Nokia Medical Expense Plan
For Active Employees

Summary Plan Description –
UnitedHealthcare (UHC) Enhanced and Standard Options

January 2026

This summary plan description (SPD) replaces the prior SPD (bearing the cover page legend "Nokia Medical Expense Plan For Active Employees Summary Plan Description—UnitedHealthcare (UHC) Enhanced and Standard Options January 2025 (Updated April 2025)"). This SPD reflects the provisions of the UnitedHealthcare (UHC) Enhanced and UHC Standard options under the Nokia Medical Expense Plan for Active Employees as of January 1, 2026.

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Introduction

The Nokia Medical Expense Plan for Active Employees is designed to provide protection against the cost of medical care and prescription drugs for you and your Eligible Dependents. This booklet--called a summary plan description ("SPD")--is intended to summarize the material terms of the Plan as in effect on January 1, 2026 and thereafter. In particular, this SPD summarizes the material terms of the plan design under both the UnitedHealthcare (UHC) Enhanced and Standard options (sometimes referred to herein collectively as the "UHC Plan" or the "UHC" options). It also summarizes the Plan's prescription drug program (for individuals covered by the UHC options) and the Plan's Employee Assistance Program ("EAP"). This SPD does not describe the terms of any of the Plan's other programs, such as the Surest options or any Health Maintenance Organization ("HMO") options (and the prescription drug programs for those options), which are set forth in other materials.

The actual terms of the Plan are reflected in the official Plan document, a copy of which can be obtained by writing to the Plan Administrator (see Section V., "Important Contacts," for the address of the Plan Administrator). Every care has been taken to ensure that this summary is accurate. In the event of a conflict between this document and the terms of the official Plan document, the official Plan document will control.

Nokia of America Corporation (the Plan's sponsoring employer, sometimes referred to herein as the "Company") expects to continue the Plan but reserves the right to amend, modify, or terminate it, in whole or in part (including any Plan option or program), at any time by resolution of the Company's Board of Directors or its duly authorized delegate(s), with or without advance notice to participants, for any reason, subject to applicable law. The Company also reserves the right to change the amount of required participant contributions under the Plan at any time, with or without advance notice to participants.

> This updated SPD replaces all prior communications regarding the UHC Enhanced and Standard options under the Plan.

Because of the many detailed provisions of the Plan, no one other than the personnel or entities identified in this document is authorized to advise you concerning your benefits or the terms of the Plan. Questions regarding your benefits should be addressed as indicated in this booklet (see Section V., "Important Contacts," for a list of Plan resources and how to contact them). Neither the Company, nor any Participating Company, nor the Plan is bound by statements made by unauthorized persons or entities. Moreover, in the event of a conflict between any information provided to you by an authorized source and information in this document, this document will control.

Section A. The Plan At-A-Glance

The Plan provides medical care and prescription drug coverage for Eligible Employees and their enrolled Eligible Dependents. Coverage is subject to limitations, as described below and elsewhere in this SPD. The Plan also includes an Employee Assistance Program ("EAP") for Plan participants and their family members. (See Section M., "Employee Assistance Program", for more details.)

Below is a summary of the key features of the Plan. (Certain words and phrases used in the table below and elsewhere in this SPD have specific meaning under the Plan. These terms are printed in initial capital letters and are defined in Section B., "Terms You Should Know".)

Plan Features	Summary
Eligible Employee	You are an Eligible Employee if you are employed by a Participating Company as a full- or part-time employee and are not an Excluded Employee.
Participating Company	The following companies are Participating Companies: • Nokia of America Corporation • Nokia Investment Management Corporation
Excluded Employee	An Excluded Employee is: (1) an individual who does not receive payment for services from a Participating Company's U.S. payroll, even if such individual is reclassified by a court or administrative agency as a common law employee of a Participating Company, (2) an employee who is employed by an independent company (such as an employment agency), (3) an employee whose services are rendered pursuant to a written agreement that excludes participation in the Company's benefit plans, (4) a Leased Employee, (5) a temporary employee (and any regular employee subclassified as a temporary employee), (6) a co-op student (other than an Eligible Co-op Student) or an intern (and any trainee/student subclassified as an intern) (other than an Eligible Intern), (7) a trainee (other than an International Graduate Trainee), (8) an International Assignee.

Plan Features	Summary
Participation and Enrollment	*Newly hired Eligible Employees (other than Eligible Co-op Students)* Newly hired Eligible Employees (other than Eligible Co-op Students) are automatically enrolled in the Plan as of their first day of employment and are assigned to the Surest Enhanced option. Employees who were not previously Eligible Employees but who become such (for example, they transfer employment from a Nokia Group company that is not a Participating Company to a Participating Company) are (unless they are Eligible Co-op Students) automatically assigned to the Surest Enhanced option under the Plan as of their first day of eligibility. Such newly hired and newly eligible employees then have 31 days within which to change their Coverage Option (see "Coverage Options", below) and/or to add Eligible Dependents (see "Eligible Dependents", below). If they do not do so within this 31-day period, they may change their Coverage Option and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if they have a Qualified Status Change). *Eligible Co-op Students:* Eligible Co-op Students must affirmatively enroll in the Plan within 31 days of receiving enrollment materials by contacting the NBRC or logging onto YBR. At that time, such Eligible Co-op Students will also have the opportunity to enroll their Eligible Dependents. Eligible Co-op Students who do not enroll in the Plan within such 31-day period may enroll in the Plan and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if they have a Qualified Status Change). *Already-Enrolled Eligible Employees (including Eligible Co-op Students)* Employees who are already enrolled in the Plan may change their Coverage Option and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if they have a Qualified Status Change).
Eligible Dependents	If you are eligible to participate in the Plan, you may also enroll your Eligible Dependents, defined as follows: • Your Spouse/Domestic or Civil Union Partner • Your Children (including your Spouse's children, i.e., your stepchildren), up until the end of the month in which they turn age 26)

Plan Features	Summary
	• The Children of your Domestic or Civil Union Partner, provided they live with you, up until the end of the month in which they turn age 26 • Your Adult Disabled Children. Note: Each of the above terms has a specific definition. See Section B., "Terms You Should Know," for more detail regarding who is an Eligible Dependent under the Plan.
Coverage Options	The Plan offers the following medical coverage options under the "UHC" plan design: • UHC Enhanced option--a plan providing a high level of benefit coverage (but requiring higher monthly contributions) • UHC Standard option--a plan with a lower level of benefit coverage (with lower monthly contributions). To see the differences between the level of coverage offered under the UHC Enhanced option and the UHC Standard option, see Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."
Coverage Categories	The following are the Coverage Categories for the Plan: • You only • You + your Spouse/Domestic or Civil Union Partner • You + your Children (including your Adult Disabled Children and, if applicable, the Children of your Domestic or Civil Union Partner) • You + your Family (i.e., your Spouse/Domestic or Civil Union Partner and your Children, including your Adult Disabled Children, and, if applicable, the Children of your Domestic or Civil Union Partner)
Cost of the Plan	You are required to contribute to the cost of coverage under the Plan for yourself and your enrolled Eligible Dependents. The cost of Plan coverage depends on the Coverage Option and Coverage Category (see above) you choose. In most instances, the cost of coverage is deducted from your paycheck on a pre-tax basis. (See Section D., "The Cost of Plan Coverage.") Information on the cost of coverage is available from the Nokia Benefits Resource Center (the NBRC) and through the Your Benefits Resources (YBR)™ website when you enroll in the Plan.

Plan Features	Summary
	For more information on how to contact the NBRC or how to log onto YBR, see Section V., "Important Contacts."
Other Plan Costs	Depending on the Medical Plan option in which you enroll and whether you utilize an In-Network or Out-of-Network provider, you might also need to pay a Copay or Coinsurance amount. Copays and Coinsurance amounts are described further in Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."
What's Covered	For a service or supply to be covered, it must be: • Medically necessary for the treatment of an illness or injury, or for preventive care benefits that are specifically stated as covered • Provided under the order or direction of a physician • Provided by a licensed and accredited healthcare provider practicing within the scope of his or her license in the state where the license applies • Listed as a covered service and satisfy all the required conditions of services of the applicable options, and • Not specifically listed as excluded. Note: In some cases, there may be additional required criteria and conditions. Services and supplies meeting these criteria will be covered up to the allowable amount or the negotiated rate, if applicable.
Annual Open Enrollment Period	The Annual Open Enrollment Period is the period when you can make selections regarding coverage for the upcoming Plan Year. You may add or cancel coverage for yourself, enroll or disenroll Eligible Dependents, and/or change your Coverage Option. Information about the Annual Open Enrollment Period, including information about any changes being made to the Plan, is communicated in the fall (usually between September and November).
Qualified Status Change	Eligible Employees may be able to change their coverage option and add or drop Eligible Dependents outside of the Plan's Annual Open Enrollment Period if they experience a Qualified Status Change. See "Changing Your Coverage During the Plan Year" in Section C., "Eligibility and Enrollment," for more information.

Plan Features	Summary
COBRA/ Continuation of Coverage	Eligible Employees (and their qualified beneficiaries) may be able to continue coverage under the Plan (for a period of time) if they would otherwise experience a loss of coverage due to a Qualifying Event (such as termination of employment). See Section Q., "COBRA Continuation Coverage," for more information.
Claims Administrator	The third-party hired to process claims for benefits under the Plan. The current claims administrator for the UHC Enhanced and UHC Standard options is UnitedHealthcare. The current claims administrator for the Prescription Drug Program is CVS Caremark. The current claims administrator for the Employee Assistance Program is Magellan. See Section V., "Important Contacts," for information on how to contact each of these claims administrators.
Nokia Benefits Resource Center (NBRC)	The Nokia Benefits Resource Center (NBRC) is the service center for the Plan and your point-of-contact for information about, and transactions concerning, the Plan. The NBRC is also your point-of-contact during the Annual Open Enrollment for the Plan. See Section V., "Important Contacts," for information on how to contact the NBRC.
Your Benefits Resources (YBR)™	Your Benefits Resources (YBR)™ is your on-line access point for the Plan. See Section V., "Important Contacts," for information on how to access YBR. (Your Benefits Resources is a trademark of Alight Solutions LLC.)

Section B. Terms You Should Know

There are several words and phrases that have specific meaning under the Plan. This section explains those terms so you can better understand your benefits. These terms are capitalized when they appear in this SPD.

Adult Disabled Child: With respect to an Eligible Employee, such Eligible Employee's Child who has attained age 26, provided such Child meets all of the following requirements:

- The Child was covered under the Plan as an eligible dependent immediately prior to attaining age 26 (note: for newly hired employees, a Child who has been continuously covered under another employer's group health plan since immediately before turning age 26 is treated as satisfying this requirement), and
- The Child, prior to attaining age 26 and thereafter was and remains--
  - Physically, mentally, or developmentally disabled, and
  - Incapable of self-support, and
  - Fully dependent on the Eligible Employee for support; and
- The Child is certified by the claims administrator for the Plan as incapacitated due to disability (certification process must be started within 31 days of the end of the month in which the Child turns age 26).

Note: Adult Disabled Child coverage is available only with respect to the Child(ren) of an Eligible Employee (including stepchildren). It is not available with respect to the Child(ren) of a Domestic or Civil Union Partner.

Adverse Benefit Determination: A denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity.

Air Ambulance: Medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605*.

Allowed Amounts: For Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are shown in Section F, "What's Covered Under the UHC Enhanced Option" and Section G, "What's Covered Under the UHC Standard Option".

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings generally in accordance with one or more of the following methodologies:

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

Alternate Facility: A health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Ancillary Services: Items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible: The total of the Allowed Amount, or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before the Plan will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or the Recognized Amount when applicable.

Annual Maximum: The maximum benefit available from the Medical Plan each calendar year for each Participant. Once the annual maximum benefit has been paid, no other benefits are available under any circumstances. You are responsible for all charges above the Annual Maximum benefit.

Annual Open Enrollment: The period of time each year designated by the Company during which you can generally make changes to your benefits. Elections made during the Annual Open Enrollment period are effective as of the first day of the subsequent calendar year.

Autism Spectrum Disorder: A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the *International Classification of Diseases section on Mental*

and Behavioral Disorders or the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*.

Beneficiary: with respect to a Participant, an Eligible Dependent who has been enrolled in and is Covered by the Plan.

Benefits: Your right to payment for Covered Health Care Services that are available under the Plan.

Birthing Center: A facility for prenatal, delivery and postpartum care that:

- Is staffed by certified nurse-midwives
- Has 24-hour access to consultation with an obstetrician/gynecologist with admitting privileges at a nearby Hospital
- Is accredited by the National Association of Childbearing Centers or the Joint Commission on the Accreditation of Healthcare Organizations, and
- Is licensed by the state.

BMI or Body Mass Index: A calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Brand Name Drug: A medication that has been patented and is produced by only one manufacturer.

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

CHD: See Congenital Heart Disease (CHD).

Chemical Dependency: Both alcoholism and drug dependency as classified by the U.S. Department of Health and Human Services' International Classification of Diseases.

Child: With respect to an Eligible Employee, such Eligible Employee's child(ren), up to the end of the month in which such child(ren) turn(s) age 26. For this purpose, child(ren) means:

- The Eligible Employee's biological child(ren)
- The Eligible Employee's stepchild(ren) (i.e., the biological child(ren) of the Eligible Employee's Spouse)
- The Eligible Employee's legally adopted child(ren), including child(ren) who are placed with the Eligible Employee for adoption
- The legally adopted child(ren) of the Eligible Employee's Spouse, including child(ren) who are placed with the Eligible Employee's Spouse for adoption
- Child(ren) for whom the Eligible Employee and/or the Eligible Employee's Spouse is (are) appointed as legal guardian as defined by a court order (this does not include wards of the state or foster child(ren)); and
- Child(ren) for whom the Eligible Employee is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

Child of a Domestic or Civil Union Partner: With respect to an Eligible Employee's Civil or Domestic Union Partner, such Domestic or Civil Union Partner's child(ren), up to the end of the month in which such child(ren) turn(s) age 26. For this purpose, child(ren) means:

- The Domestic or Civil Union Partner's biological child(ren), provided such child(ren) is (are) living with the Eligible Employee
- The Domestic or Civil Union Partner's legally adopted child(ren), including child(ren) placed with such partner for adoption, provided such child(ren) is (are) living with the Eligible Employee
- Child(ren) for whom the Domestic or Civil Union Partner is appointed as legal guardian as defined by a court order (this does not include wards of the state or foster child(ren)), provided such child(ren) is/are living with the Eligible Employee.

Civil Union Partner: See Domestic or Civil Union Partner.

Claim: A request for Benefits made by a Participant or his/her Authorized Representative in accordance with the procedures described in this SPD. It includes Prior Authorization requests; pre-service request for Benefits and appeals; urgent care request for Benefits and appeals; concurrent care request for Benefits and appeals; and post-services Claims.

Claims Administrator: The third-party hired to process claims for benefits under the Plan. See Section V., "Important Contacts," for information of how to contact the Claims Administrator.

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: An acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This refers to federal legislation that governs the offer of temporary continued Plan coverage to participants who otherwise would lose coverage due to certain reasons, such as loss of employment.

Coinsurance: The charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

Company: Nokia of America Corporation, a Delaware corporation, or its successor(s).

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that 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

- Have no known cause.

Continuity of Care: The option for existing Participants to request continued care from their current health care professional if that professional is no longer working with their health plan and is now considered Out-of-Network.

Copayment: The charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment.
- The Allowed Amount, or the Recognized Amount when applicable.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Cost Effective: The least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Dependent: With respect to an Eligible Employee who is enrolled in the Plan, each Eligible Dependent of such employee who is enrolled in the Plan.

Covered Health Care Service(s): Health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service under *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
- Not excluded under *Section H., "Exclusions and Limitations*."

Covered Person: Either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care: Services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal

needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

CVS Caremark: The company that administers the Prescription Drug Program for participants in the UHC Enhanced and UHC Standard options under the Plan.

Deductible: See Annual Deductible.

Default Option: The Medical Plan option to which you are assigned if you are an Eligible Employee and have not actively enrolled in the Medical Plan or if your current option is eliminated and you do not actively select a new option. Eligible Employees working less than 20 hours per week are not assigned a Default Option; these Eligible Employees must actively enroll in the Medical Plan to have coverage.

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

Dependent: An individual who meets the eligibility requirements specified in the Plan. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Provider: A provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions, or
- The Claims Administrator has identified through the Claims Administrator'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.

Domestic or Civil Union Partner: An individual, regardless of sex or gender, who, together and with respect to an Eligible Employee, meets the following criteria:

(A) If the Eligible Employee and the individual reside in a state or locality that maintains a registry of domestic partnerships or civil union partnerships, comply with such state or local registration process.

(B) If the Eligible Employee and the individual do <u>not</u> reside in a state or locality that maintains a registry of domestic partnerships or civil union partnerships, meet all of the following criteria (and so certify under penalty of perjury)--

(i) They reside in the same household

(ii) They are each age 18 or older

(iii) They have the mental capacity sufficient to enter into a valid contract

(iv) They are not related to each other by blood

(v) They are not married to each other or to another person and are not the domestic partner or civil union partner of another individual
(vi) They consider themselves to have a close and committed personal relationship and have no other such relationship with any person
(vii) They are responsible for each other's welfare and financial obligations, and
(viii) They provide such other information as may be necessary for the Plan to determine whether the individual (or the Children of such individual) are Eligible Dependents under the Plan.

An Eligible Employee may not enroll more than one Domestic or Civil Union Partner in the Plan (and, if the Eligible Employee has a Spouse, may not enroll any Domestic or Civil Union Partner in the Plan).

Domestic or Civil Union Partnership: With respect to an Eligible Employee, the status of having a Domestic or Civil Union Partner.

Domestic Partner: See Domestic or Civil Union Partner.

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:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Charge: A charge for health care services, subject to all of the terms, conditions, limitations, and exclusions for which the Plan, or Participant will pay.

Eligible Co-op Student: A co-op student who completes an average of 28 or more hours of service per week. For this purpose, hours of service shall be calculated in a manner consistent with Section 4980H of the Code and any applicable regulations issued thereunder. Eligible Co-op Students shall be eligible to participate in the Plan upon calculation of such average of 28 or more hours of service per week.

Eligible Dependent: With respect to an Eligible Employee: the Eligible Employee's Spouse, Domestic or Civil Union Partner, as applicable; Child(ren); and Adult Disabled Child(ren). For Eligible Employees who have a Domestic or Civil Union Partner, Eligible Dependent also includes a Child of a Domestic or Civil Union Partner.

Eligible Employee: An individual employed by a Participating Company as a full- or part-time employee who is not an Excluded Employee.

Eligible Expenses: Charges for Covered Health Services that are provided while the Plan is in effect and determined by the Claims Administrator.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As indicated in the most recent editions of the Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) Codes.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage 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.

Note: Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described above, except as required under the No Surprises Act, which is a part of the Consolidated Appropriations Act of 2021.

Eligible Intern: An intern who completes a 90-day period of continuous employment with a Participating Company and who completes an average 30 or more hours of service per week. For this purpose, hours of service shall be calculated in a manner consistent with Section 4980H of the Code and any applicable regulations issued thereunder. Eligible Interns shall be eligible to participate in the Plan beginning after the completion of such 90-day period with a Participating Company or, if later, after completion of such 90-day period and upon such time when the student intern averages 30 or more hours of service per week.

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 Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services: With respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
  - The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
  - The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  - The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
  - The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
  - Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Employee Benefits Committee (EBC): The committee appointed by the Company to undertake certain administrative responsibilities with respect to the Plan. The EBC serves as the final review committee for all questions relating to eligibility to participate in the Plan and all other questions related to administration of the Plan, to the extent not delegated to the Claims Administrator or

to the Nokia Benefits Review Team. Decisions by the EBC are conclusive and binding on all parties and not subject to further internal review.

ERISA: The Employee Retirement Income Security Act of 1974 as amended from time to time. The federal law that regulates retirement and employee welfare benefit plans maintained by employers.

E-Visit and Telephone Consult with Your Physician: Services provided by Physician performed without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal messages.

Excluded Employee: Each of the following:

(1) an individual who does not receive payment for services from a Participating Company's U.S. payroll, even if such individual is reclassified by a court or administrative agency as a common law employee of a Participating Company
(2) an employee who is employed by an independent company (such as an employment agency)
(3) an employee whose services are rendered pursuant to a written agreement that excludes participation in the Company's benefit plans
(4) a Leased Employee
(5) a temporary employee (and any regular employee subclassified as a temporary employee)
(6) a co-op student (other than an Eligible Co-op Student) or an intern (and any trainee/student subclassified as an intern) (other than an Eligible Intern)
(7) a trainee (other than an International Graduate Trainee)
(8) an International Assignee.

Experimental or Investigational Service(s): 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.

- 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 Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section E. How the UHC Medical Options Work; Covered Health Care Services.*
- The Claims Administrator may at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section E. How the UHC Medical Options Work; Covered Health Care Services*: and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB): A statement that provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Participant's responsibility. The EOB is not a bill, it is a statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains the Benefits provided (if any); the allowable reimbursement amounts; copayments; 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.

Extended Care Facility: See Skilled Nursing Facility.

Family Security Program or FSP: A program available to the Covered Dependent who is the surviving Spouse/Domestic or Civil Union Partner of an Eligible Employee who dies while employed by a Participating Company. Under the FSP (which is not a part of this Plan but rather is available through the Nokia Medical Expense Plan for Retired Employees (the "Retiree Medical Plan"), a component of the Nokia Retiree Welfare Benefits Plan), Company-provided group health plan coverage provided to your surviving Spouse/Domestic or Civil Union Partner (and your surviving Covered Dependents) who elected COBRA continuation coverage under this Plan can be continued under the Retiree Medical Plan. Information regarding the FSP is provided shortly before the end of your surviving Spouse's/Domestic Partner's original 36-month COBRA continuation period (unless such period terminated before the end of such 36-month period).

Note: The FSP is not "lifetime coverage"; it may be modified or terminated by the Company at any time.

FMLA: The Family and Medical Leave Act of 1993, as amended from time to time.

Formulary: A list of preferred prescription drugs selected by CVS Caremark for Prescription Drug Program participants in the UHC Enhanced and UHC Standard options under the Plan.

Freestanding Facility: An outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gender Dysphoria: A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association:*

Generic Drug: A drug that does not bear the trademark of the original manufacturer but that is chemically identical to and generally costs less than a Brand Name Drug.

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

Genetic Counseling: Counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing, and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing: Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier: A female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Health Plan Carrier(s): Any company authorized by Nokia to provide services under the Medical Plan, including UnitedHealthcare and CVS Caremark.

Home Health Agency: A program or organization authorized by law to provide health care services in the home.

Hospital: An institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility: An outpatient facility that performs services and submits claims as part of a Hospital.

Independent Freestanding Emergency Department: A health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Care Services.

Infertility: A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

Injury: Damage to the body, including all related conditions and symptoms.

In-Network: The benefit choice that permits you to access the services of contracted Network Providers.

In-Network Benefits: See Network Benefits.

Inpatient Rehabilitation Facility: Any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay: A continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT): Outpatient Mental Health Care 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. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Program(s): A structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care: Skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

International Assignee: Any of the following:

- An Employee who is classified as an Expatriate (Outbound Assignee) meaning the employee's home country is the United States, and the Expatriate is on a long-term international assignment for the Company outside of the United States, or
- An Employee who is classified as an Inpatriate (Inbound Assignee) meaning the employee's home country is outside of the United States, and the Inpatriate is on a long-term or short-term international assignment for the Company in the United States, or
- An Employee who is classified as on an International Professional Contract (IPC) meaning the employee does not have a designated home country and is on an international assignment for the Company in the United States.

Lifetime Maximum: The maximum benefit available from the Medical Plan in a lifetime for each Participant with respect to certain services. Once the lifetime maximum benefit has been paid, no other benefits are available under any circumstances with respect to those services. You are responsible for all charges above the lifetime maximum benefit.

Manipulative Treatment (adjustment): A form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medicaid: A federal program administered and operated individually by participating state and territorial governments. The program provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

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

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has 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 the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.

Medical Plan: The Nokia Medical Expense Plan for Active Employees, an employee welfare benefit plan (within the meaning of ERISA) maintained by the Company.

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 Care Services: Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of *the* International Classification of Diseases section on *Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the International Classification of Diseases section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by

the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

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

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 the Claims Administrator's affiliate to participate in the Claims Administrator's Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of the Claims Administrator's products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits: The description of how Benefits are paid for Covered Health Care Services provided by Network providers.

Network Retail Pharmacy: A retail pharmacy that participates in the CVS Caremark network.

Nokia Benefits Resource Center: The resource to call to enroll, to make changes to your coverage or to ask questions about your Medical Plan options. See the Section V., “Important Contacts,” for information on how to contact the Nokia Benefits Resource Center.

Nokia Benefits Review Team: The team within the Nokia Benefits Resource Center assigned the responsibility to decide claims for eligibility to participate in the Plan.

Observation Stay: Observation care consists of evaluation, treatment, and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital.

Out-of-Network: When used to describe a provider of health care services, this means a provider that does not have a participation agreement in effect (either directly or indirectly) with the

Claims Administrator or with its affiliate to participate in the Network, including providers providing services to a Participant in a foreign country while the Participant is traveling outside the United States. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be 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 an Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Out-of-Network Benefits: The level of Benefits paid for Covered Health Services provided by out-of-network providers. See Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option" and Appendix 1, "Benefits at a Glance - Medical" for details.

Out-of-Pocket Limit: The maximum amount you pay every year.

Partial Hospitalization/Day Treatment/High Intensity Outpatient: A structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Participant: Each Eligible Employee and such Eligible Employee's Eligible Dependents who are enrolled in and covered under the Plan.

Participating Company: Each of the following:

- Nokia of America Corporation
- Nokia Investment Management Corporation.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)* : Approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician: Any *Doctor of Medicine* (M.D.) or *Doctor of Osteopathy* (D.O.) 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 their license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a Provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan: The Medical Plan.

Plan Administrator: The Company or its designee.

Plan Sponsor: The Company.

Plan Year: The consecutive 12-month period commencing on January 1 and ending on December 31 (i.e., the calendar year).

Pre-Admission Notification: Process whereby the Provider or you inform the Plan that you will be admitted to the inpatient hospital, Skilled Nursing Facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization, or Residential Treatment Facility. This notice is required in advance of being admitted for inpatient care for any type of non-Emergency admission and for partial hospitalization. All contracted facilities are required to provide Pre-Admission Notification to you.

Pregnancy: Includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Prescription Drug Program: The program that provides benefits for prescription drugs to individuals covered under the UHC options.

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

Primary Care Physician: A Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Prior Authorization: Pre-service, urgent care request, concurrent care benefit coverage decision for a service, procedure, or test that has been subject to an evidence-based review resulting in a Medical Necessity determination.

Private Duty Nursing: Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Provider: A health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term "Provider" refers to an In-Network Provider unless otherwise specified.

Qualified Medical Child Support Order (QMCSO): A judgment, decree, or order issued by a court that requires coverage under the Plan for an Eligible Employee's Eligible Dependent and that has been determined by the Plan Administrator to be qualified under ERISA. You may obtain a copy of the Plan's QMCSO administrative procedures, free of charge, from the Nokia QMCSO Administrator. See Section V., "Important Contacts," for information on how to contact the Nokia QMCSO Administrator.

Qualified Status Change: A change in status with respect to an Eligible Employee or the Eligible Employee's Eligible Dependents that permits certain changes in coverage under the Plan. See "Changing Your Coverage During the Plan Year" in Section C., "Eligibility and Enrollment," for more information.

Recognized Amount: The amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1. An *All Payer Model Agreement* if adopted,
2. State law, or
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Reconstructive: Surgery or procedure to restore or correct:

- A defective body part when such defect is incidental to or follows surgery resulting from illness, injury, or other diseases of the involved body part.
- A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician.
- A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the Claim Administrator to be Medically Necessary.

Remote Physiologic Monitoring: The automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment: A program of Mental Health Care Services or Substance-Related and Addictive Disorders Services that meets all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

Residential Treatment Facility: A Hospital or facility licensed and operated as required by law, that provides Residential Treatment.

Secretary: As that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room: A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Sickness: Physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders.

Skilled Care: Skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be 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.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility: A Hospital or nursing facility that is licensed and operated as required by law.

Specialist: A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Drugs: Infusions, injectables and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics:

- Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes.
- Intensive patient training and compliance assistance are required to facilitate therapeutic goals.
- There is limited or exclusive product availability and/or distribution.
- There are specialized product handling and/or administration requirements.
- Are produced by living organisms or their products.

Spinal Treatment: Detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse: A person of the same or opposite gender or sex who is lawfully married to an Eligible Employee. You may not have more than one Spouse under the Plan.

Substance-Related and Addictive Disorders Services: Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical*

Manual of Mental Disorders published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate: A female who becomes pregnant by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. A surrogate provides the egg and therefore is biologically (genetically) related to the child.

Telehealth/Telemedicine: Live, interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Transitional Living: Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the American Society of Addiction Medicine (ASAM) Criteria and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery. Please note: these living arrangements are also known as supportive housing (including recovery residences).

Transition of Care: The option for a new Participant to request coverage from your current, Out-of-Network health care professional at In-Network rates for a limited time due to a specific medical condition, until the safe transfer to an In-Network health care professional can be arranged.

Unproven Service(s): Services, including medications, and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-designed systemic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.

- Well-designed observational studies with one or more concurrent comparison group(s), including cohort studies, case-control studies, cross-sectional and systematic reviews (with or without meta-analysis) of such studies.

The Claims Administrator has a process by which the Claims Administrator compiles and reviews clinical evidence with respect to certain health care services. From time to time, the Claims Administrator 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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center: An entity that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

USERRA: An acronym for the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Utilization Management: Utilization Management processes are conducted by UHC to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review (review of Claims to ensure services were Medically Necessary).

Virtual Care: Virtual care is for Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides 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 or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).

Section C. Eligibility and Enrollment

Who Is Eligible?

If you are an Eligible Employee, coverage under the Plan is available to you and to your Eligible Dependents. (Your Eligible Dependents must be covered under the same Medical Plan option that you choose for yourself.)

Eligible Dependents who may be covered under the Plan are limited to:

- Your Spouse or Domestic or Civil Union Partner
- Your Child (through the end of the month in which such Child attains age 26)
- Your Adult Disabled Child
- The Child of your Domestic or Civil Union Partner (through the end of the month in which such Child attains age 26 and provided such Child lives with you).

Note: See Section B.,"Terms You Should Know," which sets forth the definitions for each type of "Eligible Dependent."

States sometimes pass laws that require employee benefit plans to provide benefits and/or coverage to individuals who otherwise are not eligible. For example, a state might require an employer to provide coverage to an ex-spouse or a child who exceeds the Medical Plan's age requirements and therefore is not eligible for benefits under the Company's Medical Plan. The federal law known as ERISA supersedes state law. As a result, the Plan only covers the individuals described in this SPD. See "Medical Plan Contributions" later in this section for information on imputed income if you cover a Domestic or Civil Union Partner or a Domestic or Civil Union Partnership Child.

Enrolling in the Plan

What you need to do to enroll in coverage under the Plan differs depending on whether you are:

- A newly hired (or newly eligible) employee
- Changing your existing coverage during an Annual Open Enrollment Period, or
- Changing your existing coverage during the year due to a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

Declining Coverage

You may decline coverage under the Plan. However, if you do, you will have to wait until the next Annual Open Enrollment Period if you want to enroll in the Plan--unless you have a Qualified Status Change. See "Changing Your Coverage During the Plan Year" later in this section.

Plan Options and Coverage Categories

The Plan offers different coverage options (plan design) and coverage categories (who is covered). Depending on the plan option and coverage category you choose, your cost of services covered under the Plan, and the amount of contributions required for such coverage, will differ.

The following coverage options are available under the "UHC Plan" options:

- UHC Enhanced option
- UHC Standard option.

To see the difference between the level of coverage offered under the UHC Enhanced option and the UHC Standard option, see Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."

You may select from one of the following coverage categories when enrolling yourself and your Eligible Dependents in the Plan:

- You only
- You + your Spouse/Domestic or Civil Union Partner
- You + your Children (including your Adult Disabled Children and, if applicable, the Children of your Domestic or Civil Union Partner)
- You + your Family (i.e., your Spouse/Domestic or Civil Union Partner and your Children, including your Adult Disabled Children, and, if applicable, the Children of your Domestic or Civil Union Partner).

Newly Hired Employees

If you are a full-time or part-time Eligible Employee (other than an Eligible Co-op Student) regularly scheduled to work 20 or more hours a week, you are assigned individual ("You only") coverage under the Medical Plan as of your first day of employment. You may add Eligible Dependents to your coverage provided you do so within 31 days of the date you are notified of your eligibility to enroll. If you are scheduled to work less than 20 hours a week, you must actively enroll. Contact the NBRC for information on how to actively enroll in the Medical Plan. See Section V., "Important Contacts," for information on how to contact the NBRC.

If you are an Eligible Co-op Student, you are not automatically assigned any coverage under the Plan. Instead, you must affirmatively enroll in the Plan by contacting the NBRC or logging onto the YBR website within 31 days of the date you are notified of your eligibility to enroll in the Plan. At the time of your enrolling in the Plan, you will also have the opportunity to enroll your Eligible

Dependents. Note: If you do not enroll in the Plan within the time period noted above, you may enroll in the Plan and add or drop Eligible Dependents only during the Plan's Annual Open Enrollment Period (or if you have a Qualified Status Change).

For all Eligible Employees: You must enroll your Eligible Dependents in the same medical plan option that you choose for yourself. If you enroll your Eligible Dependents at the same time you enroll yourself (or within 31 days of the date you are notified of your eligibility to enroll), coverage for those Eligible Dependents begins the same day your coverage begins.

You generally will receive an e-mail from the Nokia Benefits Resource Center pointing you to the YBR website for more information about your coverage options, including the cost, how to enroll yourself and your Eligible Dependents, and the date by which you must make your elections (generally, within 31 days after you receive your enrollment information).

If You Don't Enroll (New Hires)

As a new hire, if you do not make any elections by the required date, here is what happens:

- If you are a regular full-time or a regular part-time Eligible Employee (other than an Eligible Co-op Student) scheduled to work 20 or more hours a week, you alone will continue to have coverage under the Surest Enhanced option. You may not add any Eligible Dependents until the next Annual Open Enrollment Period, unless you have a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

- If you are an Eligible Co-op Student or are scheduled to work fewer than 20 hours per week, you will not be assigned a coverage option. This means you and your Eligible Dependents cannot enroll in the Plan until the following Plan Year. You must wait until the next Annual Open Enrollment Period to enroll, unless you have a Qualified Status Change (see "Changing Your Coverage During the Plan Year" later in this section).

Note: Your Eligible Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse/Domestic or Civil Union Partner are both Eligible Employees, you may each be enrolled separately (as a covered Eligible Employee) or one of you may be covered as the Eligible Dependent of the other person, but not both. If you and your Spouse/Domestic or Civil Union Partner enroll separately, either parent (but not both) may enroll any eligible dependent child.

Annual Open Enrollment Period

During annual open enrollment each year, you will have the opportunity to select the coverage that best meets your needs for the coming year. This means that you may "add" or "cancel" coverage for yourself and your Eligible Dependents and/or change coverage options. Annual open enrollment is held once a year, usually in the fall. Elections made during annual open enrollment take effect on the first day of the next calendar year.

Before annual open enrollment, you will receive enrollment materials that will include information about the coverage options available to you under the Plan in the upcoming year. In most cases, if you are currently enrolled in the Plan and do not make any changes to your coverage, your current coverage elections will remain in effect unless a particular Plan option is being discontinued or replaced by another option.

If your Plan option is being discontinued and you do not select another Plan option, you will be enrolled in a default option.

Changing Your Coverage During the Plan Year

You may change your coverage under the Plan during the Plan Year **only** if you have a "qualified status change." In order to be able to make a change during the year, qualified status changes must be reported through YBR or to the Nokia Benefits Resource Center within 31 days of the event.

A "qualified status change" is an event that causes someone to become eligible for, or to no longer be eligible for, coverage under the Medical Plan or another employer's plan. These events are listed in the table below.

Please note: Your election change under the Medical Plan during the year must be due to and consistent with the type of qualified status change that has occurred. For example, if you legally adopt a child, you may enroll the newly adopted child in the Medical Plan. You may not, however, cancel coverage for your Spouse.

Qualified Status Change	Description
Change in Marital Status	Your marriage, divorce, legal separation, the annulment of your marriage, or the death of your Spouse.
Change in Domestic or Civil Union Partner Status	The entering into of, or termination of, a Domestic or Civil Union Partner relationship.
Change in the Number of Eligible Dependents	The birth, death, legal adoption, or placement for legal adoption of one of your Eligible Dependents.
Change in Employment Status, Work Schedule, or Worksite That Causes a Change in Eligibility	You or Eligible Dependent: • Becomes employed or loses employment • Experiences a change in worksite, or • Reduces or increases hours of employment, including a switch between part-time and full-time employment or the start of, or a return from, a leave of absence.

Qualified Status Change	Description
	Note: Without a corresponding change in your or your Eligible Dependent's eligibility under the Medical Plan, the above changes will not permit a mid-year change under the Medical Plan.
Your Eligible Dependent Meets or No Longer Meets the Medical Plan's Eligibility Requirements	An event that causes a dependent to meet or to no longer meet the Medical Plan's eligibility requirements, for example, your Child reaches the maximum age for coverage.
Change in Place of Residence	A change in residence for you or an Eligible Dependent that causes a gain or loss of eligibility for coverage.
Significant Cost or Coverage Changes	A significant change in the cost or coverage under the Plan (for example, if costs significantly increase mid-year, you may be eligible to drop coverage) or a significant change in cost or coverage under another employer's group health plan in which one of your Eligible Dependents participates. (For example, if costs significantly increase under your Spouse's plan mid-year, your Spouse may be able to disenroll from the other employer's plan and enroll in the Medical Plan.)
Court-Ordered Coverage	A change in your responsibility to provide healthcare coverage for a dependent Child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). Documentation must be submitted.

Note: The fact that another employer's plan has a different enrollment period than the Plan is not considered a qualified status change under the Plan. For example, if one plan's annual open enrollment period is in October and the other plan's annual open enrollment period is in November, you may not make changes to your coverage under the Plan as a result of the different timing of the enrollment periods.

Special Enrollment Rights

The Plan provides "special enrollment rights" for both Eligible Employees and their Eligible Dependents in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and also the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). Special enrollment rights refer to the ability to enroll for coverage under the Plan outside the Plan's normal enrollment periods (e.g., when first becoming eligible for coverage or during an Annual

Open Enrollment Period) in certain limited circumstances, provided timely notice is provided to the Plan, as described below.

Under HIPAA, if you declined coverage under the Plan (either when you first became eligible for coverage or during a subsequent Annual Open Enrollment Period) because you had other health insurance or other group health plan coverage (for example, coverage available under a Spouse's plan), you may be able to enroll yourself and your Eligible Dependents in this Plan if you (or any of your Eligible Dependent(s)) lose eligibility for that other coverage or if, in the case of an employer-sponsored group health plan, the other employer stops contributing toward your or your dependents' other coverage. However, you must request enrollment in the Plan within 31 days plan after your or your Eligible Dependent's(s') other coverage ends (or within 31 days after the other employer stops contributing toward that other coverage).

Also under HIPAA, if you "gain" a new dependent during the Plan Year as a result of marriage, entering into a Domestic or Civil Union Partnership, or the birth, adoption, or placement for adoption of a child, you may be able to enroll yourself and your Eligible Dependents (both "new" Eligible Dependents and existing but unenrolled Eligible Dependents) in the Plan. However, you must request enrollment within 31 days after the event, i.e., the marriage, entering into such Domestic or Civil Union Partnership, birth, adoption, or placement for adoption.

If you timely request enrollment in the Plan due to a special enrollment event as described above, coverage will be effective as follows:

- If the event is the birth, adoption or placement for adoption of a child, coverage will be effective as of the date of birth, adoption or placement for adoption
- For all other events, coverage will be effective on the day first of the month following the month in which your request for enrollment is received.

In addition to the foregoing special enrollment rights under HIPAA, the Plan provides for special enrollment rights under CHIPRA. If you or your Eligible Dependent is eligible for but not enrolled in coverage under the Plan, you are eligible to enroll in the Plan outside of the Plan's Annual Enrollment Period if you meet either of the following conditions and you request enrollment with the Plan no later than the deadline described below:

- You or your Eligible Dependent loses eligibility for Medicaid or State Children's Health Insurance Program (CHIP) coverage
- You or your Eligible Dependent becomes eligible for premium assistance with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

In order to enroll in the Plan for any of those circumstances, you must request enrollment within 60 days of the event.

If you timely request enrollment in the Plan due to a CHIPRA special enrollment event as described above, coverage will be effective on the first day of the month following the month in which your request for enrollment is received.

For more information about your special enrollment rights under these laws, please contact the Nokia Benefits Resource Center.

Section D. The Cost of Plan Coverage

Employee Contributions

The Plan is "self-insured" by the Company, meaning the Company is responsible for the cost of providing benefits due under the Plan as well as the cost of administering the Plan. You are required to contribute toward this cost. The amount you pay depends on the medical plan option you choose (e.g., UHC Enhanced vs. UHC Standard) and the Coverage Category (e.g., you only, you plus your Spouse/Domestic or Civil Union Partner, etc.). You are provided with information regarding the amount of contribution that you are required to pay at the time of enrollment. You can also find cost information for all the available options by visiting the YBR website or contacting the NBRC.

In most instances, your contributions are deducted from your paycheck on a pre-tax basis (that is, before taxes are deducted from your pay).

Tax Treatment of Coverage for Domestic and Civil Union Partners and Their Children

Most Eligible Dependents under the Plan are considered to be "Tax Dependents" of the Eligible Employee, meaning that covering such dependents under the Plan does not result in additional taxable income to the employee under state or federal tax law. You are not taxed on the value of your Plan benefits for Tax Dependents.

Nokia assumes all Covered Dependents are Tax Dependents, with the exception of Domestic or Civil Union Partners and their Children. If you are eligible to cover a Domestic or Civil Union Partner or a Child of your Domestic or Civil Union Partner (or some other person who is not a Tax Dependent), Nokia is required to report income for you that reflects the value of the coverage (minus any after-tax contributions) for tax reporting purposes. This is known as imputed income. You will receive a W-2 annually for the value of coverage for any Eligible Dependent who is not a Tax Dependent, and this additional taxable income is subject to both income tax and FICA withholding.

For more information about the tax implications of coverage for a Domestic or Civil Union Partner or Domestic or Civil Union Dependent under the Plan, please consult with your personal tax advisor. Neither the Company nor the Plan provides personal tax advice.

Cost of COBRA Coverage

"COBRA" coverage is continuation coverage that is available under the Plan in certain circumstances. See Section Q., "COBRA Continuation Coverage," for more information. There is

a difference between the contributions required for active employee coverage and coverage as COBRA continuant. Please contact the Nokia Benefits Resource Center or visit the YBR website or refer to your COBRA Enrollment Notice for details on the current cost of your coverage. See Section V., "Important Contacts," for more information on how to contact the Nokia Benefits Resource Center.

Section E. How the UHC Medical Options Work; Covered Health Care Services

Understanding Your UHC Options

The Medical Plan offers two types of Point of Service ("POS") coverage options:

- The Standard Option; and
- The Enhanced Option.

The options vary by the level of covered services and how much you pay out of your pocket.

The details pertaining to your Medical Plan options, including Coinsurance, Deductibles, and Annual Maximum can be found in Section F, "What's Covered Under the UHC Enhanced Option" and Section G, "What's Covered Under the UHC Standard Option" and Appendix 1, "Benefits at a Glance - Medical".

What this section includes:

- Accessing Benefits
- Eligible Expenses
- Annual Deductible
- Copayment
- Coinsurance
- Out-of-Pocket Maximum.

Accessing Benefits

As a Participant in this 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 this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with the Claims Administrator to provide those services.

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain

Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Out-of-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, including those provided in a foreign country while traveling outside the United States for non-business reasons. In general health care terminology, Out-of-Network Benefits may also be referred to as Non-Network Benefits.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

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.

Participants who live in Massachusetts, Maine and New Hampshire (and their covered dependents regardless of where those dependents live) will receive In-Network coverage through the Harvard Pilgrim Health Care network when seeking covered health services in Massachusetts, Maine and New Hampshire or through the UnitedHealthcare network when seeking covered health services outside Massachusetts, Maine and New Hampshire.

Participants who live outside Massachusetts, Maine and New Hampshire (and their covered dependents regardless of where those dependents live) will receive In-Network coverage through the UnitedHealthcare network.

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 when Covered Health Services are received 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.

Looking for a Network Provider?

In addition to other helpful information, **www.myuhc.com,** the Claims Administrator's consumer website, contains a directory of health care professionals and facilities in the Claims Administrator'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

The Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, the Claims Administrator 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 the Claims Administrator at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of Nokia or the Claims Administrator.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

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

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the Claims Administrator at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of the Claims Administrator's products. Refer to your provider directory or contact the Claims Administrator for assistance.

Designated Providers

If you have a medical condition that the Claims Administrator believes needs special services, the Claims Administrator may direct you to a Designated Provider chosen by the Claims Administrator. If you require certain complex Covered Health Services for which expertise is limited, the Claims Administrator may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, the Claims Administrator may reimburse certain travel expenses at the Claims Administrator's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all of your future Covered Health Services.

If you don't make a selection within 31 days of the date you are notified, the Claims Administrator will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Out-of-Network Benefits.

Eligible Expenses

The Plan Administrator has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for anything except your cost sharing obligations. For Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you are responsible to work with the non-Network physician or provider to resolve any amount billed to you that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. Eligible Expense are

determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

When Covered Health Services are received from a non-Network provider, Eligible Expenses are an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law), or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Advocacy Services

The Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and UnitedHealthcare, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Don't Forget Your ID Card

Remember to show your 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.

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 In-Network and Out-of-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the

provider. Copays count toward the Out-of-Pocket Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying.

Out-of-Pocket Maximum

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

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 In-Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the In-Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	No	No
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary.

- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section O: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

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 disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in Section F. What's Covered Under the UHC Enhanced Option and Section G. What's Covered Under the UHC Standard Option.

This section describes Covered Health Care Services for which Benefits are available. Please refer to *Section F. What's Covered Under the UHC Enhanced Option and Section G. What's Covered Under the UHC Standard Option* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

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

Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services.*

Clinical Trials

Routine patient care costs incurred while taking part 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 which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the 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 taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
    - Certain *Category B* devices.
    - Certain promising interventions for patients with terminal illnesses.
    - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part 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. It takes place in relation to the prevention,

detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).*)
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place 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. It must have been approved by all relevant institutional review boards (IRBs) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of Fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- 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.
- Replacement of lost teeth due to Injury with 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*. Benefits for blood glucose meters, including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are available as described in *Section J. Overview of the Prescription Drug Program.*

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).

- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *SPD*.
- Shoe inserts, arch supports and shoe orthotics when prescribed by a Physician.
- Shoes (standard or custom), lifts and wedges.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include dedicated speech-generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in Section F. What's Covered Under the UHC Enhanced Option and Section G. What's Covered Under the UHC Standard Option.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section H: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are available for services to treat a condition that does not meet the definition of an Emergency.

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a medical or behavioral disabling condition to learn or improve skills and functioning for daily living. The Claims Administrator will decide 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 medical or behavioral disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy, including cognitive therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a medical or behavioral disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
    - Licensed speech-language pathologist.
    - Licensed audiologist.
    - Licensed occupational therapist.
    - Licensed physical therapist.
    - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.

- Day care.
- Therapeutic recreation.
- Educational/vocational training.
- Residential Treatment.
- A service or treatment plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Medical records.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress the Claims Administrator may request additional medical records.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Hearing Aids

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). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *SPD*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

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.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Major Diagnostic and Imaging - 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 include:

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

Mental Health Care and Substance-Related and Addictive Disorders Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance-Related and Addictive Disorders Services. If you need assistance with coordination of care, locating a provider, and confirmation that serrvices you plan to receive are Covered Health Care Services, you can contact the Delegate at the telephone number on your ID card.

Mental Health Care and 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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Programs.
- Outpatient treatment.

Inpatient treatment and Residential Treatment include room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care 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 Behavior Analyst* (*BCBA*) or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *SPD*.

Nutritional Counseling (Non-Preventive)

Non-preventive nutritional counseling services for mental health and substance-related and addictive disorders and medical diagnosis that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals.

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 - Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- You have a body mass index (BMI) of greater than 40.
- You have a body mass index (BMI) of greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *SPD*.

If you require certain Pharmaceutical Products the Claims Administrator may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, Specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

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

The Claims Administrator 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 by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

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 Care Services include related tests and treatment.

The Plan will pay Benefits for an Inpatient Stay of at least:

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations 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*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of any rental).
- Timing of purchase or rental.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section H: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you 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.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. 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 Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- Vision therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health

Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

Biofeedback is a covered Benefit.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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 and colorectal diagnostic services.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

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

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily 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.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

The reversal of voluntary sterilization is covered.

Benefits include:

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

Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.

- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies
- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/small intestine
- Pancreas
- Small intestine
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Plan, limited to donor:

- Identification
- Evaluation
- Organ removal
- Direct follow-up care.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Urinary Catheters

Benefits are provided for external, indwelling, and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit)
- Anchoring device
- Irrigation tubing set.

Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious conditions. Virtual care provides communication of medical information in real-time or

asynchronous time between the patient and a distant Physician or health specialist, 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 contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Wigs

Wigs and other scalp hair prostheses for hair loss due to disease or treatment of disease.

Section F. What's Covered Under the UHC Enhanced Option

Described below is information relating to covered health services under the UHC Enhanced option. For relevant limitations, see Section "H", "Exclusions and Limitations--What the UHC Options Do Not Cover."

Payment Term and Description	Amounts	
	The Amount You Pay Network	**The Amount You Pay Out-of-Network**
Annual Deductible		
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care 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/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount.	$500 per Covered Person not to exceed $1,500 for all Covered Persons in a family.	$1,500 per Covered Person not to exceed $4,500 for all Covered Persons in a family.

Payment Term and Description	Amounts	
	The Amount You Pay Network	**The Amount You Pay Out-of-Network**
Out-of-Pocket Limit		
The maximum you pay per year for Copayments and Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any amounts you pay toward the Annual Deductible. • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	$4,000 per Covered Person, not to exceed $8,000 for all Covered Persons in a family. The Out-of-Pocket Limit does not include the Annual Deductible	$6,000 per Covered Person, not to exceed $18,000 for all Covered Persons in a family. The Out-of-Pocket Limit does not include the Annual Deductible.

Payment Term and Description	Amounts	
	The Amount You Pay Network	**The Amount You Pay Out-of-Network**
Copayment		
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount, or the Recognized Amount when applicable.		
Coinsurance		
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in *Section B: Terms You Should Know*.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Acupuncture Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	Out-of-Network Benefits for needle therapy are limited to 30 treatments per year. Network Benefits for needle therapy are not limited.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Ambulance Services			
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	*Ground Ambulance:* 15% *Air Ambulance:* 15%	Same as Network	Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Section F.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	*Ground Ambulance:* 15% *Air Ambulance:* 15%	Same as Network	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Section F.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Cellular and Gene Therapy			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F.*	Out-of-Network Benefits are not available.	For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.
Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F..*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F.*	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Section F.* Benefits are available when the Covered Health Care Services are provided by either Network or out-of-Network providers.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F.*	
Dental Services - Accident Only			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$30 per visit for a Primary Care Physician office visit or $40 per visit for a Specialist office visit	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Section F*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Section F*.	
Diabetes Self-Management Items	For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. For diabetes supplies, see *What's Covered Under the Prescription Drug Program in* Section J. "Overview of the Prescription Drug Program".	For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. For diabetes supplies, see *What's Covered Under the Prescription Drug Program* in Section J. "Overview of the Prescription Drug Program".	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years. To receive Network Benefits, you must obtain the DME or orthotic from the vendor the Claims Administrator identifies or from the
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
			prescribing Network Physician.
Emergency Health Care Services - Outpatient			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$250 per visit.	Same as Network	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within two business days 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 out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
			the Emergency Health Care Services Copayment, Coinsurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Section F*.
Enteral Nutrition			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Gender Dysphoria **Prior Authorization Requirement for Surgical Treatment** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.** **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Section F*.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$40 per visit ***Post-cochlear implant aural therapy*** *Office visit* $30 per visit for a Primary Care Physician office visit or $40 per visit for a Specialist office visit *Outpatient professional, including Cardiac Rehabilitation Services* 15%	40%	Outpatient therapies: • Physical therapy. • Occupational therapy, including cognitive therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. For the above outpatient therapies: • Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hearing Aids			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	Same as Network	Benefit limited to $2,500 every 36 months (Network and Out-of-Network combined). Benefits are further limited to a single purchase per hearing impaired ear every 36

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Same as Network	months. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.
Does the Annual Deductible Apply?	Yes	Same as Network	
Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	Out-of-Network Home Health Care is limited to 100 visits per year. Network Benefits are not limited. A separate 100 visit limit applies to Out-of-Network Private Duty Nursing in the same manner. To receive Network Benefits for Private Duty Nursing,
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes	services must be provided by a Network provider. These visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40% after you pay $300 per Inpatient Stay.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Lab, X-Ray and Diagnostic - Outpatient			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, for Genetic Testing, and sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	40%	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Major Diagnostic and Imaging - Outpatient			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA); psychological testing and transcranial magnetic stimulation. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
Inpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40% after you pay $300 per Inpatient Stay.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	*Office Visits* $30 per visit *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 15% *Intensive Behavioral Therapy* $30 per session	*Office Visits* 40% *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 40% *Intensive Behavioral Therapy* 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	
Nutritional Counseling (Non-Preventive)			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits. Benefits for non-preventive nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.	Not covered	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Not covered	
Does the Annual Deductible Apply?	Yes	Not covered	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Obesity - Weight Loss Surgery			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of obesity - weight loss surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F.*	
Ostomy Supplies			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes	
Pharmaceutical Products - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, for growth hormone injections, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Physician Fees for Surgical and Medical Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	deductible) as if those services were provided by a Network provider; however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Section F*.
Does the Annual Deductible Apply?	Yes	Yes	
Physician's Office Services - Sickness and Injury			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$30 per visit for a Primary Care Physician office visit or $40 per visit for a Specialist office visit None for allergy injections when no other service is provided during the office visit	40%	Copayment/Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
			• Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and Manipulative Treatment. • Habilitative therapy services described under *Habilitative Services*.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn 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. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. **It is important that you notify the Claims Administrator 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.**			
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preventive Care Services			
Physician office services What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	40%	Routine hearing exam/screenings covered In Network for all members

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	No	Yes	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	No	Yes	
Breast pumps What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	40%	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	No	Yes	
Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$40 per visit ***Post-cochlear implant aural therapy*** *Office visit* $30 per visit for a Primary Care Physician office visit or $40 per visit for a Specialist office visit	40%	Limited per year as follows: • 30 Network or Out-of-Network Manipulative Treatments. • Out-of-Network Benefits for speech therapy are limited to 30 visits per year. Network Benefits for

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Outpatient professional, including Cardiac Rehabilitation Services 15% ***Vision therapy*** $30 per visit for a Primary Care Physician office visit or $40 per visit for a Specialist office visit.		speech therapy are not limited. • Out-of-Network Benefits for speech therapy for developmental delay are limited to 100 visits per year. Network Benefits for speech therapy for developmental delay are not limited.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15% Colorectal Diagnostic Service: None	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes Colorectal Diagnostic Service: No	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes Colorectal Diagnostic Service: No	Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	• Out-of-Network Benefits are limited to 60 days per year. Network Benefits are not limited.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Surgery - Outpatient			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Temporomandibular Joint (TMJ) Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	
Therapeutic Treatments - Outpatient			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy, and MR-guided focused ultrasound. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain 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 do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section F*.	For Network Benefits, transplantation services must be received from a Designated Provider or Network Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.
Urgent Care Center Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$75 per visit	40%	Co-payments/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
			Pharmaceutical Products - Outpatient. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Urinary Catheters			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	15%	40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes	
Virtual Care Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$10 per visit	Out-of-Network Benefits are not available.	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Wigs			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	Same as Network	Benefit limited to $300 per year (Network and Out-of-Network combined).
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.

For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Allowed Amounts.

For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider, which is based on the Recognized Amount as defined in the SPD.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines, or as required by law, as described in the SPD.

Section G. What's Covered Under the UHC Standard Option

Described below is information relating to covered health services under the UHC Standard option. For relevant limitations, see Section "H", "Exclusions and Limitations--What the UHC Options Do Not Cover."

Payment Term and Description	Amounts	
	The Amount You Pay Network	**The Amount You Pay Out-of-Network**
Annual Deductible		
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care 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/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount.	$1,000 per Covered Person not to exceed $3,000 for all Covered Persons in a family.	$2,000 per Covered Person not to exceed $6,000 for all Covered Persons in a family.
Out-of-Pocket Limit		

Payment Term and Description	Amounts	
	The Amount You Pay Network	**The Amount You Pay Out-of-Network**
The maximum you pay per year for Copayments and Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any amounts you pay toward the Annual Deductible. • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	$6,000 per Covered Person, not to exceed $12,000 for all Covered Persons in a family. The Out-of-Pocket Limit does not include the Annual Deductible	$12,000 per Covered Person, not to exceed $36,000 for all Covered Persons in a family. The Out-of-Pocket Limit does not include the Annual Deductible.
Copayment		
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of:		

Payment Term and Description	Amounts	
	The Amount You Pay Network	**The Amount You Pay Out-of-Network**
• The applicable Copayment. • The Allowed Amount, or the Recognized Amount when applicable.		
Coinsurance		
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in *Section B: Terms You Should Know*.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Acupuncture Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	Out-of-Network Benefits for needle therapy are limited to 30 treatments per year. Network Benefits for needle therapy are not limited.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Ambulance Services			
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	*Ground Ambulance:* 25% *Air Ambulance:* 25%	Same as Network	Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this Section G.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	*Ground Ambulance:* 25% *Air Ambulance:* 25%	Same as Network	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Section G.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Cellular and Gene Therapy			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G.*	Out-of-Network Benefits are not available.	For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Section G*. Benefits are available when the Covered Health Care Services are provided by either Network or out-of-Network providers.
Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Care Service category in this *Section G*.	category in this *Section G*.	
Dental Services - Accident Only			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$35 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	stated under each Covered Health Care Service category in this *Section G*.	Care Service category in this *Section G*.	
Diabetes Self-Management Items	For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. For diabetes supplies, see *What's Covered Under the Prescription Drug Program in* Section J. "Overview of the Prescription Drug Program" le	For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. For diabetes supplies, see *What's Covered Under the Prescription Drug Program in* Section J. "Overview of the Prescription Drug Program"	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	purchase. This limit does not apply to wound vacuums. Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years. To receive Network Benefits, you must obtain the DME or orthotic from the vendor the Claims Administrator identifies or from the prescribing Network Physician.
Does the Annual Deductible Apply?	Yes	Yes	
Emergency Health Care Services - Outpatient			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$300 per visit.	Same as Network	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The
Does the Amount You Pay Apply to	Yes	Same as Network	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
the Out-of-Pocket Limit?			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 out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Section G*.
Does the Annual Deductible Apply?	Yes	Same as Network	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Enteral Nutrition			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.** **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Section G*.			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	
Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$60 per visit ***Post-cochlear implant aural therapy*** *Office visit* $35 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit *Outpatient professional, including Cardiac Rehabilitation Services* 25%	50%	Outpatient therapies: • Physical therapy. • Occupational therapy, including cognitive therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. For the above outpatient therapies: • Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hearing Aids			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	Same as Network	Benefit limited to $2,500 every 36 months. Benefits are further limited to a single purchase per hearing impaired ear every 36 months. Repair and/or replacement of a hearing

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Same as Network	aid would apply to this limit in the same manner as a purchase.
Does the Annual Deductible Apply?	Yes	Same as Network	
Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	Out-of-Network Home Health Care is limited to 100 visits per year. Network Benefits are not limited. A separate 100 visit limit applies to Out-of-Network Private Duty Nursing in the same manner. To receive Network Benefits for Private Duty Nursing, services must be provided by a Network provider. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
			must receive services from a provider the Claims Administrator identifies.
Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	*Inpatient facility* 25% after you pay $500 per Inpatient Stay. *Inpatient professional* 25%	50% after you pay $700 per Inpatient Stay.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, for Genetic Testing, and sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Major Diagnostic and Imaging - Outpatient			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA); psychological testing; transcranial magnetic stimulation If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Inpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	Inpatient facility 25% after you pay $500 per Inpatient Stay. Inpatient professional 25%	50% after you pay $700 per Inpatient Stay.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Ys	Yes	
Outpatient What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	*Office Visits* $35 per visit *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 25% *Intensive Behavioral Therapy* $35 per session	*Office Visits* 50% *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 50% *Intensive Behavioral Therapy* 50%	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	
Does the Annual Deductible Apply?	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy*	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Yes		
Nutritional Counseling (Non-Preventive)			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits. Benefits for non-preventive nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.	Not covered	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Not covered	
Does the Annual Deductible Apply?	Yes	Not covered	
Obesity - Weight Loss Surgery			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of obesity - weight loss surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	
Ostomy Supplies			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	Yes	
Pharmaceutical Products - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, for growth hormone injections, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Physician Fees for Surgical and Medical Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	Physician's office 25% after you pay $250. Inpatient and outpatient professional 25%	50%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	by a Network provider; however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Section G*.
Does the Annual Deductible Apply?	Yes	Yes	
Physician's Office Services - Sickness and Injury			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$35 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit None for allergy injections when no other service is provided during the office visit	50%	Copayment/Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
			procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and Manipulative Treatment. • Habilitative therapy services described under *Habilitative Services*.
Pregnancy - Maternity Services			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn 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. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. **It is important that you notify the Claims Administrator 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.**			
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preventive Care Services			
Physician office services What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	50%	Routine hearing exam/screenings covered In Network for all members

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	No	Yes	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	No	Yes	
Breast pumps What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	50%	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Yes	
Does the Annual Deductible Apply?	No	Yes	
Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Reconstructive Procedures			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$60 per visit ***Post-cochlear implant aural therapy*** *Office visit* $35 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit *Outpatient professional, including Cardiac Rehabilitation Services* 25% ***Vision therapy*** $35 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit.	50%	Limited per year as follows: • 30 Network or Out-of-Network Manipulative Treatments. • Out-of-Network Benefits for speech therapy are limited to 30 visits per year. Network Benefits for speech therapy are not limited • Out-of-Network Benefits for speech therapy for developmental delays are limited to 100 visits per year. Network Benefits for speech therapy for developmental delay are not limited. • .
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Scopic Procedures - Outpatient Diagnostic and Therapeutic			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25% Colorectal Diagnostic Service: None	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes Colorectal Diagnostic Service: No	Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	• Out-of-Network Benefits are limited to 60 days per year. Network Benefits are not limited.

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25% after you pay $300 per date of service.	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Temporomandibular Joint (TMJ) Services			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	
Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy, and MR-guided focused ultrasound. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	25%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Transplantation Services			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain 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 do not obtain prior authorization as required, Benefits will be subject to a $400 reduction. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Section G*.	For Network Benefits, transplantation services must be received from a Designated Provider or Network Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.
Urgent Care Center Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$100 per visit	50%	Co-payments/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
			• Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Urinary Catheters			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or bBoth.	25%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Virtual Care Services			
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	$20 per visit	Out-of-Network Benefits are not available.	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Wigs			

Covered Health Care Service	The Amount You Pay Network	The Amount You Pay Out-of-Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This may Include a Copayment, Coinsurance or both.	None	Same as Network	Benefit limited to $300 per year Network and Out-of-Network combine.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.

For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Allowed Amounts.

For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below***, you are not responsible, and the out-of-Network provider may not bill you, for

amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider, which is based on the Recognized Amount as defined in the SPD.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines, or as required by law, as described in the SPD.

Section H. Exclusions and Limitations--What the UHC Options Do Not Cover and Prior Authorization

The UHC Options Do Not Pay Benefits for Exclusions

The UHC medical options will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*

Please note that in listing services or examples, when the exclusion or limitation says that "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the exclusion or limitation will state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) 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 F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option".

Dental

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option.*

This exclusion does not apply to dental care (oral exam, 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, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

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 tooth decay or cavities 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, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*.

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 F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option"*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.

- Enuresis alarm.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech-generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Over-the-counter continuous glucose monitors.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
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 used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*

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 up to six times during a calendar year. This exclusion does not apply to Harvard Pilgrim plans.
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 up to six times during a calendar year. This exclusion does not apply to Harvard Pilgrim plans.
9. 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 or prescription drug product. For the purpose of this exclusion, a "biosimilar" is a biological Pharmaceutical Product approved based on showing that is highly similar to a reference product (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 to six times per calendar year. This exclusion does not apply to Harvard Pilgrim plans.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another Pharmaceutical Product, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. This exclusion does not apply to Harvard Pilgrim plans.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

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

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*

Foot Care

1. Routine foot care. Examples include:
   - Cutting or removal of corns and calluses.

- Nail trimming, nail cutting, or nail debridement.
- Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- 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, except as part of a genital reconstruction procedure by a physician for the treatment of Gender Dysphoria.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples include:

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard

Option." This exception does not apply to supplies for the administration of medical food products.

- Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
- Urinary catheters and related urologic supplies for which Benefits are provided as described under Urinary Catheters in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Nutrition

1. Non-preventive nutritional counseling, which is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force or to Benefits provided under *Nutritional Counseling (non-preventive)* as described in *Section F., "What's Covered Under the UHC Enhanced Option" and Section G., "What's Covered Under the UHC Standard Option"*.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - 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 with the exception of shower chairs for quadriplegics.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Safety equipment.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Treadmills.
   - Vehicle modifications such as van lifts.
   - Video players.
   - Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section B. Terms You Should Know*. Examples include:

   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.

- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Sclerotherapy treatment of veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition.
6. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
7. 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.
8. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.

9. Non-surgical treatment of obesity.
10. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
11. 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 F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*. This exclusion does not apply to breast reduction surgery for treatment of Gender Dysphoria.
12. Helicobacter pylori (H. pylori) serologic testing.
13. Intracellular micronutrient testing.
14. Cellular and Gene Therapy services not received from a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
    - Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
    - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
    - Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
    - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
5. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
6. InVitro fertilization regardless of the reason for treatment.
7. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

Services Provided under Another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health care services for transplants involving animal organs.

Travel

1. Travel or transportation expenses, even though prescribed by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program* in *Clinical Programs and Resources*. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back at the Claims Administrator's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*

Types of Care, Supportive Services, and Housing

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing received on an inpatient basis.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).
9. Independent living services.
10. Assisted living services.
11. Educational counseling, testing, and support services, including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individual with Disabilities Education Act*.

12. Vocational counseling, testing, and support services, including job training, placement services and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
13. Transitional Living services (including recovery residences).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses with the exception of the first set of lenses after treatment of keratoconus or following cataract surgery.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Plan.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.
6. Over-the-counter hearing aids.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *SPD* under *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
   - Not otherwise excluded in this *SPD* under *this Section H: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:

- Required only for school, sports or camp, career or employment, insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders unless Medically Necessary.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section F., "What's Covered Under the UHC Enhanced Option," and Section G., "What's Covered Under the UHC Standard Option."*
- Required to get or maintain a license of any type.

3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
6. Health care services when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected by an out-of-Network provider.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care 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.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide these services to you.

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 number on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Out-of-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization. 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.

Services for which you are required to obtain prior authorization are identified in this SPD, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

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

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

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in Section F, "What's Covered Under the UHC Enhanced Option" and Section G, "What's Covered Under the UHC Standard Option" to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, Nokia urges you to confirm with the Claims Administrator that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the Claims Administrator's final coverage determination will be changed to account for those differences, and the Plan will only pay and the Claims Administrator will only process payments for Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Claims Administrator processes payments for Benefits under the Plan), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Claims Administrator will process payments for the Plan as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain prior authorization before receiving Covered Health Care Services.

Section I. Clinical Programs and Resources

The Medical Plan offers the following clinical programs and resources for participants.

Personal Health Support

Personal Health Support is a program 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, the Claims Administrator 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. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

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

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

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

Complex Medical Conditions, Programs and Services

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Cancer Support Program

Your Plan provides a program that identifies and supports a Covered Person who has cancer. You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies 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 your ID card or call the program directly at 1-866-936-6002.

Congenital Heart Disease (CHD) Resource Services

Your Plan provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on your ID card.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Care Service under the Plan.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program*.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services Described Below

Your Plan Sponsor may provide you with Travel and Lodging assistance for certain Covered Health Care Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the requisite distance from your home address to the facility is at least 50 miles. Allowed Amounts are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the number on your ID card.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Covered Person and a travel companion, provided the Covered Person is not covered by Medicare as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.
- The Allowed Amount for lodging for the Covered Person (while not a Hospital inpatient) and one companion.

- If the Covered Person is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

Lodging Reimbursement Assistance

- A per diem rate, up to $50.00 per day, for the Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Diabetes Reversal (Virta)

Virta is a personalized virtual weight loss and diabetes control clinic focused on nutritional changes, medication changes, and biomarker feedback with the goal of helping implement lifestyle changes. Combining personalized, expert support from a dedicated care team and digital health tools, Virta can help you sustainably lose weight, reverse diabetes and transform your health. To find out additional information, visit www.myuhc.com, use the UHC mobile app or call UHC Member Services at 1-800-577-8539.

Real Appeal

The Real Appeal weight loss program is a step-by-step, guided program personalized to each member. The program provides tools, information and ongoing support and guidance aimed at helping Participants achieve their weight loss goals. For Participants 18 years of age or older who qualify, the program is free of charge. Enrollment and participation in the program are accessible via https://realappeal.com/.

Decision Support

In order to help you make informed decisions about your health care, your Plan offers a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.

- Information on 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.
- 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 your ID card.

Disease Management

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, 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 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.
- 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 your ID card.

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.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Consumer Solutions and Self-Service Tools

To help you be an educated health care consumer, several convenient educational and support services which are accessible by phone and the Internet, can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- 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 more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Plan Sponsor 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, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

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 self-service tools.

With www.myuhc.com you can:

- 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.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- 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 on www.myuhc.com, simply go to www.myuhc.com and click on "Register Now." Have your 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.
- View and print all of your Explanation of Benefits (EOBs) online.
- 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.

UnitedHealth Premium® Designation Program

To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality. The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® designation program including how to locate a *Premium Care Physician*, log onto www.myuhc.com or call the number on your ID card.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit www.myuhc.com for additional information.

Section J. Overview of the Prescription Drug Program

About the Prescription Drug Program Generally

If you enroll in the UHC Enhanced or UHC Standard medical option, you are automatically covered under the Prescription Drug Program, which is administered separately by CVS Caremark. If you select coverage under an HMO, you'll receive prescription drug benefits through your HMO. Contact your HMO for specific information about prescription drug benefits.

Note: There are certain words and phrases that have specific meanings under the Medical Plan, including the Prescription Drug Program. These terms are printed in initial capital letters and are defined in Section B., "Terms You Should Know."

What's Covered Under the Prescription Drug Program

Overview

Generally, the Prescription Drug Program covers:

- Drugs prescribed by a Physician and provided by a pharmacist (but see below, "What's Not Covered", for exceptions)
- Birth control medications and contraceptive devices (including oral contraceptives, implants and injections)
- Insulin
- Disposable supplies ordered by a Physician for a diabetic patient, including needles and syringes
- Blood and urine testing supplies,
- Seasonal, non-seasonal and travel vaccines offered under the broad retail vaccination network,
- Prescription (not over-the-counter) smoking deterrents (including nicotine products such as inhalers and nasal sprays), and
- Certain weight-loss drugs with prior authorization.

Prescription-Drug Formulary

The Prescription Drug Program uses the CVS Caremark formulary. A formulary is a list of commonly prescribed medications that have been shown to be clinically effective as well as cost effective. If your doctor prescribes formulary medications, you can help control rising

health care costs while still maintaining high-quality care. The Formulary Drug List is available online at www.caremark.com or by calling CVS Customer Care at 1-800-240-9623.

The CVS Caremark formulary is reviewed and updated on a quarterly basis. Additionally, Products with egregious cost inflation that have readily available, clinically appropriate and more cost-effective alternatives may be evaluated and potentially removed from the formulary at additional times.

Because the formulary is subject to change, you should consult CVS Caremark before filling a prescription to ensure you have the most current information.

If you choose to purchase a brand medication not on the formulary, referred to as a Nonpreferred Brand, you will be responsible for paying a higher copayment or coinsurance, as applicable. If there is a clinical reason why you cannot take the formulary (Preferred Brand) medication, you can request an appeal through CVS Caremark by calling Customer Care at 1-800-240-9623. If the appeal is approved, you will only be charged the Preferred Brand copayment or coinsurance. This approval is valid for one year.

Under the Prescription Drug Program, there may be times when you use a participating pharmacy and are filling a prescription with a Nonpreferred brand-name drug. The pharmacist will receive a message stating the status of the medication is non-formulary (or Nonpreferred). Your retail pharmacist may decide to discuss with your physician whether an alternative drug listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. If you prefer to have the originally prescribed medication, you have the option to refuse the alternative medication before it is filled and to request the pharmacist fill the prescription as it was originally written. However, you will be responsible for paying the higher, Nonpreferred Brand copayment or coinsurance.

When you order through the mail-order program, the pharmacist may also decide to discuss with your physician whether an alternative medication listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative medication and a confirmation letter will be sent to you and your physician explaining the change.

Let your physician know if you have any questions about a change in prescription. Your physician always makes the final decision about what medication to prescribe for you.

Drugs Requiring Authorization

Certain medications must be authorized for specific conditions before they are eligible for coverage. CVS Caremark will work with you, your pharmacist and your Physician to secure the necessary confirmation. The list of these drugs changes from time to time as new drugs are approved, new clinical guidelines for appropriate use are developed or problems are identified. Visit the CVS Caremark Web site or call CVS Caremark for a list of medications requiring authorization.

Drugs Subject to Quantity Limits

Some medications are subject to quantity limits. Visit the CVS Caremark Web site or call CVS Caremark for a list of medications that are subject to quantity limits.

Specialty Medications

Complex conditions, such as the following, are treated with specialty medications:

- Anemia
- Cancer
- Growth hormone deficiency
- Hepatitis C
- Multiple sclerosis, and
- Rheumatoid arthritis.

Specialty medications are often injectable medications administered either by the individual or a healthcare professional. These medications require special handling.

If you are using specialty medications, you receive them through CVS Caremark's specialty care pharmacy — CVS Specialty®. This specialty care pharmacy also provides customer support related to complex conditions. CVS Caremark's specialty care pharmacy can be reached at 1-800-237-2767.

What's Not Covered Under the Prescription Drug Program

The Prescription Drug Program does not cover, and will not pay any benefits for:

- Drugs and medicines provided (or that can be obtained) without a prescription from a Physician
- Non-federal legend drugs
- Prescription drugs with an over-the-counter (OTC) equivalent
- OTC contraceptives, jellies, creams, foams, and devices
- Plan B/Plan B One-Step through age 17 and older
- Diabetic blood testing monitors
- Isopropyl alcohol solution
- Insulin pumps
- Kutapressin
- Ostomy supplies
- Foreign drugs
- Mifeprex (but this might be covered under the UHC Enhanced or UHC Standard options or other medical portion of the Plan)
- Therapeutic devices or appliances
- Drugs used solely to promote hair growth for cosmetic purposes only
- Immunization agents, vaccines or biologicals (except if listed as covered)
- Allergy sera (serums)

- Blood or blood plasma (except if listed as covered)
- Patch, kit and most compounds
- Drugs labeled "Caution — limited by federal law to investigational use" or Experimental Drugs even if you are charged for those drugs
- Drugs used for Experimental or Investigational purposes
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or local governmental agency or any drug or medical service furnished at no cost to the covered individual
- Medication provided to a covered individual while a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility (for example, a Skilled Nursing Facility), convalescent Hospital, nursing home, Home Health Care Agency or similar institution that has a facility for dispensing pharmaceuticals on its premises
- Prescriptions filled in excess of the refill number specified by the Physician or any refill dispensed one year after the original prescription
- Charges for the administration or injection of any drug
- Nutritional dietary supplements
- Any drug or medicine not Medically Necessary to treat the condition, and
- Prescriptions filled through the mail that exceed the 90-day limit.

Cost Sharing

Your cost varies depending on how you choose to fill your prescription as well as by the three levels of Copayments/Coinsurance available under the Prescription Drug Program:

- Generic
- Preferred Brand, and
- Nonpreferred Brand.

Separate Out-of-Network Annual Deductible

The Prescription Drug Program Out-of-Network annual Deductible is separate from any Deductible you may be required to pay under your medical option. After you meet the program's annual Deductible, you'll be responsible for the Copayment/Coinsurance calculated on the Allowable Amount for covered medications. You'll be reimbursed for the remaining amount.

Separate Out-of-Pocket Maximum

The Out-of-Pocket Maximum applies to Copayments/Coinsurance for prescription drugs filled through Network Retail Pharmacies or the mail service. It doesn't apply to prescriptions filled at non-network pharmacies.

The Prescription Drug Program Out-of-Pocket Maximum is separate from the Out-of-Pocket Maximum under your medical option.

Once your Copayments/Coinsurance for prescriptions filled through Network Retail Pharmacies or the mail service total the Out-of-Pocket Maximum amount in a calendar year, you won't be required to pay any additional Copayments/Coinsurance for prescriptions filled through Network Retail Pharmacies or the mail service for the rest of that calendar year.

For information about specific Copayment/Coinsurance amounts, refer to Appendix 2.

Section K. Filling Prescriptions

How to Fill a Prescription

Prescriptions may be filled under the Prescription Drug Program in any of the following ways:

- At any CVS retail pharmacy
- At any Costco Pharmacy
- At any Network Pharmacy, or
- Through the CVS Caremark® Mail Service Pharmacy.

Use a CVS retail pharmacy and any Network Pharmacy (including a Costco Pharmacy) for short-term prescriptions, i.e., prescriptions of up to 30 days (90 days for insulin).

If you need to take a medication on an ongoing basis (maintenance medications such as those that are taken regularly for conditions like diabetes, high blood pressure, asthma, etc.), you can receive refills of 90-day supplies at a time by using the Mail Service Pharmacy or a CVS retail pharmacy or any Costco Pharmacy. Note: Unless a state exception applies (see below), prescription drug copays for 30-day supplies of maintenance medications will double after the third time you receive such a 30-day supply at a retail pharmacy.; for cost savings, use the Mail Service Pharmacy (or a CVS retail pharmacy or a Costco Pharmacy). Note: this doubling of copays is modified for certain states as follows:

- **Florida:** Participants residing in Florida can also obtain 90-day supplies of medications taken on an ongoing basis at any Network retail pharmacy that fills 90-day supplies.

- **Minnesota:** Participants residing in Minnesota also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find a Network participating pharmacy.

- **Oklahoma:** Participants residing in or filling their prescriptions in Oklahoma can also obtain 90-day supplies of medications taken on an ongoing basis at any Network retail pharmacy that fills 90-day supplies.

- **Tennessee:** Participants residing in Tennessee also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy.

- **West Virginia:** Participants residing in West Virginia also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find a participating pharmacy.

The above state-exception rules are subject to modification from time to time. Also, other states may be added to this list. For a complete list of participating pharmacies, go to www.Caremark.com/PharmacyLocator.

Network Retail Pharmacies

When you go to a Network Retail Pharmacy, give the pharmacist your Prescription Drug Program ID card, which you should have received in the mail from CVS Caremark when you first enrolled. (If you have misplaced your ID card or need additional ones for your dependents, you may print them from the CVS Caremark website.) The pharmacist will charge you the appropriate Copayment/Coinsurance for your prescription. That is the only amount you will pay.

If you do not have your Prescription Drug Program ID card with you at the time of your prescription purchase, be sure to identify yourself as a Participant. You or your pharmacist can contact CVS Caremark for verification of your eligibility. If you do not use your Prescription Drug Program ID card or cannot otherwise prove your eligibility, you will be responsible for paying the full cost of the prescription upfront and must file a claim form (claim forms are available on the CVS Caremark Web site at www.caremark.com for reimbursement). In addition, you may have to pay more out of your pocket because benefits may not be based on the lower Network prescription drug cost, but on the non-discounted price of the prescription and will be reimbursed based on the Allowable Amount.

To find a Network Retail Pharmacy near you:

- Call CVS Caremark at 1-800-240-9623
- Contact CVS Caremark directly through their Web site at www.caremark.com, or
- Ask your local pharmacy if it is a CVS Caremark network pharmacy.

Out-of-Network Retail Pharmacies

You may fill your prescription at an Out-of-Network retail pharmacy. However, when you use such a pharmacy, you pay the entire cost at the time of purchase. Then you file a claim with CVS Caremark for reimbursement. (See “Cost Sharing”, below.)

Claim forms are available on the CVS Caremark Web site or by calling CVS Caremark.

Mail Service Pharmacy

The CVS Caremark Mail Service Pharmacy is a great way to fill prescriptions if you regularly take the same medication on an ongoing basis. Up to a 90-day supply is available.

- To order a prescription online, log on to at www.caremark.com
- To have your Physician fax your prescription, have your Physician call 1-800-240-9623
- To order a prescription by mail, download a home delivery order envelope on the CVS Caremark Web site. Follow the instructions and enclose the appropriate Copayment/Coinsurance. Your prescription will be filled and sent to your home within 7-10 days of the date you mailed the prescription to CVS Caremark.

Refills are even easier. You can order a refill online, by mail or by calling the number on your refill sticker. Use your credit card to pay.

Prescription Drug Coverage Management Programs

Retail Refill Allowance

For prescriptions you take on an ongoing basis (90 days or more), you may use a retail pharmacy for your initial prescription and up to two refills (for a total of three fills), for up to a 30-day supply each time. If you remain on that medication, you must order subsequent refills through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy. Otherwise, you will be required to pay twice the retail Copayment at the non-CVS retail pharmacy.

Member Pays the Difference Program (DAW Program)

You will pay the generic Copayment, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available.

The Caremark.com App

The Caremark.com app allows you access to most of the same functionality that is available on the web site, including check drug costs, request refills or renewals, check order status, show/print your member ID card, pharmacy locator and check drug interactions. The app is available on both iOS and Android operating systems.

Section L. Other Prescription-Drug-Related Services

Cost Saver

Through the Caremark® Cost Saver™ program, members will have automatic access to GoodRx's prescription pricing to allow them to pay lower prices, when available, on generic medications in a seamless experience at the retail pharmacy counter. The amount paid will automatically be applied to any deductible and out-of-pocket thresholds (if applicable). You (or your Covered Dependent(s)) only need to show their CVS ID card at their preferred in-network pharmacy to obtain the lowest price for their generic medication. No action is required by the plan member.

Drug Utilization Review

Prescriptions filled through the Prescription Drug Program become part of a computerized database that alerts the Network Retail Pharmacy or the CVS Specialty® Pharmacy pharmacists to potential drug interactions each time you have a prescription filled.

PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your Covered Dependent(s), the Prescription Drug Program includes a special, called the PrudentRx Solution, for certain specialty medications. The PrudentRx Solution assists you and/or your Covered Dependent(s) by helping with enrollment in manufacturer copay assistance programs. Medications that are on the PrudentRx Program Drug List are subject to a 30% co-insurance, after satisfaction of any applicable Plan deductible. However, if you or your Covered Dependent(s) (as applicable) participate in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, you or your Covered Dependent(s) (as applicable) will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient Member Cost Share for select medications--in particular, specialty medications. The PrudentRx Solution will assist you and your Covered Dependent(s) in obtaining copay assistance from drug manufacturers to reduce your or their cost share for eligible medications, thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs; be assured that this is done in compliance with HIPAA.

If you or your Covered Dependent(s) currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that

provides information about the PrudentRx Solution as it pertains to such medication. You (or your Covered Dependent(s)) must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for a covered specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will contact you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403. Eligible participants who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking a medication covered under the PrudentRx Solution but will start taking one soon, you can reach out to PrudentRx, or they will proactively contact you, so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800- 578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your or a Covered Dependent's behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution, will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you (or your Covered Dependent(s)) for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your deductible or ACA out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available by calling PrudentRx at 1-800- 578-4403. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

Zerigo Skin Health Program

Psoriasis and eczema can significantly impact your quality of life. The Zerigo Skin Health Program – a no-cost[1] home-based phototherapy treatment program - has helped hundreds of people find relief and improve their skin's appearance.

How it works:

1. Get a prescription: Schedule a brief, no-cost1 telehealth visit with a Zerigo Health partner clinician, or schedule with your own doctor or dermatologist (co-pays may apply).
2. Receive your device: Once the prescription is generated, Zerigo Health will ship your home phototherapy device directly to you.

3. Start your treatment: Your dedicated Care Guide will help you set up your device and complete your first treatment. Care Guides are available to support you at any time.

With Zerigo Health, most members:
- Manage their chronic skin condition more effectively
- Reduce the frequency and severity of flares
- Improve their overall quality of life.

[1] The Zerigo Skin Health Program is available through your healthcare benefits as a value-added service. You may have to pay a copay or coinsurance if you see your personal doctor to get a prescription for phototherapy. Prescriptions issued by a CirrusMD clinician, during Zerigo Health's enrollment process, typically have no copay.

Toll-Free Prescription Drug Customer Service

CVS Caremark maintains a toll-free customer service number (1-800-240-9623) to help you with:

- General questions about the Prescription Drug Program
- Locating an In-Network Retail Pharmacy
- Obtaining an order form/envelope for the mail service or a claim form for a prescription filled at an Out-of-Network Pharmacy
- Emergency pharmacist consultations, 24 hours a day, seven days a week
- Large print or Braille labels on medications filled through the mail service, upon request, and
- Telephone numbers for hearing impaired employees (1-800-759-1089) and overseas employees (1-972-915-6698) weekdays from 8:00 a.m. to 12 midnight, Eastern Time and on Saturdays from 8:00 a.m. to 6:00 p.m., Eastern Time.

Section M. The Employee Assistance Program (EAP)

Need help coping with stress, family pressures, money issues or work demands?

The Medical Plan includes an Employee Assistance Program (EAP). The EAP offers you and your household members free, confidential, 24/7 assistance for a wide range of behavioral health issues, such as emotional difficulties, alcoholism, drug abuse, marital or family concerns, and other personal and life issues. Enrollment in the EAP is not required, nor do you need to be enrolled in Nokia's medical plan in order to access the medical plan's EAP coverage. To speak with a counselor, call Magellan at 1-800-327-7348 or visit Member.MagellanHealthcare.com.

Section N. Coordination of Benefits (COB); Subrogation, Overpayment and Reimbursement

Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.
- 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.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

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.

Each Plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. 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, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

If a court decree states that one of the parents is responsible for the dependent 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 care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial Parent.

The Plan covering the Custodial Parent's spouse.

The Plan covering the non-Custodial Parent.

The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

(i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies. (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of

benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary, it determines the amount it will pay for a Covered Health Care Services 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 applicable Copayment, 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.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

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 an out-of-Network provider for this Plan, the allowable expense is the Primary Plan's network rate. When the provider is an out-of-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 an out-of-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* ".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

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 reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge - often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare - typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with 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, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable expense for both the Plan and Medicare.

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 carriers 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 continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on 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. The Claims Administrator 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.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are 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 the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowed Amounts.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of you, you, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Subrogation and Reimbursement

The Plan has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation Example:

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

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to 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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds

held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- 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, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile Plan - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any

third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any 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. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by 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 the Plan's interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian brings 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 any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect

third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plan's 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.

When Does the Plan Receive Refunds of Overpayments?

If the Plan pays Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to the Plan if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Section O. When Coverage Ends

When Employee Coverage Ends

Your coverage under the Plan ends on the last day of the month in which any of the following events occurs:

- Your employment with a Participating Company terminates or you otherwise cease to be an Eligible Employee
- You do not make a required contribution toward coverage under the Plan
- You request that your coverage be canceled, or you decline coverage, when permitted
- The company you work for ceases to be a Participating Company, or
- The Plan is terminated.

When your coverage ends, you may be able to continue coverage under certain circumstances. See Section Q., "COBRA Continuation Coverage," for more information.

When Dependent Coverage Ends

Your Eligible Dependent's(s') coverage under the Plan will end as follows:

- If your coverage ends, your Eligible Dependent's(s') coverage will end on the same day.
- If your Eligible Dependent Child attains age 26, such Child's coverage will end on the last day of the month in which the Eligible Dependent Child reaches age 26.

***Please note**: If your Dependent Child is an Adult Disabled Child within the meaning of the Plan, he or she may be able to continue his or her coverage regardless of age. This coverage is not automatic. The Medical Plan Claims Administrator must certify that the child is eligible for coverage. To apply for coverage, contact the Medical Plan Claims Administrator and notify the Nokia Benefits Resource Center of your intention to seek this coverage.*

If your Eligible Dependent's coverage ends for any other reason, coverage for the Dependent will end on the last day of the month in which the event occurs.

- If you and your Spouse divorce, your Spouse's coverage will end on the last day of the month in which the divorce becomes final.

- If your Domestic or Civil Union Partnership ends (or you and your Domestic or Civil Union Partner no longer satisfy the Plan's eligibility criteria for Domestic or Civil Union Partnership), your Domestic or Civil Union Partner's coverage, and coverage for any enrolled Child(ren) of your Domestic or Civil Union Partner, will end on the last day of the month in which the Domestic or Civil Union Partnership ends (or in which the eligibility criteria are no longer satisfied).

Section P. Employment-Related Events

If You Terminate Employment

Your coverage under the Plan ends on the last day of the month in which your employment ends. You may, however, be eligible for coverage under the group healthcare plan that the Company maintains for retired employees, provided you meet the eligibility criteria of that plan. The benefits provided by the group healthcare plan for retired employees may differ from the benefits provided for active Eligible Employees under this Plan. This Plan and the plan for retired employees are subject to amendment, modification, or termination by the Company at any time, including before or during your retirement.

When coverage under this Plan ends, you may be eligible to continue coverage for yourself and your eligible Covered Dependents under COBRA. For more information, see Section Q., "COBRA Continuation Coverage."

If You Transfer Employment to Another Nokia Group Company

If you transfer employment to another Nokia Group company, whether your coverage will continue depends on whether the other company is also a Participating Company with respect to this Plan. If you transfer employment to a Participating Company, your participation in the Medical Plan will not be affected. If, however. you transfer employment to a non-Participating Company, you will be treated as having had a termination of employment for purposes of the Plan and will no longer have coverage under the Plan. However, you may be eligible to continue coverage for yourself and your eligible Covered Dependents through COBRA. For more information, see Section Q., "COBRA Continuation Coverage."

If You Leave Nokia and Are Later Rehired by a Participating Company or If You Transfer Employment to Another Nokia Group Company and You Later Transfer Back to a Participating Company

If you leave Nokia and are later rehired by a Participating Company (after a break in service), you will be treated as a new-hire for purposes of the Plan; you will automatically be enrolled in coverage under the Plan as of your first day of active employment upon your return. For more information, see Section C., "Eligibility and Enrollment."

If You Become Disabled

If you are absent due to a disability, but still employed with a Participating Company, then your coverage under the Plan continues (provided you are still an Eligible Employee).

If You Take an Approved Leave of Absence

If you take an approved leave of absence--including, but not limited to, absence due to disability, leave under FMLA, and qualified military leave under USERRA--you can continue Plan coverage for yourself and your Covered Dependents. In some instances, you might have to pay the full cost of Plan coverage.

State and Local Leave Laws

To the extent continued Plan coverage is required by state and/or local leave laws and is not otherwise preempted by federal law, the Plan will comply.

Section Q. COBRA Continuation Coverage

Overview

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (certain covered employees and certain of their covered dependents) the opportunity to continue their group health benefit coverage at their own expense for a limited period of time if they lose coverage due to a "qualifying event".

Note: Domestic or Civil Union Partners and their children are not typically eligible for continuation coverage under federal law, as they do not meet the definition of "qualified beneficiary" under COBRA. However, the Plan provides COBRA-like rights to covered Domestic or Civil Union Partners and to the Child(ren) of Domestic or Civil Union Partners as outlined in this section of the SPD. While not legally applicable in all cases, references herein to "COBRA" and to "qualified beneficiary" includes, respectively, "COBRA-like" coverage and Domestic or Civil Union Partners and the Child(ren) of Domestic or Civil Union Partners.

Qualifying Events

In order to become eligible for continuation coverage under the Plan's COBRA continuation of coverage provisions, you (or your Covered Dependents) must face a loss of Plan coverage due to a "qualifying event". The following constitute qualifying events under the Plan:

- Termination of your employment for any reason (other than for gross misconduct)
- A reduction in your work hours
- Your divorce or legal separation from your Spouse or the termination of your Domestic or Civil Union Partnership
- A child's loss of eligibility under the terms of the Plan (e.g., your Child turns age 26)
- Your death.

The qualifying event is deemed to occur on the date that coverage under the Plan would be lost due to the occurrence of the event. For example, because coverage under the Plan continues until the end of the month in which you experience an involuntary termination of employment, this qualifying event is considered to occur on the first day of the following month.

Notice Requirement

It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of a qualifying event (other than your termination of employment, reduction in hours of employment, or death, or your Covered Dependent child turns age 26) that makes you or your

Covered Dependent(s) eligible for COBRA continuation coverage. The deadline for providing such notice is 60 days from the end of the calendar month in which the qualifying event occurs. For example, if you become legally separated from your Spouse on May 15, your Spouse and covered dependents (or you on their behalf) will have until July 31 (60 days from the first day of the month immediately following the month in which this event occurs) to notify the Nokia Benefits Resource Center of this event.

The individual eligible for COBRA continuation coverage must respond by the date on the notice of COBRA rights to be eligible for COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses/Domestic or Civil Union Partners, and parents may elect COBRA continuation coverage on behalf of their children.

Maximum Period of Continuation Coverage

The table below shows the maximum period of continuation coverage available under the Plan's COBRA continuation-of-coverage provisions:

If This Qualifying Event Occurs…	**COBRA Continuation Coverage Can Last for…**
• Termination of your employment for any reason other than gross misconduct; or • A reduction in your work hours.	Up to 18 months (for you and your Covered Dependents) **Note:** If you become entitled to Medicare while you are an active employee and, less than 18 months later, you experience a qualifying event that is a termination of your employment (for any reason other than gross misconduct) or a reduction in your work hours, COBRA continuation coverage for your Covered Dependents can last for up to 36 months (rather than 18 months)
• Your divorce or legal separation • Termination of your Domestic or Civil Union Partnership	Up to 36 months (for your Covered Dependents)
• Your death	Up to 36 months (for your Covered Dependents). Note: your surviving Spouse/Domestic or Civil Union Partner who elected COBRA continuation coverage can, at the end of this 36-month period (or upon becoming eligible for Medicare, if sooner), enroll in the Family Security Program ("FSP"), a program available under the Nokia Medical

If This Qualifying Event Occurs…	**COBRA Continuation Coverage Can Last for…**
	Expense Plan for Retired Employees (the "Retiree Medical Plan"), a component of the Nokia Retiree Welfare Benefits Plan. Your surviving Spouse/Domestic or Civil Union Partner can also enroll your Covered Dependents who were enrolled in the Plan immediately before your death and who elected COBRA continuation coverage. Under the FSP, Company-provided group health plan coverage for your Spouse/Domestic or Civil Union Partner can continue until death, and coverage for any such Covered Dependents can continue until death or until they cease to be eligible dependents within the meaning of the Retiree Medical Plan. (If your eligible Spouse/Domestic or Civil Union Partner and an eligible dependent drops coverage under the FSP, they can never re-enroll in it.) Information regarding the FSP will be provided shortly before the end of your surviving Spouse's/Domestic Partner's original 36-month COBRA continuation period. **Note:** The FSP is not "lifetime coverage"; it may be modified or terminated by the Company at any time.
• Your Child's loss of eligibility under the Plan	Up to 36 months (for your covered Child)
• You or your Covered Dependent becoming disabled at any time during the first 60 days of the COBRA continuation coverage period and such disability lasting at least until the end of the initial 18-month period of COBRA continuation coverage.	The continuation-of-coverage period may be extended from 18 months to up to 29 months (for the disabled qualified beneficiary). To be eligible for the additional period of coverage, the disabled person must call the Nokia Benefits Resource Center before the end of the initial 18-month period and within 60 days of receiving notice of disability from the Social Security Administration. The individual must also notify the Nokia Benefits Resource Center within 30 days after the Social Security Administration determines that he or she is no longer disabled.

How COBRA Continuation Coverage Is Affected by Multiple Qualifying Events

A qualified beneficiary (other than you--the Eligible Employee or former employee) may be eligible for an additional period of COBRA continuation coverage, not to exceed a total of 36 months from the initial qualifying event, if there is a second qualifying event because of your death, the divorce or legal separation of you and your Spouse, the termination of your Domestic or Civil Union Partnership, or your child losing eligibility under the Plan. The second event can be a second qualifying event only if it would have caused a loss of coverage under the Plan in the absence of the first qualifying event.

For example, suppose you terminate employment on December 31, 2024, and you are eligible to continue coverage for up to 18 months (i.e., until June 30, 2026). Your Child, who is a Covered Dependent on December 31, 2024, reaches age 26 (a second qualifying event) on December 31, 2025. Your child is then eligible for up to an additional 18 months of COBRA continuation coverage from the date of the original qualifying event. In this case, your child is eligible to continue coverage through December 31, 2027, which is 36 months from December 31, 2024, the date of your termination of employment (the original qualifying event).

To be eligible for extended coverage after a second qualifying event, you or your qualified beneficiary must notify the Nokia Benefits Resource Center within 60 days of the date of the second qualifying event.

Adding a Newborn or Newly Adopted Dependent During a Period of Continuation Coverage

If, while you are enrolled in COBRA continuation coverage, you have a baby, legally adopt a child or a child is placed with you for legal adoption and the child meets the Plan's rules for being an Eligible Dependent, the child will be a considered a "qualified beneficiary" and will be eligible for COBRA continuation coverage. The maximum coverage period for such a child will be the remainder of the maximum coverage period for that qualifying event.

Electing COBRA Continuation Coverage

Complete details about COBRA continuation coverage, including information about election and cost, are automatically sent to your preferred address if you (the employee):

- Terminate employment with a Participating Company,
- Experience a reduction in work hours, or
- Die,

or if your Covered Dependent child turns age 26.

For certain qualifying events, information regarding COBRA coverage is not automatically sent. It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of the occurrence of the following qualifying events:

- Divorce from a Spouse
- Legal separation from a Spouse

- Termination of a Domestic or Civil Union Partnership, or
- A Child no longer satisfying the Plan's eligibility criteria, other than turning age 26.

You and/or your qualified beneficiaries must notify the Nokia Benefits Resource Center within 60 days of the occurrence of the qualifying event.

What Does COBRA Coverage Cost?

COBRA participants must pay monthly contributions for coverage.

Generally, monthly contributions are based on the full cost per covered person, set at the beginning of the year, plus two percent for administrative costs. Covered Dependents making separate elections must contribute at the same rate as the former employee. If your COBRA continuation coverage is extended to 29 months due to a qualifying disability, you may be required to pay the full cost of COBRA continuation coverage plus a 50 percent administrative fee for each month beyond 18 months.

Where the initial qualifying event is the employee's death, Covered Dependents electing COBRA continuation coverage pay the active-employee rate for the first six months of continuation coverage and the regular COBRA rate, as described above, thereafter. (The active-employee rate only applies where the initial qualifying event is due to death and does not apply where the death occurs later, i.e., during a previously elected COBRA continuation period.)

Payment is due at enrollment, but there is a 45-day grace period from the date you (or your Covered Dependents) elect coverage to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the 10th of each month, but there is a 45-day grace period (for example, the June payment is due June 10th, but will be accepted if postmarked up to 45 days after that).

Termination of COBRA Continuation Coverage Before the End of the Maximum Period of Continuation Coverage

COBRA continuation coverage will end before the end of the maximum continuation period if one of the following occurs:

- You or your Covered Dependent does not make timely premium payments or contributions as required
- The Company stops providing medical and prescription drug benefits to its employees, or
- You or any of your Covered Dependents become covered under another group healthcare plan not offered by a Nokia Group Company.

Continuation coverage also may be terminated for any reason where the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud).

Section R. Claims and Appeals

The Plan maintains claims and appeals procedures designed to afford you a fair and timely review of any claim you might have relating to the Plan. Generally, you are legally required to pursue all your claim and appeal rights on a timely basis before seeking any other legal recourse, including litigation.

For information regarding how to contact parties referenced in this section, see Section V., "Important Contacts."

Overview

Disagreements about eligibility to participate in the Plan (or in one of the Plan's programs) or about benefits provided under the Plan can and do arise. To resolve these disagreements, the Plan provides for a formal claims and appeals process.

Note: You must exhaust the claim and appeal procedures as described in this SPD before filing any legal action (whether in state or federal court) regarding your Plan dispute.

The Plan has separate claims and appeals procedures depending on whether you have:

- An eligibility claim
- A benefit claim under the UHC Enhanced or UHC Standard options
- A benefit claim relating to the Prescription Drug Program.

An eligibility claim is a claim by you (or your dependent) concerning the right to participate in the Plan. For example, you may believe an error was made during Annual Open Enrollment that resulted in your (or your dependent) being assigned incorrect coverage, or you may believe you (or your dependent) experienced a "qualified status change" that entitles you (or your dependent) to make a change in Plan coverage during the year, but you are being told to wait until the next Annual Open Enrollment to make the change. Another example of an eligibility claim is a claim to be included as a participant in the Plan (e.g., there is a disagreement regarding your employment status that affects your eligibility for Plan coverage). Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.

In contrast to eligibility claims, benefit claims (whether under the UHC Enhanced or UHC Standard option or the Prescription Drug Program) concern the question of benefits provided under the Plan. Such claims can include, for example, whether a procedure or course of treatment is

covered under the terms of the Plan, the amount of Copays or Coinsurance payable under the Plan with respect to a particular service, or the extent to which Plan limits or other restrictions apply to the service at issue.

The claim and appeal procedures for eligibility claims, for benefit claims under the UHC Enhanced and UHC Standard options, and for benefit claims under the Prescription Drug Program are described separately below. (References to "you" refer to any claimant, including the authorized representative of any claimant.) To the extent you have a claim that does not neatly fall into one of these categories, address your claim using the Plan's eligibility claims procedures.

Decision-Making Authority

The authority to adjudicate claims and appeals has been assigned to different entities—for eligibility claims, to the Nokia Benefits Review Team (the "NBRT") and then to the Nokia Employee Benefits Committee (the "EBC"); for benefit claims under the UHC Enhanced or, UHC Standard options, to the Claims Administrator for those Options; and for benefits claims under the Prescription Drug Program, to the Claims Administrator for that program. (For contact information for each of these entities, see Section V., "Important Contacts.") Each of these entities (NBRT, EBC, and Claims Administrators) is a fiduciary under ERISA and is required to review and decide your claim in accordance with the Plan's terms (the documents and instruments governing the Plan) and these procedures. In this regard, the Plan grants to each of these entities (as applicable) sole and complete discretionary authority to determine conclusively for all parties, and in accordance with such documents and instruments, any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to participation in the Plan and eligibility for Plan benefits, determination of all relevant facts, determination of the amount and type of benefits payable under the Plan, and construction of all Plan terms. In the case of an appeal, the EBC's and the Claims Administrator's decisions are final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the decision was an abuse of administrator discretion.

Eligibility Claims and Appeals

In instances where you are required to file a claim form (as opposed to the automatic submission with some benefit-related claims), you should submit claims within 60 days of the date the medical service is provided. If it is not reasonably possible to submit a claim within this time frame, an extension of up to 12 months from the date of such service will be allowed. However, no benefits will be paid for claims submitted more than 12 months after the date the services were rendered.

Submitting an Eligibility Claim

If you have an eligibility claim, contact the Nokia Benefits Resource Center and request an eligibility claim form ("Claim Initiation Form" or "CIF"). Your eligibility claim is not filed until you complete and mail your CIF, including any supporting documentation to:

Claims and Appeals Management
Dept 07544
PO Box 299107
Lewisville, TX 75029-9107

If your eligibility claim is coupled with a claim for benefits, follow the benefits Claims Administrator's process, but also include a copy of the benefits claim information with your CIF. You should indicate on your CIF whether the benefits claim is a post-service claim, pre-service claim, an urgent (pre-service) claim, or a concurrent care claim.

When You Can Expect to Receive a Decision with Respect to Your Eligibility Claim

Since the vast majority of eligibility claims are post-service, you will receive a response within 30 days from the date that your CIF is received. The NBRT may extend the period for making the claim decision by 15 days if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If your eligibility claim is being submitted in conjunction with a benefit claim, see the timing applicable to your "type" of claim or appeal in the *Benefit Claims and Appeals—UHC Enhanced and UHC Standard Options* section or *Benefit Claims and Appeals--Prescription Drug Program* section, as applicable, of this SPD.

Special Rule: If you do not provide sufficient information to allow the NBRT to make a decision with respect to your eligibility claim, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the NBRT's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the NBRT notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If the NBRT then receives that information on, for example, Day 30 of your 45-day response time, the time within which the NBRT is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

What You Will Be Told if Your Eligibility Claim Is Denied

If your claim is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).

- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

Eligibility Appeals Procedure and Deadline to Submit Your Appeal

If your eligibility claim is denied and you wish to have it re-reviewed, you must file an appeal. You must file your appeal within **180 days** from the date on the claim denial letter. To file an appeal, you must write to:

Nokia
Employee Benefits Committee ("EBC")
600–700 Mountain Avenue
Room 6C-402A
Murray Hill, NJ 07974

You should include a copy of your initial claim denial notification, the reason(s) for the appeal, and relevant documentation with your appeal request.

You may request access, free of charge, to all documents relating to your appeal. Your appeal will be reviewed "de novo," which means you get a "start fresh" to establish the merits of your claim and the EBC will not place deference upon the original decision. The EBC is a fiduciary who is not the individual who made the initial decision and who is not the subordinate of the initial reviewer.

When You Can Expect to Receive a Decision with Respect to Your Eligibility Appeal

You will be notified of the decision by the EBC within 60 days after receipt of your appeal. If special circumstances cause the EBC to need additional time to make a decision, a representative of the Committee will notify you in writing within the initial 60-day review period and explain why such additional time is needed. An additional 60 days—for a total of 120 days—may be taken if the EBC sends this notice.

Please Note: *If your eligibility appeal is coupled with a non-urgent pre-service benefits appeal, urgent pre-service benefits appeal, or concurrent care benefits appeal, as the case may be, an effort will be made to decide your eligibility appeal within the time frames applicable to the benefits claim.*

What You Will Be Told if Your Eligibility Appeal Is Denied

If your eligibility claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial
- The Plan provisions on which the denial is based

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request)
- A statement about your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) and a statement about voluntary alternative dispute resolution options.

The decision on your appeal is final. Upon denial by the EBC, you have the right to bring a civil action in federal court. This option is available to you only after you have exhausted all the administrative remedies available to you through the Plan's claims and appeals process as described in this section.

Benefit Claims and Appeals—UHC Enhanced and UHC Standard Options

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the *Required Information* listed below. If any *Required Information* is missing from the bill, you can include it in your letter.

How Are Covered Health Care Services from Network Providers Paid?

The Claims Administrator processes payment to Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact the Claims Administrator. However, you are required to meet any applicable deductible and to pay any required Copayments and Coinsurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health care service will be denied or reduced, in the Claims Administrator's discretion. This time limit 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.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Employee's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.

A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with the Claims Administrator at the address on your ID card.

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- Is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- Is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- Shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 7: Coordination of Benefits*.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator 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 the amount the provider owes to other plans for which the Claims Administrator processes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Claims Administrator in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.

- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

For medical claims, the appeals address is:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

Appeal Process
A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied

claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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.

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 decision letter to you.

Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.

The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review Program

You may be entitled to request an external review of the Claims Administrator's determination after exhausting your internal appeals if either of the following apply:

You are not satisfied with the determination made by the Claims Administrator.

The Claims Administrator fails to respond to your appeal within the timeframe required by the applicable regulations.

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 Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the Claims Administrator at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Claims Administrator's final appeal decision.

An external review request should include all of the following:

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

An external review will be performed by an *Independent Review Organization (IRO)*. The Claims Administrator has entered into agreements with three or more *IROs* that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

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

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administrator will assign requests by either rotating the assignment of claims 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 and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned *IRO* the documents and information considered in making the Claims Administrator's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Claims Administrator.
- 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. The Claims Administrator will include it with the documents forwarded to the *IRO.*

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. 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 the Claims Administrator, and it will include the clinical basis for the determination.

If the Claims Administrator receives a *Final External Review Decision* reversing the Claims Administrator's determination, the Plan will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Plan, and any applicable law regarding plan

remedies. If the *Final External Review Decision* agrees with the determination, 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 main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, 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, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:

- The life or health of the individual.
- The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

A final appeal decision, that either:

- Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
- Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

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

After the Claims Administrator completes the review, the Claims Administrator will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an *IRO* in the same manner the Claims Administrator utilizes to assign standard external reviews to *IROs*. The Claims Administrator will provide all required documents and information the Claims Administrator used 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 method in a timely manner. The *IRO*, to the extent

the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly 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 IRO's final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the Claims Administrator at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	15 days
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Benefit Claims and Appeals--Prescription Drug Program

Filing a Claim

If you use an Out-of-Network Pharmacy or are unable to prove your eligibility at a Network Retail Pharmacy, you'll need to pay the full cost for the prescription and file a claim for reimbursement.

Filing an Appeal

To appeal a decision under the Prescription Drug Program, call CVS Caremark at 1-800-240-9623 and ask for a CVS Caremark appeals form for Nokia employees. Your appeal will be reviewed, and you will be notified of the decision.

Section S. Your Rights Under ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA, as described below.

Your Right to Receive Information About the Plan and About Your Benefits under the Plan

Under ERISA, all Plan Participants have the right:

- To examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan and a copy of the latest Annual Return/Report (the Form 5500) filed by the Plan Administrator with the U.S. Department of Labor. The Plan's Annual Return/Report (Form 5500) is also available at the Public Disclosure Room, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.

- To obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan and copies of the latest Annual Return/Report (Form 5500) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for such copies.

Your Right to Prudent Actions by the Plan's Fiduciaries

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

Enforcing Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know the reasons for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request a copy of Plan documents or the latest Annual Return/Report (Form 5500) from the Plan Administrator 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 to you and also to pay you up to $110 a day until you receive the materials (unless the materials were not

sent because of reasons beyond the control of the Plan Administrator). If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. 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. If it should happen that the Plan's fiduciaries misuse the money belonging to the Plan, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement of your ERISA rights or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by going to www.dol.gov/EBSA or calling the publications hotline of the Employee Benefits Security Administration at (866) 444-EBSA (3272).

Section T. Other Information About the Plan

The Official Plan Documents Are Controlling

This booklet, called an SPD, is intended to summarize the material terms of the Plan (in particular, the UHC options under the Plan). The SPD is for informational purposes only. The actual terms of the Plan are reflected in the official Plan document, a copy of which can be obtained by writing to the Plan Administrator (see Section V, "Important Contacts"). Every care has been taken to ensure that this summary is accurate. In the event of a conflict between this SPD and the terms of the official Plan document, the official Plan document will control.

Because of the many detailed provisions of the Plan, no one other than the personnel or entities identified is this summary (see "Important Contacts" at the end of this SPD) is authorized to advise you concerning the terms of the Plan. Questions regarding your benefits or the Plan should be addressed as indicated in this SPD. Neither the Company nor the Plan is bound by statements made by unauthorized persons or entities. Moreover, in the event of a conflict between any information provided to you by an authorized resource and this SPD, this SPD (or the official Plan document in the event of a conflict between this SPD and the official Plan document) will control.

The Company Has the Right to Modify, Suspend, or Terminate the Plan

The Company expects to continue the Plan. However, the Company has expressly reserved the right to modify, suspend, change or terminate the Plan at any time and for any reason.

The Plan is Not a Contract of Employment

Your participation in the Plan, and your right to amounts contributed to and earned under your Plan account, do not create a contract of employment, which is generally considered to be "at will."

Plan Funding and Payment of Benefits

The UHC Enhanced and UHC Standard options, Prescription Drug Program, and Employee Assistance Program are provided as part of the Medical Plan. The claims and expenses of these self-insured Medical Plan options are paid from employer and employee contributions.

The Company pays fees to outside organizations (i.e., UnitedHealthcare, CVS Caremark, Magellan, and Alight Solutions) to process claims and provide recordkeeping and other third-party administrative services with respect to the Plan. The fees and all benefit payments are paid from company revenues. These self-insured Medical Plan options do not guarantee benefits

under a contract or policy of insurance. The administrator of the self-insured Medical Plan options administers the benefits under the options.

Your Plan Benefits and Rights Are Not Assignable

Benefits payable under the Plan are not subject to assignment or alienation, nor may any Participant assign any cause of action relating to such benefits, nor any other rights with respect to the Plan, to any other person or entity, including any medical provider. Any such purported assignment or alienation shall be null and void. Notwithstanding the foregoing:

- in accordance with Section 609(b) of ERISA, payments for benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act; and

- the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan.

Authority of Plan Administrator and Claims Administrators

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Medical Plan, to determine eligibility for Medical Plan benefits, to interpret and construe the terms and provisions of the Medical Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Medical Plan as the Plan Administrator may deem appropriate in accordance with the terms of the Medical Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Medical Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Medical Plan, including the discretionary authority to interpret and construe the terms of the Medical Plan, to direct disbursements, and to determine eligibility for Medical Plan benefits.

The Plan Administrator has delegated its responsibility to review claims relating to eligibility to participate in the Medical Plan to the Nokia Benefits Review Team. The Plan Administrator has delegated its responsibility to review appeals of denied claims relating to eligibility to participate in the Medical Plan to the Employee Benefits Committee. The Plan Administrator has delegated its responsibility to review all other claims and appeals relating to benefits under the Medical Plan to the Claims Administrators. Each Claims Administrator has the full discretionary authority and power to control and manage all aspects of the Medical Plan with respect to which they have been delegated responsibility, including the discretionary power and control to determine eligibility for Medical Plan benefits, to interpret and construe the terms and provisions of the Medical Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Medical Plan as they may deem appropriate in accordance with the

terms of the Medical Plan and all applicable laws. See also "Decision-Making Authority" in Section R., "Claims and Appeals."

Section U. Administrative Information

Plan Name	The official name of the Plan is the Nokia Medical Expense Plan for Active Employees.
Plan Sponsor Name and Address	The Plan Sponsor of the Plan is Nokia of America Corporation. The address of the Plan Sponsor is: Nokia Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA
Plan Administrator Name and Address	The Plan is administered by Nokia of America Corporation. The address of the Plan Administrator is: Nokia Plan Administrator Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA The Plan Administrator has retained various third-party administrators (contract administrators) responsible for certain administrative activities, including administering claims and paying benefits under the terms of the Plan. In this regard: • For the UnitedHealthcare (UHC) options, the Plan Administrator has retained UnitedHealthcare. • For the Prescription Drug Program, the Plan Administrator has retained CVS Caremark. • For the Employee Assistance Program, the Plan Administrator has retained Magellan. In addition, the Plan Administrator has retained Alight Solutions LLC (using the name the Nokia Benefits Resource Center (NBRC)) as third-party administrator responsible for eligibility and enrollment under the terms of the Plan.

	For contact information for each of these third-party administrators, see Section V., "Important Contacts."
Type of Administration	The Plan is administered by the Plan Sponsor.
Type of Plan	The Plan is considered an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").
Plan Records and Plan Year	The Plan and all its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Agent for Service of Legal Process	The Nokia Legal & Compliance organization is the agent for service of legal process. Service of legal papers, including service of subpoenas, may be served directly to: Nokia Legal & Compliance Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA
Employer Identification Number	The Employer Identification Number assigned by the IRS to the Plan Sponsor is 22-3408857.
Plan Number	The Plan Number assigned by the Plan Sponsor to the Plan is 502.
Plan Trustee	None. Plan benefits are paid from the general assets of the Company (for the UHC options, the Prescription Drug Program, and the EAP).

Section V. Important Contacts

Here is a list of important contacts for the Plan:

Contact/Service Provided	Address
UnitedHealthcare (UHC) Claims Administrator for the UHC medical options	www.myuhc.com 1-800-577-8539
CVS Caremark Claims Administrator for the Prescription Drug Program	Caremark.com 1-800-240-9623
Magellan Administrator for the Employee Assistance Program	Member.MagellanHealthcare.com 1-800-327-7348
Plan Administrator Administers the Plan; adjudicates eligibility claims; oversees third-party service-providers, responsible for certain disclosure to Participants regarding the Plan.	Plan Administrator Nokia 600-700 Mountain Avenue Room 6D-401A Murray Hill, NJ 07974 USA
Nokia Benefits Resource Center (NBRC) Call center where you can: • Enroll in coverage • Make changes to your coverage • Review, add or change your dependent's information on file • Understand how a Life Event may affect your benefits • Get answers to your questions regarding eligibility and enrollment in the Plan	1-888-232-4111 (domestic) 1-212-444-0994 (if calling from outside the U.S., Puerto Rico or Canada) Representatives are available between 9:00 a.m. and 5:00 p.m., Eastern Time (ET), Monday through Friday. If you are hearing or speech impaired, please use a Relay Service when calling a representative.

Contact/Service Provided	**Address**
	The mailing address of the NBRC is: Nokia Benefits Resource Center Dept. 07544 P.O. Box 64116 The Woodlands, TX 77387-4116 USA Overnight mail should be sent to: Nokia Benefits Resource Center Dept. 07544 8770 New Trails Drive The Woodlands, TX 77381 USA
Nokia BenefitAnswers Plus Website where you can: • See benefits news and updates • View plan-related documents such as Summary Plan Descriptions (SPDs), Summaries of Material Modifications (SMMs), and Summary Annual Reports • View enrollment materials • Find carrier contact information during the year	https://www.benefitanswersplus.com/
Nokia Benefits Review Team The team within the Nokia Benefits Resource Center assigned the responsibility to decide claims for eligibility to participate in the Plan	Claims and Appeals Management Dept 07544 PO Box 299107 Lewisville, TX 75029-9107
Nokia Employee Benefits Committee Serves as final review committee for Plan eligibility appeals.	Employee Benefits Committee Nokia 600-700 Mountain Avenue Room 6C-402A Murray Hill, NJ 07974 USA
Nokia Legal & Compliance Organization Authorized agent for service of process of all legal papers for the Plan, the Severance Plan Administrator, and the Nokia Employee	Legal & Compliance Organization Nokia 600-700 Mountain Avenue Room 6D-401A Murray Hill, NJ 07974 USA

Contact/Service Provided	**Address**
Benefits Committee. Also authorized agent for service of subpoenas.	
Nokia QMCSO Administrator Handles matters relating to Qualified Medical Child Support Orders ("QMCSOs") for the Plan	Send all draft or court-certified orders to: Nokia Qualified Order Team P.O. Box 1542 Lincolnshire, IL 60069-1542 USA You can also fax documents and inquiries to: 1 (847) 442-0899. For information or if you have questions: visit the Qualified Order Center website at www.QOcenter.com, email your questions to QOcenter@alight.com, or contact the Nokia Benefits Resource Center.
Your Benefits Resources (YBR)™ Website where you can: • View your current coverage • Review and compare your healthcare options and contribution costs • Enroll in coverage • Make changes to your coverage • Learn more about your Nokia benefits • Review, add or change your dependent's information on file • Understand how a Life Event may affect your benefits (Your Benefits Resources is a trademark of Alight Solutions LLC.)	You can access YBR at https://digital.alight.com/nokia, 24 hours a day, seven days a week.

Appendices

Appendix 1

Benefits at a Glance - Medical

UnitedHealthcare® (UHC) plan options

Please note: For the medical services shown in the table below and on the following pages, where coverage is expressed as a percentage, it is a percentage of the provider's contracted rate for in-network UHC Enhanced and UHC Standard services. When medical services are received from a non-network provider, eligible expenses are an amount negotiated by UHC, a specific amount required by law (when required by law) or an amount UHC has determined is typically accepted by a healthcare provider for the same or similar service.

Feature	UHC Enhanced		UHC Standard	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Choice of doctors	Select from within a network of medical providers	Select any medical provider	Select from within a network of medical providers	Select any medical provider
Annual deductible	**Individual:** $500 **Two-person:** $1,000 **Family:** $1,500	**Individual:** $1,500 **Two-person:** $3,000 **Family:** $4,500	**In-network:** **Individual:** $1,000 **Two-person:** $2,000 **Family:** $3,000	**Individual:** $2,000 **Two-person:** $4,000 **Family:** $6,000
Annual out-of-pocket maximum	**Individual:** $4,000 (excludes deductible) **Family:** $8,000 (excludes deductible)	**Individual:** $6,000 (excludes deductible) **Family:** $18,000 (excludes deductible)	**Individual:** $6,000 (excludes deductible) **Family:** $12,000 (excludes deductible)	**Individual:** $12,000 (excludes deductible) **Family:** $36,000 (excludes deductible)
Lifetime maximum benefit	Unlimited for essential benefits. Generally, the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care). For all other benefits: unlimited; some exclusions apply.			
Copay/coinsurance for covered services				
Acupuncture	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied; limited to 30 visits/year	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied; limited to 30 visits/year
Ambulance services (air and ground) — emergency	Plan pays 85% after deductible is satisfied	Plan pays 85% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 75% after deductible is satisfied
Ambulance services (air and ground) — nonemergency	Plan pays 85% after deductible is satisfied	Plan pays 85% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 75% after deductible is satisfied
Anesthesia	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Autism spectrum disorder services	**Inpatient:** Plan pays 85% after deductible is satisfied **Outpatient:** You pay $30 copay/visit after deductible is satisfied	**Inpatient:** Plan pays 60% after deductible is satisfied and you pay $300 copay/ admission **Outpatient:** Plan pays 60% after deductible is satisfied	**Inpatient:** Plan pays 75% after deductible is satisfied and you pay $500 copay/ admission **Outpatient:** You pay $35 copay/visit after deductible is satisfied	**Inpatient:** Plan pays 50% after deductible is satisfied and you pay $700 copay/ admission **Outpatient:** Plan pays 50% after deductible is satisfied

Feature	UHC Enhanced		UHC Standard	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Birth control (prescription birth control or medication only)	See “Coverage through the CVS Caremark prescription drug program” on page 14.			
Birthing center	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied and you pay $300 copay/admission	Plan pays 50% after deductible is satisfied
Blood and blood derivatives	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Cardiac rehabilitation (phase three maintenance not covered)	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Chemotherapy	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Chiropractic	You pay $40 copay/visit after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)	Plan pays 60% after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)	You pay $60 copay/visit after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)	Plan pays 50% after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)
Colonoscopy — preventive and diagnostic	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Dental services — accident only	Plan pays 100% after deductible is satisfied and you pay $30 PCP/$40 specialist copay/visit	Plan pays 60% after deductible is satisfied	Plan pays 100% after deductible is satisfied and you pay $35 PCP/$60 specialist copay/visit	Plan pays 50% after deductible is satisfied
Diabetes self-management items	**Equipment:** Plan pays 85% after deductible is satisfied **Supplies:** Provided under the prescription drug program	**Equipment:** Plan pays 60% after deductible is satisfied **Supplies:** Provided under the prescription drug program	**Equipment:** Plan pays 75% after deductible is satisfied **Supplies:** Provided under the prescription drug program	**Equipment:** Plan pays 50% after deductible is satisfied **Supplies:** Provided under the prescription drug program
Durable medical equipment	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Emergency room — emergency use	Plan pays 100% after deductible is satisfied and you pay $250 copay (copay waived if admitted)	Plan pays 100% after deductible is satisfied and you pay $250 copay (copay waived if admitted)	Plan pays 100% after deductible is satisfied and you pay $300 copay (copay waived if admitted)	Plan pays 100% after deductible is satisfied and you pay $300 copay (copay waived if admitted)
Emergency room — nonemergency use	Plan pays 100% after deductible is satisfied and you pay $250 copay	Plan pays 100% after deductible is satisfied and you pay $250 copay	Plan pays 100% after deductible is satisfied and you pay $300 copay	Plan pays 100% after deductible is satisfied and you pay $300 copay

Feature	UHC Enhanced		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
Habilitative and rehabilitation services (outpatient physical, occupational, speech, pulmonary)	**Physical, occupational, speech and pulmonary rehabilitation:** You pay $40 copay/visit after deductible is satisfied	Plan pays 60% after deductible is satisfied; speech therapy limited to 100 visits/year for developmental delays and 30 visits/year otherwise	**Physical, occupational, speech and pulmonary rehabilitation:** You pay $60 copay/visit after deductible is satisfied	Plan pays 50% after deductible is satisfied; speech therapy limited to 100 visits/year for developmental delays and 30 visits/year otherwise
Hearing aids	$2,500 allowance every 36 months after deductible is satisfied (in- and out-of-network combined)	$2,500 allowance every 36 months after deductible is satisfied (in- and out-of-network combined)	$2,500 allowance every 36 months after deductible is satisfied (in- and out-of-network combined)	$2,500 allowance every 36 months after deductible is satisfied (in- and out-of-network combined)
Home healthcare	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied; limited to 100 visits/year	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied; limited to 100 visits/year
Hospice care	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Inpatient hospitalization	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied and you pay $300 copay/admission	Plan pays 75% after deductible is satisfied and you pay $500 copay/admission	Plan pays 50% after deductible is satisfied and you pay $700 copay/admission
Maternity (office visits [pre/postnatal], in-hospital delivery services)	**Office visits:** Plan pays 85% after deductible is satisfied and you pay first office copay **In-hospital delivery services:** Plan pays 85% after deductible is satisfied	**Office visits:** Plan pays 60% after deductible is satisfied **In-hospital delivery services:** Plan pays 60% after deductible is satisfied and you pay $300 copay/admission	**Office visits:** Plan pays 75% after deductible is satisfied and you pay first office copay **In-hospital delivery services:** Plan pays 75% after deductible is satisfied and you pay $500 copay/admission	**Office visits:** Plan pays 50% after deductible is satisfied **In-hospital delivery services:** Plan pays 50% after deductible is satisfied and you pay $700 copay/admission
Mental health and chemical dependency	**Inpatient:** Plan pays 85% after deductible is satisfied **Outpatient:** You pay $30 copay/visit after deductible is satisfied	**Inpatient:** Plan pays 60% after deductible is satisfied and you pay $300 copay/admission **Outpatient:** Plan pays 60% after deductible is satisfied	**Inpatient:** Plan pays 75% after deductible is satisfied and you pay $500 copay/admission **Outpatient:** You pay $35 copay/visit after deductible is satisfied	**Inpatient:** Plan pays 50% after deductible is satisfied and you pay $700 copay/admission **Outpatient:** Plan pays 50% after deductible is satisfied
Nutritional counseling	You pay $40 copay/visit after deductible is satisfied	Not covered	You pay $60 copay/visit after deductible is satisfied	Not covered
Outpatient lab/X-ray	After deductible is satisfied, Plan pays 100% for minor services, 85% for major services	Plan pays 60% after deductible is satisfied	After deductible is satisfied, Plan pays 100% for minor services, 75% for major services	Plan pays 50% after deductible is satisfied
Physician hospital visits and consultations	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied

Feature	UHC Enhanced		UHC Standard	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Physician visits (virtual visits, primary care physician [PCP] office visits, specialist office visits and urgent care center visits) (non-preventive)	**Virtual visit:** You pay $10 copay/visit **PCP:** You pay $30 copay/visit after deductible is satisfied **Specialist:** You pay $40 copay/visit after deductible is satisfied **Urgent care center:** You pay $75 copay/visit after deductible is satisfied	**Virtual visit:** Not covered **PCP, specialist and urgent care center:** Plan pays 60% after deductible is satisfied	**Virtual visit:** You pay $20 copay/visit **PCP:** You pay $35 copay/visit after deductible is satisfied **Specialist:** You pay $60 copay/visit after deductible is satisfied **Urgent care center:** You pay $100 copay/visit after deductible is satisfied	**Virtual visit:** Not covered **PCP, specialist and urgent care center:** Plan pays 50% after deductible is satisfied
Private duty nursing	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied; limited to 100 shifts/year	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied; limited to 100 shifts/year
Prosthetic devices	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Radiation therapy	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Second surgical opinion	You pay $40 copay/visit after deductible is satisfied	Plan pays 60% after deductible is satisfied	You pay $60 copay/visit after deductible is satisfied	Plan pays 50% after deductible is satisfied
Skilled nursing facility	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied; limited to 60 days/year	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied; limited to 60 days/year
Smoking deterrents (prescription only)	See “Coverage through the CVS Caremark prescription drug program” on page 14.			
Surgery — in-office	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied and you pay $250 copay	Plan pays 50% after deductible is satisfied
Surgery — inpatient	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied	Plan pays 50% after deductible is satisfied
Surgery — outpatient	Plan pays 85% after deductible is satisfied	Plan pays 60% after deductible is satisfied	Plan pays 75% after deductible is satisfied and you pay $300 copay/procedure	Plan pays 50% after deductible is satisfied
Wigs	Plan pays up to $300/year after deductible is satisfied (in- and out-of-network combined)			

Feature	UHC Enhanced		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
Preventive care				
Routine physical exams	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Well-child care (including immunizations)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Well-woman care (ob-gyn exam)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Mammogram screening	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Pap smear (in doctor's office)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Digital rectal exam and blood test for PSA (in doctor's office — prostate cancer screening for men age 50 and older)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Newborn in-hospital care	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Other important information about your medical coverage				
Are you responsible for charges in excess of the allowable amount?	No	Yes	No	Yes
Who is responsible for prior authorization?	Your provider; check with your provider to ensure prior authorization is obtained	You	Your provider; check with your provider to ensure prior authorization is obtained	You
What is the penalty for failure to obtain prior authorization?	No benefits paid by plan	Up to $400 maximum reduction in benefits/ occurrence	No benefits paid by plan	Up to $400 maximum reduction in benefits/ occurrence
Do you have to file claim forms?	No	Yes	No	Yes
Are Centers of Excellence available?	Yes			

Appendix 2

Benefits at a Glance – Prescription Drug Program

Prescription drug coverage

	Surest Enhanced and UHC Enhanced		Surest Standard and UHC Standard	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Coverage through the CVS Caremark prescription drug program[1,2]				
Prescription drug annual out-of-pocket limit	**Individual:** $4,000 **Family:** $8,000	Not applicable	**Individual:** $4,150 **Family:** $8,300	Not applicable
Retail[3] (up to a 30-day supply)	**Generic:** You pay $20 copay **Preferred brand:** You pay $90 copay **Nonpreferred brand:** You pay $150 copay	Plan pays 60% coinsurance after you pay separate deductible **Individual:** $175 **Two-person:** $350 **Family**: $525	You pay $20 copay for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of $30 and maximum of $150/prescription	Plan pays 50% coinsurance after you pay separate deductible: **Individual:** $225 **Two-person:** $450 **Family:** $675
Mail order (up to a 90-day supply)	**Generic:** You pay $50 copay **Preferred brand:** You pay $225 copay **Nonpreferred brand:** You pay $375 copay	Not applicable	You pay $50 copay for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of $75 and maximum of $375/prescription	Not applicable
Member pays the difference	You will pay the generic copay, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available.			
Other important information about your medical and prescription drug coverage				
$0 out-of-pocket cost for certain preventive medications	Certain preventive medications, including some over-the-counter (OTC) medications, are covered 100% without imposing a copay, coinsurance or deductible as long as they are presented with a prescription from a licensed healthcare provider. The list of eligible medications is subject to change as Affordable Care Act guidelines are updated or modified.			

1 The deductibles and out-of-pocket maximums for the prescription drug program are separate from the deductibles and/or out-of-pocket maximums for Surest and UHC medical coverage. “Member pays the difference” program charges do not count toward prescription drug annual out-of-pocket maximums.

2 Where prescription drug coverage is expressed as a percentage, it is a percentage of the plan’s cost for the drug.

3 Prescription drug copays will double after the third time you receive a 30-day supply of a maintenance medication at a retail pharmacy; for cost savings, fill up to a 90-day supply through mail order or pick up at a CVS retail pharmacy or at any Costco Pharmacy. Note the following state exceptions to the doubling of copays: **FLORIDA:** Participants residing in Florida can also obtain 90-day supplies of medications taken on an ongoing basis at any in-network retail pharmacy that fills 90-day supplies. **MINNESOTA:** Participants residing in Minnesota also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy. **OKLAHOMA:** Participants residing in or filling their prescriptions in Oklahoma can also obtain 90-day supplies of medications taken on an ongoing basis at any in-network retail pharmacy that fills 90-day supplies. **TENNESSEE:** Participants residing in Tennessee also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy. **WEST VIRGINIA:** Participants residing in West Virginia will have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find a participating pharmacy.

Note: Your CVS Caremark prescription drug coverage includes the PrudentRx Copay Program, a cost-saving program for certain specialty medications. For information about PrudentRx, see the *Nokia Medical Expense Plan for Active Employees Summary Plan Description (SPD) — Surest Enhanced and Standard Options* and the *Nokia Medical Expense Plan for Active Employees SPD — UHC Enhanced and Standard Options* at www.benefitanswersplus.com/active_m/spd.html.

Remember: You may not be eligible for all of the coverage options shown in the tables above. For information about the Kaiser HMO, contact Kaiser. Carrier contact information is on page 23.

About Nokia

Nokia is a global leader in connectivity for the AI era. With expertise across fixed, mobile, and transport networks, powered by the innovation of Nokia Bell Labs, we're advancing connectivity to secure a brighter world.