs	**AWP** rate

Important note: If the provider bills less than the amount calculated using the non-network Plan rate described above, the recognized charge is what the provider bills.

In the event you receive a balance bill from a provider for your non-network service, Patient Advocacy Services may be available to assist you in certain circumstances.

If NAP does not apply to you, the recognized charge for specific services or supplies will be the non-network Plan rate set forth in the above chart.

The non-network Plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by a non-network provider, unless that non-network provider is an assistant surgeon for your surgery;
- Not available from a network provider; or
- Emergency services.

Aetna will calculate your cost share for involuntary services in the same way as it would if you received the services from a network provider.

Special terms used

- **Average wholesale price (AWP**): The AWP is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- **Geographic area:** The Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If Aetna determines it needs more data for a particular service or supply, Aetna may base rates on a wider geographic area such as an entire state.
- **Facility charge review (FCR) rate:** The FCR rate is an amount that Aetna determines is enough to cover the facility provider's estimated costs for the service and leave the facility provider with a reasonable profit. For hospitals and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. Aetna may adjust the formula, as needed, to maintain the reasonableness of the recognized charge. For example, Aetna may make an adjustment if it determines that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.

Aetna reserves the right to apply its reimbursement policies to all non-network services including involuntary services. Our reimbursement policies may affect the recognized charge.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider.

The Aetna reimbursement policies may consider:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas
- Aetna's own data and/or databases and methodologies maintained by third parties.

Aetna uses commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Rehabilitation facility—A facility, or a distinct part of a facility, that provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative services—The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

Residential treatment facility (mental disorders)—An institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;

- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for mental health residential treatment programs:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

Residential treatment facility (substance abuse)—An institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for chemical dependence residential treatment programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above requirements, for chemical dependence detoxification programs within a residential setting:

- An R.N. is onsite 24 hours per day for seven days a week; and
- The care must be provided under the direct supervision of a physician.

Room and board charges—Charges made by an institution for room and board and other necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

If a hospital or other health care facility does not identify the specific amounts charged for room and board charges and other charges, Aetna will assume that 40% of the total is the room and board charge, and 60% is other charges.

Semi-private room rate—The room and board charge that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility—An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  – Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  – Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  – It is licensed or approved under state or local law.
  – Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  – The Joint Commission on Accreditation of Health Care Organizations;
  – The Bureau of Hospitals of the American Osteopathic Association; or
  – The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g., acute) and portions of a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
  – Minimal care;
  – Custodial care services;
  – Ambulatory; or
  – Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

Skilled nursing services—Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an R.N. or L.P.N. within the scope of his or her license.
- The services are not custodial.

Specialist—A physician who practices in any generally accepted medical or surgical subspecialty, and provides care that is not considered routine medical care.

Substance abuse—A physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery center—A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

It must have all of the following:

- A physician trained in cardiopulmonary resuscitation;
- A defibrillator;
- A tracheotomy set;
- A blood volume expander;
- A written agreement with a hospital in the area for immediate emergency transfer of patients; (Written procedures for such a transfer must be displayed and the staff must be aware of them.); and
- An ongoing quality assurance program, that includes reviews by physicians who do not own or direct the facility.

The facility must keep a medical record on each patient.

Terminally ill—A medical prognosis of 12 months or less to live.

Urgent admission—An admission where the physician admits the person to the hospital due to:

- The onset of or change in an illness; or
- The diagnosis of an illness; or
- An injury caused by an accident; which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

Urgent care provider—

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of physicians. At least one physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
  - Has contracted with Aetna to provide urgent care; and
  - Is, with Aetna's consent, included in the directory as a network urgent care provider.
- It is not the emergency room or outpatient department of a hospital.

Urgent condition—A sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition that would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

SECOND SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH BENEFIT UNDER THE ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)

Attachment E

NOTICE: This document is a Program Document for the Oxy Retiree Medical Program for Anadarko Retirees, which is part of the Anadarko Petroleum Corporation Retiree Health Benefits Plan (APC Retiree Plan). Please see the Second Summary of Material Modification to the APC Retiree Plan for more information.

OXY Benefits

Summary Plan Description

RETIREE DENTAL PLAN

Dental PPO/PDN with PPO II Network

FOR RETIREES AND THEIR DEPENDENTS

OCCIDENTAL PETROLEUM CORPORATION

your health.
your life.
your future.

Table of Contents

Effective date of this SPD is July 1, 2014. Refer to subsequent issues of *Retiree News* for any material changes to the Plan made after the date of this document.

BENEFITS AT A GLANCE

The Occidental Petroleum Corporation Retiree Dental Plan ("Dental Plan" or "Retiree Dental Plan") is designed to promote and encourage preventive dental care, provide benefits for services that are essential to the proper care of your teeth and help you pay for a portion of your covered dental expenses.

The dental benefits described in this booklet are offered to retirees of Occidental Petroleum Corporation or an affiliated company ("Oxy"), as defined in the *Eligibility and Enrollment* section. This information serves as your Summary Plan Description. You should keep and refer to it when you have questions about your dental benefits.

This Plan is administered by Aetna Life Insurance Company (referred to as "Aetna"). The dental benefits described in this booklet are not insured with Aetna or any of its affiliates, but are paid from Occidental Petroleum Corporation's general assets.

Capitalized words or phrases are defined in the *Glossary* at the end of this booklet.

The chart below summarizes the Plan's deductibles, maximums and Plan payment percentages (percentage of covered expenses paid by the Plan). See *What the Plan Covers* for more detail.

DENTAL PLAN INFORMATION	
Calendar Year Deductible • Individual	$50
• Family	$150
Calendar Year Maximum *(applies to diagnostic/preventive, basic and major services)*	$2,000 per individual
Orthodontia Lifetime Maximum *(for Dependent child(ren) under age 19 only)*	$2,500 per individual

DENTAL PLAN BENEFITS	
Covered Services	**Dental Plan Pays** (Network or Out-of Network)
Diagnostic and Preventive Services *(e.g., exams, cleanings, fluoride applications, diagnostic X-rays)*	100% not subject to deductible
Basic Restorative Services *(e.g., fillings, extractions, periodontal treatment)*	80% after deductible
Major Restorative Services *(e.g., crowns, bridges, dentures, inlays)*	50% after deductible
Orthodontia *(for Dependent child(ren) under age 19 only)*	50% not subject to deductible

FOR HELP AND INFORMATION

Contact Information		
Provider:	**Address:**	**Phone:**
Aetna	**P.O. Box 14094** **Lexington, KY 40512-4094** Website: **www.aetna.com**	**800-334-0299**
OxyLink Employee Service Center	**4500 South 129th East Avenue** **Tulsa, OK 74134-5870** Email: **oxylink@oxy.com** Website: **oxylink.oxy.com**	**800-699-6903** **918-610-1990** (International)

Visit Aetna Navigator™ at www.aetna.com

Aetna Navigator is a web-based portal designed to provide access to a wide range of tools and information 24 hours a day, 7 days a week. The website is secure, private, and accessible anywhere an internet connection is available. From Aetna Navigator you can obtain health and benefits information using self-service features and interactive tools. After a simple registration process, a personal home page is created where you can:

- Access your claim Explanations of Benefits (EOBs),
- Check remaining deductibles and balances,
- Print an ID card* for you and your Dependents
- Download a list of claims for each covered family member, and
- Contact Member Services.

You can also take advantage of many other features, including:

- **DocFind®,** Aetna's online provider directory,
- **Intelihealth®,** Aetna's health website,
- **Healthwise® Knowledgebase,** an innovative decision-support tool, and
- **Estimate the Cost of Care,** for many diseases and conditions.

Mobile Access

You can also access your benefits information on your mobile phone. To learn more, visit **www.aetna.com/mobile**.

* Dental plan ID cards are no longer required to receive dental services. Your provider can confirm coverage and plan information directly with Aetna.

ELIGIBILITY AND ENROLLMENT

Eligibility

You and your Dependents are eligible for coverage under the Retiree Dental Plan if you:

- Are eligible for coverage under the Occidental Petroleum Corporation Retiree Medical Plan;
- Retire or enroll for retiree coverage on or after January 1, 2014*; and
- Are not eligible for coverage under another Oxy-sponsored retiree dental plan.

Dependents

Generally, those persons eligible to be covered as dependents include your legal spouse (unless legally separated) and your children under age 26.

For a complete definition, refer to "Dependent" in the *Glossary* section.

Adding Dependents

If after your Oxy retirement date, you acquire a new dependent(s) through marriage, birth, adoption or placement for adoption, and you wish to add this dependent(s) to your Retiree Dental Plan coverage, you must enroll your new dependent(s) within 31 days of his or her first date of eligibility (i.e., the date of marriage), or if later, within 31 days of loss of other coverage. You will be required to submit proof of the event.

Dependent Coverage After Your Death

If you die while you are covered as a retiree under this Plan, your spouse may elect to continue coverage for your Dependents as of your date of death by paying the appropriate amount of retiree contributions, as described in the section entitled *Contributions*. If you had not elected retiree coverage for yourself and/or your Dependents under this Plan, your surviving spouse may elect to enroll for coverage for your Dependents within 31 days of loss of other coverage. Proof of loss of coverage will be required.

Coverage for your Dependents may continue as described in the section entitled *When Coverage Ends.*

Enrollment

You must complete an application (or waiver) for retiree dental coverage no later than 31 days after your retirement date, or the date you are first eligible to enroll, if later. You may waive coverage, but if you do, you may not reenroll for coverage under the Retiree Dental Plan, with the following exception:

> **If you or your spouse (or a surviving spouse) currently have other coverage, including through COBRA continuation coverage, and you lose eligibility for**

* If you retired prior to January 1, 2014, you are eligible for the Retiree Dental Plan effective July 1, 2014.

that coverage, you or your spouse may enroll in the Dental Plan within 31 days of the loss of coverage. Proof of loss of coverage will be required.

You may elect not to cover your spouse if he or she is covered under another group plan. You may not be covered as both a retiree and a Dependent spouse under Oxy's Retiree Dental Plan. If you and your spouse work for or are retired from Oxy, only one of you may cover your children as Dependents. If your spouse has Dependents as an Oxy employee and later leaves Oxy for any reason, you may enroll yourself and your Dependents within 31 days of the loss of coverage.

CONTRIBUTIONS

Oxy does not subsidize the cost of Retiree Dental Plan coverage; retirees pay the full cost of the plan. The cost of coverage and the coverage level you select (retiree only, retiree plus one dependent, or family) determine the amount of your contribution.

The cost of coverage is typically announced annually in the *Retiree News*, which is posted online at **oxylink.oxy.com** under *Forms, Publications & Info > Publications > Benefits News*. Current contributions are also shown on the Retiree Dental Plan summary which is posted online at **oxylink.oxy.com**.

Contributions are billed quarterly by Aetna's Individual Billing Unit. Once your retirement is processed you will receive information about how to enroll.

Dependent Contributions After Your Death

If you die while you are covered as a retiree under the Dental Plan, your spouse may elect to continue coverage for your Dependents as of your date of death by paying the appropriate amount of retiree contributions.

USING THE PLAN

This section describes how the Dental Plan works and how to make the most of your coverage. You will find information about choosing a Dentist and sharing the cost of your care, as well as details about certain important Plan rules and requirements.

How much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a Network Provider or an Out-of Network Provider.

Using Network and Out-of-Network Providers

Under the Dental Plan, you have the freedom to choose any licensed Dental Provider when you need dental care. You can select a Dentist that belongs to the network (a Network Provider) or one that does not belong to the network (an Out-of Network Provider).

Your out-of-pocket expenses may be lower when your care is provided by a Network Provider because Network Providers have agreed to provide covered services and supplies at a Negotiated Charge. In no event will you have to pay any amounts above the Negotiated Charge for a covered service or supply. Aetna's Negotiated Fees do not apply to care that is not covered under the Plan.

If you use Network Providers, you will not have to submit dental claims for treatment received. Your Network Provider will take care of claim submission. You will receive notification of what the plan has paid toward your Covered Expenses and you will be responsible for the deductible and your payment percentage.

If you receive care from an Out-of-Network Provider, your benefits are limited to the Recognized Charge and your expenses will generally be higher. If the Out-of-Network Provider's charge is more than the Recognized Charge (as defined by Aetna), you pay the difference. This excess amount will not apply toward your deductible. You must file a claim to receive reimbursement from the plan.

Aetna Provider Network

To participate in Aetna's network, a Dentist must meet certain standards through a process called credentialing—which looks at factors such as education and licensing.

To find a network Dentist in your area:

- ***Use DocFind at www.aetna.com.*** Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you are willing to travel. When you are asked to select a plan, choose "Dental PPO/PDN with PPO II Network" from the "Dental PPO/PDN/EPP/HealthFund®/DentalFund® with PPO II network" plan list. You can search the online directory for a specific Dentist or all

Dentists in a given ZIP code and/or travel distance. You can also get information about a Dentist's practice, such as address, phone number(s), and access for the disabled.

- ***Call or email Aetna Member Services.*** A representative can also help you find a network Dentist in your area. The Aetna Member Services toll-free number is shown on your ID card. You also may email Aetna Member Services from Aetna's secure member website, Aetna Navigator. Just go to **www.aetna.com** and select "Member Log In."

Sharing the Cost

When you receive dental care, you pay a calendar year deductible for certain services. There are two types of deductible: individual and family.

The *individual* calendar year deductible is the part of covered expenses you and/or your covered Dependents pay each year (January 1 to December 31) before the Plan starts to pay benefits. You start over each January 1 with a new calendar year deductible.

If the covered dental expenses of all family members reach the *family* deductible, no other deductible is required for the rest of the calendar year.

After you meet the deductible, the Plan pays a percentage of the covered dental expenses and you pay the rest. The portion of covered expenses you pay is called your coinsurance.

Diagnostic and Preventive services are not subject to the deductible.

The Plan's benefits for Diagnostic and Preventive, Basic and Major services are limited to a calendar year maximum. There is a separate lifetime maximum benefit for orthodontia expenses.

You may access information regarding current deductibles and maximum benefits online at **oxylink.oxy.com**.

Advance Claim Review

If your Dentist recommends a Course of Treatment expected to cost $350 or more, an Advance Claim Review (Pre-Treatment Estimate) is recommended. Ask your Dentist to provide a full description of the treatment you need, using a Dental Benefits Request form available online at **oxylink.oxy.com**. Your Dentist should send the form to Aetna *before* treatment begins. In processing the request, Aetna may ask for supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your Dentist with a statement

that outlines the benefits payable by the Plan. You and your Dentist can use this information to decide how to proceed.

Advance Claim Review is a service that gives you information that you and your Dentist can consider when deciding on a Course of Treatment. It is not necessary for emergency treatment or routine care such as cleanings or check-ups.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services or courses of treatment needed to accomplish the appropriate result.

In the event that an Advance Claim Review is not completed, Aetna will base its benefit decision on the amount of covered dental expenses that can be verified.

Alternate Treatment

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your Dental Provider. Of course, you and your Dental Provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

WHAT THE PLAN COVERS

The Plan covers medically Necessary dental care expenses incurred while your coverage is in effect. An expense is incurred on the day you receive a dental service or supply. Also, the Plan covers only expenses related to a Non-Occupational Injury or a Non-Occupational Illness. Coverage for services and supplies applies only if they are provided to a person at the time he or she is covered under the Plan.

This section lists the services covered under each of the four types of dental care. If any limits apply, they are described below.

Diagnostic and Preventive Services

To encourage regular dental checkups, the Plan pays 100 percent of the Negotiated or Recognized Charges, with no deductible, for preventive and diagnostic services. For purposes of this Plan, diagnostic and preventive services include the following:

- Routine oral exams twice per calendar year
- Cleaning and scaling of teeth (prophylaxis) (limit of 3 treatments per calendar year)
- Problem-focused exams
- One topical application of fluoride per calendar year for Dependents under age 16
- Diagnostic X-rays, and other X-rays not to exceed one full mouth or panoramic series every three years
- Two sets of bitewing X-rays in a calendar year for Dependents under age 14
- One set of bitewing X-rays in a calendar year for individuals age 14 and older
- Sealants only for permanent molars once every three rolling years, for Dependents under age 16
- Emergency treatment to relieve pain
- Space maintainers for premature loss of primary teeth only

Basic Restorative Services

The Plan will pay 80 percent of the Negotiated or Recognized Charges for basic restorative services after the annual deductible is satisfied. The following services are considered basic restorative services under the Plan:

- Simple extractions
- Oral surgery for non-impacted wisdom teeth extractions
- Oral surgery (including extraction of impacted teeth) if the procedure is not covered under your medical plan
- Fillings, except gold
- General anesthetics, if medically necessary
- Treatment of diseased periodontal structures
- Endodontic treatment, such as pulp capping and root canals
- Repair or recementing of crowns, inlays, bridgework or dentures
- Relining/rebasing of dentures

Major Restorative Services

The Plan will pay 50 percent of the Negotiated or Recognized Charges for major restorative services after the annual deductible is satisfied. For purposes of the Dental Plan, the following are considered major restorative services:

- Inlays, gold fillings or crowns. This includes precision attachments for dentures.
- First installation of removable dentures and partial dentures to replace one or more natural teeth. This includes adjustments for the six-month period after they were installed.
- First installation of fixed bridgework to replace one or more natural teeth. This includes inlays and crowns as abutments.
- Occlusal adjustment for temporomandibular joint disease (TMJ). Covered services include night guards for grinding the teeth or equilibration, capping the teeth and fixed or partial bridgework.
- Dental implants and related services.
- Replacement of an existing removable denture or fixed bridgework by a new denture or fixed bridgework, or addition of teeth to existing partial removable denture or fixed bridgework. The Replacement Rule below must be met.

Replacement Rule

Inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces an extracted tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The Plan does not cover dental services that are given after your coverage terminates. There is an exception. The Plan will cover the following services if they are ordered while you were covered by the Plan, and installed within 60 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Orthodontic Treatment

Orthodontic coverage is only for covered dependent children who are under age 19 on the date active orthodontic treatment begins.

The Plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces")*; or
- Removable acrylic aligners (i.e. "invisible aligners")*.

* These services may be subject to the Alternate Treatment provision.

WHAT THE PLAN DOES NOT COVER

Not every dental care service or supply is covered by the Plan, even if prescribed, recommended, or approved by your Physician or Dentist. The Plan covers only those services and supplies that are Medically Necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or are subject to special limitations.

The Plan does not cover expenses for:

- Any instruction for diet, plaque control and oral hygiene.

- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section.

- Crown, inlays and onlays, and veneers unless:

  - It is treatment for decay or traumatic Injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.

- Dental services and supplies that are covered in whole or in part:

  - Under any other part of this plan; or
  - Under any other plan of group benefits provided by the contractholder.

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

- Except as covered in the What the Plan Covers section, treatment of any Jaw Joint Disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

- Orthodontic treatment except as covered in the *What the Plan Covers* section.

- Prescribed drugs; pre-medication; or analgesia.

- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

- Services and supplies provided in connection with treatment or care that is not covered under the plan.

- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

- Surgical removal of impacted wisdom teeth only for orthodontic reasons.

- Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  - Scaling of teeth;
  - Cleaning of teeth; and
  - Topical application of fluoride.

Additional Items Not Covered By A Health Plan

Not every health service or supply is covered by the Plan, even if prescribed, recommended, or approved by your Physician or Dentist. The Plan covers only those services and supplies that are Medically Necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section.

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this booklet.

- Charges submitted for services by an unlicensed hospital, Physician or other provider or not within the scope of the provider's license.

- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the Plan.

- Court ordered services, including those required as a condition of parole or release.

- Examinations:
  - Any dental examinations:
    - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
    - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
    - any special medical reports not directly related to treatment except when provided as part of a covered service.

- Experimental or investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
  - There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved; or
  - Approval required by the FDA has not been granted for marketing; or
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
  - It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
  - The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

- Miscellaneous charges for services or supplies including:

  - Cancelled or missed appointment charges or charges to complete claim forms;

  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    - Care in charitable institutions;
    - Care for conditions related to current or previous military service; or
    - Care while in the custody of a governmental authority.

- Non-Medically Necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not Medically Necessary, as determined by Aetna, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your Physician or Dentist.

- Routine dental exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

- Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this booklet.

- Work related: Any Illness or Injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational Illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular Illness or Injury under such law, that Illness or Injury will be considered "non-occupational" regardless of cause.

COORDINATION WITH OTHER PLANS

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one plan. "Plan" and "This Plan" are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or Recognized Charges, any amount in excess of the highest of the reasonable or Recognized Charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or Recognized Charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;

- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

  1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

  2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:

     A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

        i. The parents are married or living together whether or not married;
        ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

     B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.

     C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
        - The plan of the custodial parent;
        - The plan of the spouse of the custodial parent;
        - The plan of the noncustodial parent; and then
        - The plan of the spouse of the noncustodial parent.

     For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan**,** the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.

6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

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 under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CLAIMS AND BENEFIT PAYMENT

This section explains the rules and provisions that affect claim filing and processing, and payment of benefits.

Keeping Records of Expenses

It is important to keep records of dental expenses for yourself and all covered family members. These will be required when you file a claim for benefits. Of particular importance are:

- Names and addresses of Dentists,
- The dates on which expenses are incurred, and
- Copies of all bills and receipts.

Filing Claims

Generally, if you use an Out-of-Network Provider, you must complete and submit a claim form to be reimbursed for covered expenses. Claim forms are available on **oxylink.oxy.com,** Aetna Navigator at **www.aetna.com** or by calling Aetna Member Services at 800-334-0299. The form contains instructions on how and when to file a claim, as well as the address to which you should send your completed form.

Claims should always be submitted to the primary plan first. When filing a claim for COB, the Explanation of Benefits statement received from the primary plan and all associated bills must be submitted to the secondary plan.

Claims should be submitted to:	Aetna P.O. Box 14094 Lexington, KY 40512-4094

All claims must be filed promptly. The deadline for filing a claim is 90 days after the date you incurred a covered expense. If, through no fault of your own, you are unable to meet this deadline, your claim will still be accepted if you file as soon as possible. However, if a claim is filed more than two years after the 90-day deadline, it will not be covered unless you are legally incapacitated.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative. An "authorized representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Time Frames for Claim Processing

Aetna will make a decision on your claim. For concurrent care claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an adverse benefit determination.

An adverse benefit determination is a denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit. It may be based on:

- Your eligibility for coverage;
- Plan limits or exclusions;
- The results of any utilization review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not Medically Necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown in the following chart. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Refer to *When You Disagree With a Claim Decision* for more information about appeals.

Type of Claim	Response Time
Urgent care claim: a claim for dental care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible, but not later than 72 hours
Pre-service claim: a request for a benefit determination in advance of obtaining dental care (Advance Claim Review).	15 calendar days
Concurrent care claim extension: a request to extend a previously approved Course of Treatment.	• Emergency or urgent care claims - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment • Other claims – 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a Course of Treatment that was previously approved.	With enough advance notice to allow you to appeal
Post-service claim: a claim for dental care or treatment that has been rendered.	30 calendar days

Extensions of Time Frames

The time frames described in the chart may be extended, as follows:

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours of the earlier of the receipt of the additional information or the end of the 48-hour period given the Physician to provide Aetna with the information.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the Plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended.

If an extension is necessary because Aetna needs more information to process your post-service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Payment of Benefits

Generally, benefits will be paid after services are rendered and as soon as Aetna receives the necessary proof to support the claim. Aetna will pay any benefits directly to you unless you or the provider tells Aetna to make benefits payable to the provider when the claim is filed.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures. See the section entitled *When You Disagree With a Claim Decision* for more information about appeals.

Recovery of Overpayment

If Aetna makes a benefit payment over the amount that you are entitled to under this Plan, Aetna has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery Aetna may have.

Legal Action

No legal action can be brought to recover a benefit after three years from the deadline for filing claims.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period.

WHEN YOU DISAGREE WITH A CLAIM DECISION

The Appeal Process

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made within 180 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally to Aetna Member Services at 800-334-0299.

Your appeal should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Written requests for appeals may be sent to:	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512

The Plan provides for two levels of appeal. If you are dissatisfied with the outcome of your Level One appeal and wish to file a Level Two appeal, your appeal must be filed no later than 60 days following receipt of the Level One notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

Type of Claim	**Level One Appeal Response Time**	**Level Two Appeal Response Time**
Urgent care claim: a claim for dental care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.

Type of Claim	Level One Appeal Response Time	Level Two Appeal Response Time
Pre-service claim: a request for a benefit determination in advance of obtaining dental care (Advance Claim Review).	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.
Concurrent care claim extension: a request to extend a previously approved Course of Treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-service claim: a claim for dental care or treatment that has been rendered.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. In the case of an urgent care claim or a pre-service claim, a Dentist familiar with the case may represent you in the appeal.

Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the appeal procedure before you initiate any litigation; arbitration; or administrative proceeding regarding an alleged breach of the contract terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure.

Claim Fiduciary

Aetna has complete discretionary authority to review all denied claims for benefits under the Dental Plan. This includes, but is not limited to, determining whether dental treatment is, or is not, medically Necessary. In exercising its responsibilities, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered Dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Aetna has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Aetna may not abuse its discretionary authority by acting arbitrarily and capriciously.

WHEN COVERAGE ENDS

Your coverage under this Plan can end for a number of reasons. This section explains how and why your coverage can be terminated, and how you may be able to continue coverage after it ends.

When Your Coverage Ends

Your coverage under this Plan ends on the first to occur of the following events:

- The Plan is discontinued;
- You voluntarily stop your coverage;
- The coverage described in this booklet is terminated under the group contract;
- You are no longer eligible as defined in the *Eligibility and Enrollment* section of this booklet; or
- You fail to make any required contribution.

Your dental coverage will cease on the last day of the month in which you lose eligibility. You may have a right to continue your coverage as described in the section entitled *Continuation of Coverage*. You may not convert your group dental coverage to an individual policy at termination.

Death

If you die and were eligible for retiree dental coverage as described in the *Eligibility and Enrollment* section, your spouse may elect retiree coverage under the Plan for your covered Dependents. If coverage is elected, your spouse must pay the applicable retiree contribution. Coverage would continue for your Dependents until the earliest occurrence of one of the following events:

- Dependent coverage is terminated under this Plan;
- A Dependent is or becomes covered as an employee;
- A Dependent is or becomes eligible for coverage under another group plan;*
- A dependent no longer meets the Plan's definition of a Dependent;
- Failure to pay any required contributions; or
- Your spouse's remarriage or death.

Your surviving Dependents may have a right to continue their coverage. See "Under COBRA" further in this section, or contact an OxyLink representative for more information.

*If your spouse subsequently loses eligibility under the other plan, he or she may reenroll in the Dental Plan within 31 days of the loss of coverage. Proof of loss of eligibility may be required.

When Dependent Coverage Ends

Your Dependent's eligibility for coverage will end on the earliest to occur of the following events:

- Dependent coverage is terminated under this Plan;
- A Dependent becomes covered as an employee;
- A dependent no longer meets the Plan's definition of a Dependent; or
- When your coverage terminates.

Dental coverage will cease on the last day of the month in which your Dependent loses eligibility. You must notify OxyLink within 31 days of your Dependent's change in eligibility status. Any applicable contribution change will take effect on the next available billing cycle. There will be no refund of contributions.

Your Dependents may have a right to continue their coverage. See "Under COBRA" further in this section, or contact an OxyLink representative for more information.

See the *Continuation of Coverage* section or contact OxyLink for details regarding how coverage may be continued.

CONTINUATION OF COVERAGE

Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your Dependents have the right to continue health coverage if it ends for the reasons ("qualifying events") described below. You may continue participation in the Plan option in which you are enrolled at the time of your qualifying event and must pay required premiums.

Qualifying Events and Continuation Periods

The chart below outlines:

- The qualifying events that trigger the right to continue coverage;
- Those eligible to elect continued coverage; and
- The maximum continuation period.

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible for Continued Coverage	Maximum Continuation Period
Divorce or legal separation	Your spouse Your Dependent children	36 months
Children no longer qualify as eligible for Dependent coverage	Your Dependent children	36 months
Death of your surviving spouse	Your Dependent children	36 months

The required premium for the 36-month continuation period will be 102% of the total Plan cost.

Electing COBRA Continuation Coverage

OxyLink will provide detailed information about how to continue coverage under COBRA at the time your Dependents become eligible. Your Dependents will need to notify OxyLink within 60 days of a divorce or legal separation or loss of Dependent child eligibility, or the date coverage ends due to those circumstances, if later.

Your Dependents will need to elect continued coverage within 60 days of the "qualifying event" or the date of the COBRA notice, if later. The election must include an agreement to pay required premiums.

Acquiring New Dependents During Continuation

If you acquire any new Dependents during a period of continuation (through birth, adoption or marriage), they can be added for the remainder of the continuation period if:

- They meet the definition of an eligible Dependent;
- You notify Aetna within 31 days of their eligibility; and
- You pay the additional required premiums.

When COBRA Continuation Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period;
- Failure to pay required premiums;
- Coverage begins under another group plan that does not restrict coverage for preexisting conditions;
- Oxy no longer offers a group health plan; or
- You or your Dependent die.

Other Continuation Provisions

Contact OxyLink for information on how other continuation provisions may affect COBRA continuation provisions.

Keep the Plan Informed of Changes

In order to protect your family's rights, you should keep the Plan informed in writing of any changes in the addresses of your family members and any changes in your marital status. You should also keep a copy, for your records, of any notices you provide. You may provide such notices to the OxyLink Employee Service Center via email to **oxylink@oxy.com** or mail to 4500 South 129th East Avenue, Tulsa, Oklahoma 74134.

GENERAL INFORMATION

Other Plan Provisions

Multiple Employers and Misstatement of Fact

You cannot receive multiple coverages under this Plan because you are connected with more than one employer.

If there is a misstatement of fact that affects your coverage under this Plan, the true facts will be investigated to determine the coverage that applies.

Outcome of Covered Services and Supplies

Neither Aetna nor Oxy is responsible for, nor do they make any guarantees concerning, the outcome of the covered services and supplies you receive.

Reporting and Disclosures

The Plan Administrator is responsible for making reports and disclosures required by applicable laws and regulations.

Privacy Notice for Health Plans

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires the Dental Plan to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available through OxyLink.

The Dental Plan and Oxy will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, Dental Plan operations and Plan administration, or as permitted or required by law. By law, the Dental Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, you may either call the OxyLink

Employee Service Center at 800-699-6903 or go directly to the OxyLink home page at **oxylink.oxy.com** and select *Health, Life and Disability*, then print the *HIPAA Privacy Notice.* If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, contact the OxyLink Employee Service Center.

Your Rights as a Plan Participant

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

Continue Dental Plan Coverage

You have the right to continue dental coverage for yourself, spouse or Dependents if there is a loss of coverage under the Dental Plan as a result of a qualifying event. You and your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Dental Plan on the rules governing your COBRA continuation coverage rights.

You also have the right to reduced or eliminated exclusionary periods of coverage for preexisting conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under a group health plan.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Help With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance with 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
- Division of Technical Assistance and Inquiries

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Documents

This benefit plan description summarizes the main features of the Plan, and is not intended to amend, modify, or expand the Plan provisions. In all cases, the provisions of the Plan document and any applicable contracts control the administration and operation of the Plan. If a conflict exists between a statement in this summary and the provisions of the Plan document or any applicable contracts, the Plan document will govern.

Discretionary Authority of Plan Administrator and Claims Administrator

In accordance with sections 402 and 503 of Title I of ERISA, the Plan sponsor has designated a Named Fiduciary under the Plan, who has complete authority to review all denied claims for benefits under the Plan. The Plan Administrator has discretionary authority to determine who is eligible for coverage under the Plan and the Claims Administrator has discretionary authority to determine eligibility for benefits under the Plan. In exercising its fiduciary responsibilities, the Named Fiduciary shall have discretionary authority to determine whether and to what extent covered Plan participants are eligible for benefits, and to construe disputed or doubtful Plan terms. The Named Fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

No Guarantee of Employment

By adopting and maintaining the Occidental Petroleum Corporation Retiree Dental Plan for certain eligible participants, Oxy has not entered into an employment contract with any employee. Nothing contained in the Plan documents or in this summary gives any employee the right to be employed by Oxy or to interfere with Oxy's right to discharge any employee at any time. Similarly, this Plan does not give Oxy the right to require any employee to remain employed by Oxy or to interfere with the employee's right to terminate employment with Oxy at any time.

Future of the Plan and Plan Amendment

Oxy expects and intends to continue this Plan but does not guarantee any specific level of benefits or the continuation of any benefits during any periods of active employment, inactive employment, disability or retirement. Benefits are provided solely at Oxy's discretion. Oxy reserves the right, at any time or for any reason, through an action of the Executive Vice President of Human Resources of Occidental Petroleum Corporation, to suspend, withdraw, amend, modify, or terminate the Plan (including altering the amount you must pay for any benefit), in whole or in part. In the case of material change in this description of the Plan, such action will be evidenced by a written announcement to affected individuals.

Plan Administration

The additional information in this section is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) regarding the Dental Plan and the persons who have assumed responsibility for its operation.

Plan Name	**Occidental Petroleum Corporation** **Retiree Dental Plan**
Employer Identification Number	**95-4035997**
Plan Number	**652**
Plan Administrative Services Provided by	**Occidental Petroleum Corporation** **10889 Wilshire Boulevard** **Los Angeles, California 90024** **310-208-8800**
Type of Administration	*Administrative Services Contract with:* **Aetna Life Insurance Company** **151 Farmington Avenue** **Hartford, CT 06156**
Plan Administrator	**Occidental Petroleum Corporation** **Employee Benefits Committee**
Plan Sponsor and Address for Legal Process	**Occidental Petroleum Corporation** **10889 Wilshire Boulevard** **Los Angeles, CA 90024** **310-208-8800**
Named Fiduciary	**Aetna Life Insurance Company**
Claims Administrator	**Aetna Life Insurance Company** **151 Farmington Avenue** **Hartford, CT 06156**
End of Plan Year	**December 31**
Type of Plan	**ERISA Welfare Plan**
Source of Contributions	**Participant Contributions**

GLOSSARY

Following are definitions of the capitalized terms and phrases used throughout this document.

Course of Treatment
A "course of treatment" is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending Dentist as a result of an oral exam, and treatment may be given by one or more Dentists. The course of treatment starts on the date a Dentist first gives a service to correct or treat the dental condition.

Dental Provider
This is:

- Any dentist;
- Group;
- Organization;
- Dental facility; or
- Other institution or person;

legally qualified to furnish dental services or supplies.

Dentist
This means a legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Dependent
Those persons eligible to be covered as dependents may include your:

- Legal spouse (unless legally separated), and
- Children, up to the end of the month in which their 26th birthday occurs.

Your children may include your:

- Natural children;
- Children legally adopted or placed for adoption with you;
- Stepchildren;
- Foster children; and
- Other children who you claim as dependents on your federal income tax return (e.g., grandchildren), for whom you and/or your spouse have primary legal custody and who live with you in a regular parent/child relationship.

A dependent also includes a child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order and who falls within one of the above categories.

If you have a disabled child, the child's coverage may be continued past the Plan's limiting age for dependents.

Your child is considered to be disabled if he or she:

- Is unable to earn a living because of a mental or physical disability that starts before the Plan age limit; and
- Depends mainly on you for support and maintenance.

You must provide proof of your child's disability to Aetna no later than 31 days after your child reaches the dependent age limit. Aetna may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency.

The child's coverage will end on the first to occur of the following:

- Your child is no longer disabled;
- You fail to provide proof that the disability continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of Physicians;
- Provides twenty-four (24) hour-a-day R.N. service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.

Such occurrence, act or event must be definite as to time and place.

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an illness;
  - an injury;
  - a disease; or
  - its symptoms.

The provision of the service, supply or prescription drug must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
c) Not mostly for the convenience of the patient, Physician, other health care or Dental Provider; and
d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with Physician or dental specialty society recommendations and the views of Physicians or Dentists practicing in relevant clinical areas and any other relevant factors.

Network Provider
This is a Dentist who belongs to Aetna's network and has contracted to furnish services or supplies at a Negotiated Charge.

Negotiated Charge (Fee)
This is the maximum charge a Network Provider has agreed to make for any service or supply for the purpose of benefits under this Plan.

Non-Occupational Illness
A non-occupational illness is an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An Illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that Illness under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Provider
This is a Dentist who does not belong to Aetna's network and has not contracted with Aetna to furnish services or supplies at a Negotiated Charge**.**

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your Illness or Injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Plan
"Plan" means the Occidental Petroleum Corporation Retiree Dental Plan, and as used in this Summary Plan Description, unless the context otherwise plainly requires, "Plan" further means the dental benefits described here. Also, in this Summary Plan Description, "Plan" is used interchangeably with "Dental Plan" or "Retiree Dental Plan."

Recognized Charge
The covered expense is only that part of a charge which is the recognized charge.

As to dental expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- The 80th percentile of the Prevailing Charge Rate (below);
- For the Geographic Area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- If follow up care is included;
- Whether there are any other characteristics that may modify or make a particular service unique; and
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are the rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates. What this means to you is that the recognized charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

Additional Information
Aetna's website, **www.aetna.com**, may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.