Summary Plan Description

Avnet, Inc.
Hawaii

Effective: January 1, 2016
Group Number: 905940

IMPORTANT INFORMATION

This is not an insured benefit plan. The benefits described in this booklet are self-insured by Avnet, Inc. which is responsible for their payment. UnitedHealthcare and OptumRx provide claim administration services to the plan, but UnitedHealthcare and OptumRx do not insure the benefits described.

This booklet serves as both the Plan document and Summary Plan Description for the Avnet, Inc. Hawaii Medical Plan (the "Plan"), which is offered as a group medical option under the Avnet Group Benefits Plan.

Nothing contained in this document shall be construed as a contract of employment between Avnet (the "Company") or any of its subsidiaries, and any Employee or other individual, nor as any limitation of the Company's right (and the right of any employing subsidiary or other entity) to discipline, discharge, or take action with respect to any Employee or other service provider, with or without cause, at any time, or otherwise limit the employment-at-will relationship between the Company (or employing subsidiary or other entity) and an Employee or other service provider.

Avnet, Inc. intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice.

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: 844-518-8072.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **myuhc.com**.

Avnet, Inc. is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Avnet, Inc. Hawaii Medical Plan ("Plan"). It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

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

Please read this SPD thoroughly to learn how the Avnet, Inc. Plan works. If you have questions, contact the Avnet Benefits department at 800-882-8638, option #4, or call the number on the back of your ID card.

How to Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any amendments at avnet.me/spds or request printed copies by contacting the Avnet Benefits department at 800-882-8638, option #4.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Avnet, Inc. is also referred to as Company or Employer.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

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

Eligibility

You will become eligible for Plan coverage on the day you complete the waiting period if:

- you are in a class of eligible Employees residing in Hawaii; and
- you are an eligible full-time, part-time, on-call or temporary Employee; and
- you work at least 20 hours per week for four consecutive weeks.

Ineligible Employees are defined in Section 14, *Glossary – Employee*.

In order to participate in the Plan, you must be employed by a participating business unit of the Employer. Most of the Employer's business units based in the United States participate in the Plan. However, certain business units do not. For more information, please contact the Avnet Benefits department at 800-882-8638, option #4.

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

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; and
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

You will become eligible for Dependent Plan coverage on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Important Note: Your Dependents can be covered under the Plan only if you are covered. In addition, if you and your Spouse are both covered under the Medical Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

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

Cost of Coverage

This Plan is offered to you as an Employee. You and Avnet, Inc. share in the cost of the Plan. For you and any eligible Dependents to be covered, you will have to pay part of the cost of coverage. Your contribution amount depends on the Plan you select, your Avnet annual target income, and the family members you choose to enroll.

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

Your contributions are subject to review and Avnet, Inc. reserves the right to change your contribution amount from time to time. For contribution rates, refer to the Benefits Resource Guide for the current calendar year.

How to Enroll

To enroll, enter your elections in Workday within 30 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment (typically in November) to make your benefit elections.

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

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections. See *Attachment II – Legal Notices* for more information about family status changes.

When Coverage Begins

You are eligible for coverage on the first day of the month after your date of hire. The waiting period applies only for new hires and people who are rehired more than six months after they last worked for the Employer. You will not be required to satisfy the waiting period if (a) you have not terminated employment with the Employer (e.g., you lose coverage as a result of having your hours reduced to less than an average of 20 hours per week and later return to an eligible position without having terminated employment); or (b) you are rehired as an eligible Employee within six months after terminating your employment. You can make an initial election to enroll in the Plan at any time during the first 30 days after you are hired into an eligible position. If you enroll during this initial

enrollment period, your participation (and that of your Dependents, if elected) will be effective as soon as you are eligible to participate in the Plan. You will not be denied enrollment for Plan coverage due to your health status.

In order to become covered on your first day of eligibility, you must be in Active Service on that date, unless the reason for not being in Active Service is due to your health status. If you do not enroll during the initial enrollment period above, you will not be allowed to enroll until the next open enrollment period, unless you qualify under the "Change in Status" or "Special Enrollment Rights Under the Health Insurance Portability & Accountability Act" rules summarized in *Attachment II – Legal Notices*. Similarly, if you enroll during the 30-day initial enrollment period, you will not be allowed to change your enrollment election until the next Open Enrollment period, except to the extent you qualify to make a mid-year change under the "Change in Status" rules.

Coverage for your Dependents will become effective on the date you enroll in the Plan, but no earlier than the day you become eligible for Dependent coverage.

- Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 30 days of your marriage.
- Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 30 days of the birth, adoption, or placement. Any Dependent child born while you are covered under the Plan will become covered under the Plan on the date of his/her birth. If you do not enroll your newborn child within 30 days after the date of his/her birth, your coverage for that child will end on the 30th day. No benefits for expenses incurred beyond the 30th day will be payable for that child. You will have another opportunity to enroll the Dependent child during the next annual Open Enrollment period (with coverage effective for the next Plan Year).

If You Are Hospitalized When Your Coverage Begins

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

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

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status such marriage, divorce, birth of a child, loss/gain of other coverage, etc. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). See *Attachment II - Legal Notices* for details of changes in status and your special enrollment rights. If you wish to change your elections based on these rights, you must contact Human Resources within 30

days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment period. These change events will also be available to you or your eligible Dependent if COBRA is elected.

Important Note: Any eligible child who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

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

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

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

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or healthcare 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 healthcare professionals who have contracted with UnitedHealthcare to provide those services. Avnet subscribes to UnitedHealthcare's Choice Plus network.

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

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

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

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

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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.

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 UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare 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, **myuhc.com,** UnitedHealthcare's consumer website, contains a directory of healthcare professionals and facilities in UnitedHealthcare's Choice Plus Network. While Network status may change from time to time, **myuhc.com** has the most current source of Network information. Use **myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for healthcare providers to participate in the Choice Plus Network. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **myuhc.com**. At your request, UnitedHealthcare will send you a directory of Network providers free of charge.

Network providers are independent practitioners and are not employees of Avnet, Inc. or UnitedHealthcare.

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

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 UnitedHealthcare. A directory of providers is available online at **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.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare 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 our products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Facilities and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Facility or Designated Physician chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare 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 Facility or Designated Physician, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare'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 Facility, Designated Physician or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-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 UnitedHealthcare determines that you are using healthcare services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 30 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

Avnet, Inc. has delegated to UnitedHealthcare 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 UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in this SPD.

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
    - When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a

comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

Important Note: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card
Remember to show your ID card (or access your ID on **myuhc.com** or the Health4You app) every time you receive healthcare 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. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Important Note: When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

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.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible. Coinsurance applies toward the Out-of-Pocket Maximum.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. If the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

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, but do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual 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 Out-of-Pocket Maximum:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance/Copayments	Yes	Yes
Covered Pharmacy Expenses	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

Medical Expense Rebate

If your annual pay (or target income) was $60,000 or less as of January 1 of the current Plan year, and you reach your Out-Of-Pocket Maximum, you will be eligible for a rebate. The rebate is $500 for individual coverage and $1,000 for coverage of the employee plus one or more dependents. (If you have family coverage and reach the individual maximum before you reach the family maximum, you will be eligible to receive $500 when you reach the individual maximum and an additional $500 if and when you reach the family maximum; the total aggregate rebate may not exceed $1,000.) If you believe you meet these criteria for the Plan (calendar) year, please contact the Avnet Benefits Department at 800-882-8638, option #4. This rebate will be subject to income and employment tax withholding, like other wages.

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

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

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice.

As of the publication of this SPD, the Personal Health Support program includes:

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

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

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

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. There are some Network Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 5, *Plan Benefits* within each Covered Health Service category.

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 the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

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

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

Covered Health Services which Require Prior Authorization

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain

services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator.

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 Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

The services that require prior authorization from the Claims Administrator are:

- Ambulance - non-emergent air and ground.
- Congenital heart disease surgery.
- Hospice care - inpatient.
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility).
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility).
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery.
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility).

Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For prior authorization timeframes and any reductions in Benefits that apply if you do not obtain prior authorization from the Claims Administrator or contact Personal Health Support, see Section 5*, Plan Benefits*.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 5 - PLAN BENEFITS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

Covered Health Services

This section provides an overview of the Plan's covered services. For detailed descriptions of your Benefits, please refer to the additional coverage details below as well as Section 6 – *Outpatient Prescription Drug Plan*. For coverage levels (deductibles, copays, coinsurance percentages, etc.), refer to Attachment III – *Plan Details*.

- Acupuncture Services
- Ambulance Services
- Chemotherapy - Oral
- Clinical Trials
- Congenital Heart Disease (CHD) Surgeries
- Dental Services – Accident Only
- Diabetes Services
- Durable Medical Equipment (DME)
- Emergency Health Services – Outpatient
- Hearing Aids
- Home Health Care
- Hospice Care
- Hospital – Inpatient Stay
- Infertility Services
- Lab, X-Ray and Diagnostics – Outpatient
- Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient
- Medical Foods
- Men's Family Planning Services
- Mental Health Services
- Neurobiological Disorders – Autism Spectrum Disorder Services
- Nutritional Counseling

- Obesity Surgery and Services
- Ostomy Supplies
- Pharmaceutical Products – Outpatient
- Physician Fees for Surgical and Medical Services
- Physician's Office Services – Sickness and Injury
- Pregnancy – Maternity Services
- Preventive Care Services
- Private Duty Nursing – Outpatient
- Prosthetic Devices
- Reconstructive Procedures
- Rehabilitation Services – Outpatient Therapy and Manipulative Treatment
- Scopic Procedures – Outpatient Diagnostic and Therapeutic
- Skilling Nursing Facility/Inpatient Rehabilitation Facility Services
- Substance Use Disorder Services
- Surgery – Outpatient
- Telehealth Services
- Temporomandibular Joint (TMJ) Services
- Therapeutic Treatments – Outpatient
- Transplantation Services
- Travel and Lodging
- Treatment of Gender Dysphoria (Gender Identity Disorder)
- Urgent Care Center Services
- Virtual Office Visits
- Vision Examinations (for Dependent Children Age 18 and Under)
- Wigs
- Women's Family Planning Services

Plan Benefits – Details

This section includes descriptions of the Benefits and any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Did you know…
You generally pay less out-of-pocket when you use a Choice Plus Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

Chemotherapy - Oral

Oral Chemotherapy.

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.

- Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before

participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.

- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (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 and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a CHD Resource Services program. 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.

Benefits are available for the following CHD services:

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

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 888-936-7246 before receiving care for information about CHD services. More information is also available at **myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.

- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Important Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

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

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.
- Dental services for final treatment to repair the damage caused by accidental Injury to sound natural teeth must be started within 6 months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.

- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Important Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for speech aid 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.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does

not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

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

Hearing Aids

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

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

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. See Section 14, *Glossary* for the definition of Skilled Care.

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

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-

based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Non-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Infertility Services

The Plan pays Benefits for the treatment of infertility for:

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must:

- Have failed to achieve a Pregnancy after one year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

Coverage is limited to one attempt of in vitro fertilization or $20,000 for any combination of Network Benefits and Non-Network Benefits for infertility services (whichever is the greater cost) per Covered Person during the entire period you are covered under the Plan.

Charges for the following apply toward the infertility lifetime maximum:

- Hospital outpatient facility.
- Surgeon's and assistant surgeon's fees.
- Anesthesia.

- Lab and x-ray.
- Diagnostic services.
- Physician's office visits.
- Consultations.
- Injections.

The cost of any prescription medication treatment for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures and zygote intrafallopian transfer (ZIFT) procedures does not count toward the infertility lifetime maximum.

Lab, X-Ray and Diagnostics - Outpatient

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

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

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

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Medical Foods

Coverage is provided for Medical Foods and Low-protein Modified Food Products prescribed for treatment of Inborn Error of Metabolism.

"Medical Foods" means a food that is formulated to be consumed or administered enterally under the supervision of a Physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

"Low protein Modified Food Product" means a food product that:

- Is especially formulated to have less than one gram of protein per serving;
- Is prescribed or ordered by a Physician as Medically Necessary for the dietary treatment of an Inborn Error of Metabolism; and
- Does not include a food that is naturally low in protein.

"Inborn Error of Metabolism" means a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital effects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.

Men's Family Planning Services

The Plan pays Benefits for office visits, inpatient/outpatient services, lab and radiology tests, and counseling for men's family planning, including coverage for:

- Surgical sterilization procedures for vasectomy (excludes reversals).

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

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use and any associated Coinsurance and Deductible. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

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

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

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.

- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
- Diet is a part of the medical management of a documented organic disease.

Some examples of such medical conditions include, but are not limited to:

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

Benefits are limited to three individual sessions per calendar year, however, any healthcare service billed with a Mental Health or Substance Abuse diagnosis will not incur a visit limit. This limit applies to non-preventive nutritional counseling services only.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services*.

Obesity Surgery and Services

The Plan covers medical and surgical services for the treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40.
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition, you must provide physician documentation of a motivated attempt of weight loss through a structured diet program for a minimum of six months prior to obesity surgery and complete a psychological evaluation to rule out major mental health disorders which would contraindicate surgery and/or undermine your compliance with post-operative follow-up care and nutrition guidelines. Please contact UnitedHealthcare at the number on your ID card for specific requirements prior to any planned surgery.

Benefits are available for obesity surgery and services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

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

Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the

treatment of infertility. See Section 6 *Outpatient Prescription Drug Plan* for details of your covered Pharmacy Benefits.

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

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

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

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare. Benefits are limited to three individual sessions per calendar year.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

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

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

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

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

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as 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 fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

- Immunizations 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*.

Also included for women is 3D imaging mammography (Tomosynthesis).

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

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

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

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

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

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- flu shots;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing;
- tests to support cardiovascular health;
- diabetes screening payable as routine when billed with routine diagnosis (no limits or frequency limits);
- skin cancer screening payable as routine when billed with routine diagnosis (no limits or frequency limits);
- colorecorectal cancer screening (fecal occult blood testing, sigmoidoscopy or colonoscopy) covered as preventive when billed as preventive. If a polyp is encountered

during preventive screening colonoscopy, the colonoscopy removal of the polyp and associated facility, lab and anesthesia fees done at the same encounter are covered under the preventive care services. Any related office visit/consult is charge covered at 100% of eligible expenses with no deductible. Virtual colonoscopies are covered as a preventive service;

- well-baby and well-child care including Child Health Supervision Services for children through age 5;
- routine well woman exams, including routine pap smears, pelvic examinations and mammograms;
- routine well man exams, including Prostate Specific Antigen (PSA) testing;
- immunizations;
- routine adult exams; and
- vision and hearing screenings, including evaluations for hearing.

Child Health Supervision Services

Child Health Supervision Services include the following:

- medical history;
- physical examinations;
- development assessment;
- anticipatory guidance; and
- appropriate immunization and laboratory tests.

Child Health Supervision Services must be in keeping with prevailing medical standards and given at or about the following age levels: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

Any preventive child care benefits are not subject to a calendar year deductible when rendered by a Network or Non-Network provider.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect, or for lost or stolen prosthetic devices.

Important Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled reconstructive procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled reconstructive procedure is performed.
- A non-scheduled reconstructive procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment (e.g., chiropractic).
- Speech therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

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

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

Habilitative Services

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

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

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

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

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Manipulative Treatment Benefits is limited to 5 visits per calendar year without confirmation of medical necessity. This visit limit applies to Network Benefits and Non-Network Benefits combined.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- 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 are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.

- You will receive skilled care services that are not primarily Custodial Care.

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

- It 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.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Important Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 days per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Substance Use Disorder Services

Substance Use Disorder Services (also known as 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.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.

- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction, not to exceed $1,000 per calendar year.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

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

Benefits under this section 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 in this section under *Physician Fees for Surgical and Medical Services*.

Telehealth Services

Coverage is provided for telehealth services the same as other Health Services.

"Telehealth" means the use of telecommunications services and enhanced services to deliver Health Services and information to parties separated by distance. Standard telephone, facsimile transmissions, or both in the absence of other integrated information and data do not constitute telehealth services. No face-to-face contact is required between a health care provider and a patient for services appropriately provided through telehealth.

"Telecommunications service" means the offering of transmission between or among points specified by a user, of information of the user's choosing, including voice, data, image, graphics, and video without change in the form or content of the information, as sent and received, by means of electromagnetic transmission, or other similarly capable means of transmission, with or without the benefit of any closed transmission medium, and does not include cable services.

Temporomandibular Joint (TMJ) Services

The Plan covers Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnostic treatment includes: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, and open or closed reduction of dislocations.

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

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis

and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

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

Transplantation Services

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

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

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

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

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Facility, Network facility that is not a Designated Facility or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Important Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Support in the event of serious illness

If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Travel and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD).
- Transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility.

Travel and Lodging Expenses

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

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the CHD service or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

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

- Airfare at coach rate.
- Taxi or ground transportation.
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

Support in the event of serious illness
If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Treatment of Gender Dysphoria (Gender Identity Disorder)

The Plan pays Benefits for the treatment of gender dysphoria (Gender Identity Disorder).

Non-Surgical Treatment of Gender Dysphoria

The Plan covers non-surgical treatment for gender dysphoria; the following non-surgical treatments are covered:

- **Psychotherapy** for gender dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section.
- **Continuous hormone replacement therapy** – hormones of the desired gender injected by a medical provider.

  Note: Coverage may be available for oral and self-injected hormones under the prescription drug products portion of your prescription drug plan.
- **Laboratory testing** to monitor the safety of continuous hormone therapy.

Surgical Treatment of Gender Dysphoria

The Plan covers surgical treatment for gender dysphoria; the following are covered when the eligibility qualifications for surgery are met below:

- **Genital surgery** and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) and related services.
  - The treatment plan must conform to identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance; and
  - For irreversible surgical interventions, the Covered Person must be age 18 years or older; and
  - Prior to surgery, the Covered Person must complete 12 months of successful continuous full-time real life experience in the desired gender.

Important Note: Certain Covered Persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the Covered Person's Physician, this will be determined on a case-by-case basis. Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

The Claims Administrator has specific guidelines regarding Benefits for treatment of gender dysphoria (Gender Identity Disorder). Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Benefits are limited to one gender transition per lifetime the entire period you are covered under the Plan.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Virtual Office Visits

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

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

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

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

Vision Examinations (For Dependent Children Age 18 and under)

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office every calendar year.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from chemotherapy or alopecia. Any combination of Network Benefits and Non-Network Benefits is limited to 1 wig per three calendar year period.

Women's Family Planning Services

The Plan pays Benefits for office visits, inpatient/outpatient services, lab and radiology tests, and counseling for women's family planning, including coverage for:

- Contraceptive devices (e.g., Depo-Provera and intrauterine devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.
- Surgical sterilization procedures for tubal ligation (excludes reversals).
- Abortion services (elective and non-elective procedures to the extent the procedure is legal under applicable law).

Benefits for preventive services are described under *Preventive Care Services* in this section.

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

SECTION 6 - OUTPATIENT PRESCRIPTION DRUG PLAN – OPTUMRX

What this section includes:

- Prescription Drugs for which the Plan pays Benefits.
- How to fill your prescriptions with retail, specialty and mail order pharmacies.
- Preventive care medications, prior authorization for certain drugs, supply limits and coordination of benefits.

The following Outpatient Prescription Drug Plan is administered by OptumRx Inc. OptumRx Inc. is a private, prescription drug benefit claims administrator for the Pharmacy Benefits described in this section.

Avnet, Inc. has entered into an agreement with OptumRx Inc., ("OptumRx") under which OptumRx will process eligible pharmacy expenses and provide certain other administrative services pertaining to the Pharmacy Plan. UnitedHealthcare does not insure or administer the pharmacy benefits described in this section.

Please read this section thoroughly to learn how the Pharmacy Plan works. If you have questions call the number on the back of your ID card.

Quick Reference Box

- Member services and claim inquiries, use the number on the back of your ID card or call 855-842-6337
- Pharmacy claims submittal address: OptumRx, Inc. P.O. Box 29044, Hot Springs, AR 71903
- Online assistance: **myuhc.com**

Pharmacy Benefits

Who Is Eligible for the Pharmacy Plan and How to Enroll

You must be covered under a medical plan sponsored by Avnet, Inc. and administered by UnitedHealthcare in order to participate in the Pharmacy Plan administered by OptumRx. You are enrolled in the Pharmacy Plan at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to participate in the Plan and enrollment information is described in the medical portion of this SPD, Section 2, *Introduction*.

Cost of Coverage

You and Avnet, Inc. share in the cost of the Plan; there is no additional charge to you for participation in the Pharmacy Plan.

Prescription Drug Product Coverage

For details of the Pharmacy Plan's Prescription Drug coverage levels, refer to Attachment III – *Plan Details*, which includes the Copayment/Coinsurance amounts that apply when you have a prescription filled at a Network Pharmacy. There is no coverage for a Non-Network Pharmacy.

Accessing Covered Pharmacy Benefits

As a Covered Person, to pay the least amount for covered Pharmacy Benefits you must get them from a Network pharmacy. Covered Pharmacy Benefits that are considered specialty medication must be obtained from OptumRx® Specialty Pharmacy. To obtain your covered Pharmacy Benefit, simply present your ID card to a Network pharmacy.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card (or access your ID on **myUHC.com** or the Health4You app) at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by OptumRx during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Pharmacy Plan as described in this section under the heading *Prescription Drug Benefit Claims*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment or Coinsurance, and any Deductible that applies.

Prescription Drug Products which Require Prior Authorization

In most cases, Network providers are responsible for obtaining prior authorization from OptumRx before they provide these services to you. Contacting OptumRx is easy. Simply call the number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Pharmacy Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Pharmacy Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

What to Do if You Have a Question or Complaint

Contact the telephone number shown on your ID card. OptumRx representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to OptumRx in writing, the OptumRx representative can provide you with the appropriate address.

If the OptumRx representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint.

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Pharmacy Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products. All Prescription Drug Products covered by the Pharmacy Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically (generally quarterly, but no more than four times per calendar year) based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **myuhc.com** or call OptumRx at the number on your ID card for the most current information.

Each tier is assigned a Copay/Coinsurance, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay/Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service. Here's how the tier system works:

- Tier-1 is your lowest Copay/Coinsurance option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay/Coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay/Coinsurance option. The drugs in tier-3 are usually more costly. Typically, there are alternatives available in tier-1 or tier-2.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge.

For Prescription Drugs at a retail Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copay/Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge that OptumRx agreed to pay the Network Pharmacy.

For Prescription Drugs from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copay/Coinsurance.
- The Prescription Drug Charge for that particular Prescription Drug.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, you will be directed to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see Section 14 *Glossary – Prescription Drugs* for a full description of Specialty Prescription Drug Product and Designated Pharmacy. A list of Specialty Prescription Drugs is posted on the Avnet intranet.

Retail

The Pharmacy Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting OptumRx at the number on your ID card or by logging onto **myuhc.com**.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Copay/Coinsurance. The Pharmacy Plan pays Benefits for certain covered Prescription Drugs:

- As written by a Physician.
- Up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copay/Coinsurance that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Important Note: Network Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach OptumRx at the number on your ID card.

The Pharmacy Plan pays mail order Benefits for certain covered Prescription Drugs:

- As written by a Physician.

- Up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Important Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Copay/Coinsurance for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Step Therapy

Step therapy is designed to promote the use of both clinical and cost effective Prescription Drugs, when appropriate, as the first step in a prescription treatment plan. If you have previously tried a Prescription Drug in the first step, you will be allowed to take a Prescription Drug on the second step. You will not need to request a prior authorization if you meet this criteria as the system will review your history at the time the claim is submitted. A list of Prescription Drugs subject to step therapy is posted on the Avnet intranet.

Preventive Care Medications

Benefits under the Pharmacy Plan include those for Preventive Care Medications as defined under Section 14 *Glossary - Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication by visiting **myuhc.com** or by calling OptumRx at the number on your ID card.

Designated Pharmacy

If you require certain Prescription Drugs, OptumRx may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Want to lower your out-of-pocket Prescription Drug costs?
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

OptumRx's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on OptumRx's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including,

but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than four times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Important Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please visit **myuhc.com** or call the number on your ID card for the most up-to-date tier status.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from OptumRx or its designee to determine if the Prescription Drug Product, in accordance with OptumRx's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary – Prescription Drugs*.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from OptumRx.

If you do not obtain prior authorization before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product.

You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Pharmacy Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from OptumRx before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) less the required Copayment and/or Coinsurance and any Deductible that applies.

To determine if a Prescription Drug Product requires prior authorization, either visit **myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring prior authorization are subject to OptumRx's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after OptumRx reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

OptumRx may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs at **myuhc.com** or by calling the number on your ID card.

Limitation on Selection of Pharmacies

If OptumRx determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, OptumRx may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 30 days of the date the Plan Administrator notifies you, OptumRx will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drug Products are subject to supply limits that may restrict the amount dispensed per Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit. To determine if a Prescription Drug Product has been assigned a maximum quantity level for dispensing, either visit **myuhc.com** or call the number on your ID card. Whether or not a Prescription Drug Product has a supply limit is subject to OptumRx's periodic review and modification.

Important Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and OptumRx have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Rebates and Other Discounts

OptumRx and Avnet, Inc. may, at times, receive rebates for certain drugs on the PDL. OptumRx does not pass these rebates on to you, nor are they taken into account in determining your Copay/Coinsurance.

OptumRx and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. OptumRx is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

OptumRx may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

Avnet, Inc. believes in giving you the tools you need to be an educated healthcare consumer. To that end, Avnet, Inc. has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the healthcare system.

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Avnet, Inc. are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You, your Spouse and Dependent child age 18 and over are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Avnet, Inc. has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take prescription drug products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Important Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Important Note: If you have a medical emergency, call 911 instead of logging onto **myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women between the ages of 40 and 68.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women between the ages of 20 and 64.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees age 65 and older.

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

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has 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 accurate, objective and relevant health care information.
- Coaching by a nurse through decisions in your treatment and care.
- Expectations of treatment.
- Information on high quality providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Choice Plus Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

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

myuhc.com

UnitedHealthcare's member website, **myuhc.com** , provides information at your fingertips anywhere and anytime you have access to the Internet. **myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **myuhc.com** you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.

- Search for Choice Plus Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine[SM] including Live Nurse Chat 24 hours a day, seven days a week.
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on myuhc.com
If you have not already registered as a **myuhc.com** subscriber, simply go to **myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- 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 **myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes[SM]

UnitedHealthcare provides a service called HealtheNotes[SM] to help educate members and make suggestions regarding your medical care. HealtheNotes[SM] provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes[SM] report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes[SM] report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health

and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

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

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.
- 24-hour access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. The program is designed to support you. This means that you may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- On-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content.
- Education on weight management and self-care strategies.
- Nutritional guidance and counseling by a health coach and registered dietician (if needed).
- Activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will more than double your chance of successfully quitting tobacco.

This six (6) month program offers:

- Home fulfillment of up to 8 weeks of over-the-counter nicotine replacement therapy, patches or gum.
- Toll free telephone access to a dedicated tobacco cessation coach (you will receive up to eight (8) scheduled coaching sessions and may place unlimited calls for support when you have a question).
- Help to identify and avoid common reasons why quit attempts fail, including weight gain and stress management.
- Educational articles, quizzes and progress tracking tools designed to provide support through this program.

Participation is completely voluntary, confidential, and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL/ PRESCRIPTION PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Plan Benefits*.

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

When Benefits are limited within any of the Covered Health Services categories, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items, or supplies that exceed these benefit limits.

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

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
2. Rolfing.
3. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 5, *Plan Benefits*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 5, *Plan Benefits*. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, 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 dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 5, *Plan Benefits*.

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 5, *Plan Benefits*.

4. Dental braces (orthodontics).

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

Devices, Appliances and Prosthetics

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

2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 5, *Plan Benefits*.

   Examples of excluded orthotic appliances and devices include but are not limited to, Copes scoliosis brace; foot orthotics and some type of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial banding unless used postoperatively for synostotic plagiocephaly.

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

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

6. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Plan Benefits*.
8. Oral appliances for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services 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 Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Plan Benefits*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes.
5. Shoe orthotics.
6. Shoe inserts.
7. Arch supports.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Plan Benefits*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Plan Benefits*.

- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 5, *Plan Benefits*.
- Urinary catheters.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section* 5, *Plan Benefits*.

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorder - Autism Spectrum Disorder* and/or *Substance Use Disorder Services* in Section 5, *Plan Benefits*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Health services or supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which UnitedHealthcare determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Plan under Section 5, *Plan Benefits* and Section 5, *Plan Benefits*.
   - Not otherwise excluded in this Plan under Section 8, *Exclusions and Limitations*.
3. Mental Health Services as treatments for R, T and Z code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, sexual dysfunctions, communication disorders, motor disorders, neurological disorders, and other disorders with a known physical basis.
5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
8. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
11. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.

12. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
13. Applied Behavior Analysis (ABA) treatment for Autism Spectrum Disorder as well as any treatments or other specialized services for that condition that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (except as may be specifically provided for under *Medical Foods* in Section 5, *Plan Benefits*).
2. Foods that are not covered include:
   - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.
3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidentals 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, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.

- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure.

   Important Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Plan Benefits*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss except for loss of hair resulting from chemotherapy or alopecia.

5. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Prescription Drugs

All other medical exclusions listed in Section 8 also apply to this subsection. When an exclusion applies to only certain Prescription Drug Products, you can access **myuhc.com** or

call the number on your ID card for information on which Prescription Drug Products are excluded.

Medications that are:

1. Pharmaceutical Products for which Benefits are provided in the medical portion of the Plan. This exclusion does not apply to immunizations administered in a Network pharmacy.
2. Available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to four times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3).
4. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered).
5. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
6. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
7. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
8. Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee.
9. Prescribed, dispensed or intended for use during an Inpatient Stay.
10. Prescribed for appetite suppression, and other weight loss products.
11. Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that OptumRx and Avnet, Inc. determine do not meet the definition of a Covered Health Service.
12. Prescription Drug Products that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
13. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.
14. Typically administered by a qualified provider or licensed health professional in an outpatient setting.

15. Unit dose packaging of Prescription Drug Products.
16. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, or used for purposes other than those approved by the Food and Drug Administration (FDA).
17. Used for Cosmetic purposes.
18. Used to enhance athletic performance.
19. Replacement of Prescription Drugs due to loss or theft.
20. Immunizations and medications used for travel prophylaxis.

Procedures and Treatments

1. Biofeedback.
2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
4. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
5. Speech therapy to treat stuttering, stammering, or other articulation disorders.
6. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 5, *Plan Benefits*.
7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
8. Psychosurgery (lobotomy).
9. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
10. Chelation therapy, except to treat heavy metal poisoning.
11. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
12. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery and Services* in Section 5, *Plan Benefits*.
13. Medical and surgical treatment of excessive sweating (hyperhidrosis).

14. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.
15. 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 as part of *Treatment of Gender Dysphoria* for which Benefits are described in Section 5, *Plan Benefits*. This exclusion also does not apply to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 5, *Plan Benefits*.
16. General population-based Genetic Testing performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.

Providers

1. Services performed by a provider who is your Spouse, parent or child (by birth or marriage). This includes any service the provider may perform on himself or herself.
2. Services ordered or delivered by a Christian Science practitioner.
3. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

Reproduction

1. The following infertility treatment-related services:
   - Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
   - Donor services and Non-medical costs of oocyte or sperm donation (e.g., donor agency fees).
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
   - All costs associated with surrogate motherhood; non-medical costs associated with a gestational carrier.
   - Ovulation predictor kits.
2. Surrogate parenting (unless surrogate is a Covered Person), donor oocytes (eggs), donor sperm and host uterus.
3. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
4. The reversal of voluntary sterilization.
5. Any services or supplies for the treatment of male or female sexual dysfunction such as treatment of erectile dysfunction, anorgasmy, and premature ejaculation except as otherwise specifically provided herein.

6. Medical and Hospital care and costs for the infant child of a Dependent, unless the infant child is otherwise eligible under the Plan.

Important Note: See eligibility requirements under *Infertility Services* in Section 5, *Plan Benefits*.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*.
2. While on active military duty.
3. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5*, Plan Benefits* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).
3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Plan Benefits*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Plan Benefits*.

Treatment of Gender Dysphoria (Gender Identity Disorder)

1. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
2. Sperm preservation in advance of hormone treatment or gender surgery.
3. Cryopreservation of fertilized embryos.
4. Voice modification surgery.
5. Facial feminization surgery, including but not limited to: facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures.

6. Treatment received outside of the United States.

Types of Care

1. Custodial Care or maintenance care as defined in Section 14, *Glossary* or maintenance care.
2. Domiciliary Care, as defined in Section 14, *Glossary*.
3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
4. Private Duty Nursing received on an inpatient basis.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Plan Benefits*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.
3. Bone anchored hearing aids except when either of the following applies:
   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.
4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.
2. Charges for:
   - Missed appointments.

- Room or facility reservations.
- Completion of claim forms.
- Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.
4. Diagnostic tests that are:
   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.
5. Expenses for health services and supplies:
   - That are received as a result of war or any act of war, whether declared or undeclared (to the extent permitted by law), while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including Covered Health Services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.
   - For which a provider waives the Copayment, Deductible, and/or Coinsurance amount(s).

Fee Forgiveness
The Plan excludes payment for any charges for which you are not obligated to pay or for which you are not billed (or would not have been billed) except that they were covered under this Plan. For example, if UnitedHealthcare determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Health Service (as shown in the attached Schedule of Benefits for your plan option) without United Healthcare's express consent, then UnitedHealthcare in its sole discretion shall have the right to deny the payment of Benefits in connection with the Covered Health Service, or reduce the Benefits in proportion to the amount of Copayment, Deductible, and/or Coinsurance amounts waived, reduced, or forgiven, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, UnitedHealthcare shall have the right to require you to provide proof sufficient to UnitedHealthcare that you have made your required cost share payment(s) prior to the payment of any Benefits by UnitedHealthcare. This exclusion includes charges of a non-Network provider who has agreed to charge you or charged you at a Network Benefits level or some other Benefits level not otherwise applicable to the Covered Health Services received.

6. Foreign language and sign language services.
7. Long-term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

   - Medically Necessary.
   - Described as a Covered Health Service in this SPD in Section 5, *Plan Benefits*.
   - Not otherwise excluded in this SPD under this Section 8, *Exclusions and Limitations*.

9. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

10. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Plan Benefits*.
    - Related to judicial or administrative proceedings or orders.
    - Required to obtain or maintain a license of any type.

11. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment, **unless** deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or if the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition, or if reconstructive jaw surgery is required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

12. Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.

13. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery. Also excluded is any blood administration for the purpose of general improvement in physical condition.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

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

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

Non-Network Benefits

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

If Your Provider Does Not File Your Claim

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

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

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

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

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews, only as they relate to the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. Except as provided above, the Plan will not treat an assignee as having stepped into the shoes of a Covered Person. For example, an assignee does not have the right to request documents governing the Plan, unless an assignee is the Covered Person's authorized representative. If an assignment form does not comply with the requirements of the first sentence above, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Avnet, Inc. reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Avnet, Inc. pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Payment of Benefits

If Benefits are paid to you or your Dependent, you are responsible for reimbursing the Provider. If any person to whom Benefits are payable is a minor or, in the opinion of the Plan Administrator, is not able to give a valid receipt for any payment due him, such payment will be made to his/her legal guardian. If no request for payment has been made by

his/her legal guardian, the Plan Administrator may, at its option, make payment to the person or institution appearing to have assumed his/her custody and support.

If you die while any of these Benefits remain unpaid, the Claims Administrator may choose to make direct payment to any of your following living relatives: Spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate. Payment as described above will release the Plan from all liability to the extent of any payment made.

If a check is not cashed or deposited within 12 months after the check is issued, the check will be canceled and the Benefits will be forfeited. Similarly, if the Claims Administrator is not able to provide Benefits because the recipient's whereabouts cannot be ascertained after reasonable efforts (for example, a letter to the recipient's last known address is returned as undeliverable), all Benefits due to the individual will be forfeited 12 months after the unprovided Benefits first became due.

Health Statements

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

If you would rather track claims for yourself and your covered Dependents online, you may do so at **myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

After your claim is processed by UnitedHealthcare, you can view and print all of your Explanation of Benefits (EOB) online at myuhc.com. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

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

Medical Claim Denials and Appeals - UnitedHealthcare

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot

resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation, evidence, testimony, or other written information to support your request.

You or your authorized representative must send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740816
Atlanta, Georgia 30374-0816

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal and will take into account all comments, documents, records, and other information that you submit, regardless of whether the information was considered in the initial benefit determination. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination, nor was the subordinate of any such individual.
- A health care professional with appropriate expertise who was not consulted, nor was the subordinate of any such individual, during the initial benefit determination process.

If the Plan obtains advice from a health care professional, you shall have the right to request the identification of such individual(s).

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. In the case of urgent care and preservice claims, UnitedHealthcare will further notify you if it reverses the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Important Note: Upon written request and free of charge, any Covered Persons may examine documents, records, and other information relevant to their claim and/or appeals and submit opinions and comments. In addition, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with a claim, as soon as possible and sufficiently in advance of the due date for the notice of final internal adverse benefit determination so that you will have a reasonable opportunity to respond prior to the due date. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to adhere to applicable regulations or requirements for internal claims and appeals (except for de minimis violations), you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based on medical judgment, including 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 set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.

- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

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

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within five business days after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- The adverse benefit determination or final adverse benefit decision does not relate to your failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review within one business day, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.

- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

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

Expedited External Review

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

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets 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.
- The adverse benefit determination or final adverse benefit decision does not relate to your failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.

- Has provided all the information and forms required so that UnitedHealthcare may process the request.

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

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

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the 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 Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours (unless your request for Benefits is incomplete)****
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

**If your request for Benefits is incomplete, UnitedHealthcare must notify you of the benefit determination within: 48 hours after the earlier of: (1) receiving the specified information, or (2) the end of the period afforded to you to provide the specified additional information.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare 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
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare 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**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Prescription Drug Benefit Claims – OptumRx

If you receive Covered Health Services from a Network Pharmacy, the Pharmacy Plan pays Network pharmacies directly for your Covered Health Services. If a Network Pharmacy bills you for any Covered Health Service, contact OptumRx. However, you are responsible for meeting any applicable deductible and for paying any required Copayments or Coinsurance to a Network Pharmacy at the time of service, or when you receive a bill from the Network Pharmacy.

If You Receive Prescription Drug Products from a Non-Network Pharmacy

When you receive Prescription Drug Products from a non-Network Pharmacy, you are responsible for requesting payment from the Pharmacy Plan. You must file the claim in a format that contains all of the information required, 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 within one year of the date of service, Benefits for that health service will be denied or reduced, in OptumRx's discretion. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of Benefits from the Pharmacy Plan, you must provide OptumRx with all of the following information:

- The Participant'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 the Pharmacy.
- An itemized bill from your provider that includes the following.
  - Pharmacy name and address.
  - Date of service.
  - Physician name or ID number.
  - NDC number (drug number).
  - Name of drug and strength.
  - Quantity and days' supply.
  - Prescription number.
  - Dispense-as-written instructions.
  - Amount paid.
  - 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 insurance 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 your claim to OptumRx, at the following address:

OptumRx, Inc.
P.O. Box 29044
Hot Springs, AR 71903

Prescription Claims Denials and Appeals – OptumRx

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after Prescription Drug Products have been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving Prescription Drug Products.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact OptumRx in writing to formally 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 service(s).
- The Pharmacy name and address.
- The Physician name or ID number.
- The reason you believe the claim should be paid.
- Any documentation, evidence, testimony, or other written information to support your request for claim payment.

You or your authorized representative must send a written request for an appeal to:

OptumRx c/o Appeals Coordinator
CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626
Fax: 877-239-4565

Your first appeal request must be submitted to OptumRx within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in (or a subordinate to a person involved in) the decision being appealed will be appointed 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 appropriate expertise in the field, who was not involved in (or a subordinate to a person

involved in) the prior determination. OptumRx may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent 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 relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by OptumRx during the determination of the appeal, OptumRx will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided a written notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as identified above, the appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

Please note that OptumRx's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from OptumRx within 60 days from receipt of the first level appeal determination.

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 OptumRx's decision letter to you.

For additional details on *Independent Review Organization (IRO)*, please refer to information under the heading*, Federal External Review Program,* in this section.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly 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 OptumRx as soon as possible.
- OptumRx 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 OptumRx needs more information from your Physician to make a decision, OptumRx 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.

Legal Action

Under ERISA, subject to the limitations described below, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals process. Before bringing an action, you must have completed all levels of internal appeals, but you are not required to have submitted your claim for external review to the IRO before you may bring a civil action. In most instances, you may not initiate a legal action against Avnet, Inc., the Claims Administrator, or any of their affiliates until you have completed the internal appeal process. You also have the right to bring a civil action under section 502(a) of ERISA after you submit the Plan's denial of your appeal for external review and the Plan's decision is upheld by the IRO.

Arbitration

To the extent permitted by law, any controversy other than a claim or appeal between an Employer or the Plan and any Covered Person (or any legal representative acting on behalf of one or more Covered Person under the Plan), arising out of or in connection with the Plan, must be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within the 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his/her (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

Period for Bringing a Legal Action/Governing Law

No legal action (including filing a lawsuit or seeking arbitration) may be brought against the Plan, an Employer, the Claims Administrator or any of their affiliates in connection with the Plan, after the earlier of: (A) 12 months after the date when a Covered Person has completed the internal appeal process under the Plan or (B) 24 months after the Covered Person was notified in writing that the Plan will not cover all or a portion of the claimed benefits that are the subject of the legal action.

If the 24-month period would otherwise expire while a Covered Person is still actively seeking resolution of a claim through the Plan's appeal process, it will be extended for an additional 90 days until the internal appeal process has been completed. If you miss the Plan's deadline for filing any required claim or appeal, you will forfeit your right to bring a legal action. If the 24-month period would otherwise expire while a Covered Person has a claim pending before the IRO, the time limit will be extended until 90 days after the IRO makes its decision.

This Plan shall be interpreted in accordance with the laws of the State of Arizona (disregarding any conflicting rules that might point to the laws of another jurisdiction) to the extent that those laws are not superseded by federal law. In general, ERISA preempts state laws that relate to the Plan.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- 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.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that

pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- The parents are married or living together whether or not they have ever been married and not legally separated.
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

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

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

Determining the Allowable Expense If This Plan is Secondary

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

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

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent 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:

- Individuals with current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their disabled 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 Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

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

this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare 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 Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan but excluding the Avnet Pension Plan and the Avnet 401(k) Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare 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 a Covered Person, that Covered Person, 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 the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- 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, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does 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, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will 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.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be 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 a third party is alleged to be 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 a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

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

The following persons and entities are considered third parties:

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

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of 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 your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

■ The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any 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, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

■ Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

■ Benefits paid by the Plan may also be considered to be Benefits advanced.

■ If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust

account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

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

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

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

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

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

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

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

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends at midnight on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Avnet, Inc. will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends.
- The date the Plan is terminated.
- The date of your death.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible (e.g., one year of consecutive medical leave).
- The last day of the month UnitedHealthcare receives written notice from Avnet, Inc. to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from Avnet, Inc. to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.
- The last day of the month following the month of your death.

Cancellation of Coverage for Submitting False Claims

If a Covered Person submits a false or fraudulent Plan claim, or knowingly participates in a transaction or arrangement with others that leads to the submission of a false or fraudulent Plan claim by others (such as a medical service provider), the Plan reserves the right to revoke coverage under the Plan for that individual and any related Covered Person, Dependent and Employee. Any decision made to revoke Plan coverage may apply retroactively and will be determined by the Avnet Executive Board (AEB). A person whose coverage under the Plan was revoked may appeal the decision to the AEB. The AEB will

also decide if, and when, coverage may resume under the Plan or another group medical plan sponsored by the Company.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

Important Note: If UnitedHealthcare, OptumRx, and/or Avnet, Inc. find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact Avnet, Inc. has the right to rescind coverage and demand that you pay back all Benefits Avnet, Inc. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. Submitting a false, fraudulent, or misleading claim may be a crime punishable by fines or prison.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to Avnet, Inc. proof of the child's incapacity and dependency within 30 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon Avnet, Inc.'s request, that the child continues to meet these conditions.

The proof might include medical examinations at Avnet, Inc.'s expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 30 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuation Coverage under State Law

If coverage stops because the Employee is hospitalized or otherwise prevented by Sickness from working, the Employee may continue the health coverage then in effect. The Employee will have to make payments to the Company for the coverage. These payments will not exceed the amount that the Employee was paying before becoming hospitalized or disabled by Sickness. Coverage will continue while the Plan is in force. It will stop on the later of the following, so long as the Employee makes payments for the coverage:

- Three months following the month in which the Employee became hospitalized or otherwise prevented by Sickness from working.

- The period for which the Company undertakes the payment of the Employee's regular wages.

See *Leave of Absence or Disability* section below for more details.

Leave of Absence or Disability

If your Active Service ends due to a leave of absence or disability (such as Injury or Sickness), your coverage may continue as follows:

- Medical leave – While you are totally and continuously disabled as a result of Injury or Sickness, until the earlier of (a) the last day of the month after the first anniversary of the start of your leave, or (b) the last day of the month after the termination of your employment; or
- Family and Medical Leave Act (FMLA) – Up to a maximum of 12 weeks for a qualifying FMLA leave. For more details, see "Family and Medical Leave Act of 1993 (FMLA)," below; or
- Military Leave – Up to two years. For more details, refer to "Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)," below; or
- Personal Leave, including vacation, short-term sick leave, and other PTO – Up to the maximum approved by your manager.

Under no circumstances will coverage under the Plan continue past the date specified by the Company, unless required by applicable law.

You must continue paying required contributions for Plan coverage during any absence. If you are eligible for benefits during an unpaid leave, you have the option to pre-pay, pay as you go, or pay upon your return from a covered unpaid leave. Please contact the Benefits department at 800-882-8638, option #4, for more information and to arrange for payment during an unpaid leave.

Family and Medical Leave Act of 1993 (FMLA)

Special rules apply if you take a leave for family or medical reasons that qualifies for protection under the FMLA.

Continuation of Health Coverage During Leave

Your Plan coverage will be continued during a leave of absence if:

- that leave qualifies for protection under the FMLA; and
- you are an eligible Employee under the FMLA.

The cost of your Plan coverage during such leave is shared by you and your Employer. You have the option to pre-pay, pay as you go, or pay upon your return from leave. Please contact the Benefits department at 800-882-8638, option #4, to arrange payment of your continued health coverage.

Reinstatement of Canceled Coverage Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the FMLA, any canceled coverage (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period, to the extent that they had been satisfied prior to the start of such leave of absence.

More information about the FMLA is posted on the Avnet Benefits intranet.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. Avnet, Inc. is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- An Employee.
- An Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law.
- An Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage*	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below

If the Company files for bankruptcy under Title 11 of the United States Code and there is substantial elimination of coverage within one year before or after the date the bankruptcy was filed, a retiree Qualified Beneficiary is entitled to COBRA coverage for life. A Qualified Beneficiary who is the spouse or dependent child of the retiree Qualified Beneficiary is also entitled to COBRA coverage for the life of the retiree, or if later, for 36 months after the retiree's death.

*Subject to the following conditions: (i) notice of the disability must be provided to the Plan Administrator or its designee within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator or its designee within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.

- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator or its designee when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator or its designee of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 30 days of marriage, or the birth or adoption of a child.

Once you have notified the Plan Administrator or its designee, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Plan Administrator or its designee with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator or its designee. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan terminates.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Uniformed Services Employment and Reemployment Rights Act

Special rules apply if you take a military leave that qualifies for protection under USERRA. The requirements summarized below apply only to coverage for you and your Dependents under this Plan. (Different rules apply for other benefits.)

For more information about whether a leave will be treated as a "qualified military leave" or about your rights under USERRA, please refer to the military leave policy posted on the Avnet Benefits intranet.

Continuation of Plan Coverage

For qualified military leaves of 30 days or less, Plan coverage will continue as if you remained in Active Service. You will have to pay for the Employee portion of Plan coverage for you and your Dependents.

After 30 days, Plan coverage for yourself and your Dependents will continue unless you notify the Company that you are going on qualified military leave and request that your Plan coverage be discontinued. You will have to pay for the Employee portion of Plan coverage for you and your Dependents.

The Company will use rules similar to those that apply under the COBRA Continuation Coverage rules (described above) for purposes of determining whether you have made timely required monthly payments for Plan coverage.

You may continue coverage during a qualified military leave until the earliest of the following:

- the second anniversary of your last day of Active Service with the Company;
- the day after the deadline by which you must return to work with the Company in order to qualify for USERRA protection, if you do not return to work with the Company by that deadline;
- the first day of a month for which your Plan coverage payment is late by more than 30 days;
- the date that your coverage would otherwise terminate under the Plan (such as for submitting a fraudulent claim); or
- the date the Company terminates all its group medical plans.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you elect not to continue coverage as permitted by USERRA (or because you do not elect an available conversion plan at the expiration of USERRA coverage) and you are reemployed by the Company, coverage for you and your Dependents may be reinstated if (a) you gave the Company advance written or verbal notice of your qualified military service leave, (b) your qualified military leave was for not more than 5 years, and (c) you return to work with the Company before your USERRA rights expire.

You and your Dependents will be subject to only the balance of any waiting period that was not yet satisfied before the leave began.

If your coverage under this Plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service starts, these reinstatement rights will continue to apply.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and Avnet, Inc.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree, or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, the child covered by the QMCSO will be eligible for the coverage required by the order. You must notify the Company and elect coverage for that child, and yourself if you are not already enrolled, within 30 days after the QMCSO is qualified by the Plan.

Generally, a QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan.

Any payment of benefits in reimbursement for Covered Health Services paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child. You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Important Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Avnet, Inc.

In order to make choices about your healthcare coverage and treatment, Avnet, Inc. believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Avnet, Inc. and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Avnet, Inc. and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Avnet, Inc. and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Avnet, Inc., UnitedHealthcare and Choice Plus Network providers are solely contractual relationships between independent contractors. Network providers are not Avnet, Inc.'s agents or employees, nor are they agents or employees of UnitedHealthcare. Avnet, Inc. and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

Avnet, Inc. and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Avnet, Inc. and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Avnet, Inc.'s employees nor are they employees of UnitedHealthcare. Avnet, Inc. and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Avnet, Inc. and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Avnet, Inc. is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.

- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Interpretation of Benefits

Avnet, Inc. and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Avnet, Inc. and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Avnet, Inc. may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Avnet, Inc. does so in any particular case shall not in any way be deemed to require Avnet, Inc. to do so in other similar cases.

Information and Records

Avnet, Inc. and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Avnet, Inc. and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Avnet, Inc. and UnitedHealthcare will keep this information confidential. Avnet, Inc. and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Avnet, Inc. and UnitedHealthcare with all information or copies of records relating to the services provided to you. Avnet, Inc. and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have electronically signed the Employee's enrollment form in Workday. Avnet, Inc. and UnitedHealthcare agree that such information and records will be considered confidential.

Avnet, Inc. and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Avnet, Inc. is required to do by law or regulation. During and after the term of the Plan, Avnet, Inc. and UnitedHealthcare

and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Avnet, Inc. recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Avnet, Inc. and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Avnet, Inc. recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Avnet, Inc. and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for

those drugs that are administered to you before you meet your Annual Deductible. Avnet, Inc. and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Medical Benefits

Active Service – You will be considered in Active Service:

- On any of your Employer's scheduled work days if you are performing the regular duties of your work on that day.
- On a day that is not one of your Employer's scheduled work days (e.g., a weekend or holiday) if you were in Active Service on your employer's last preceding scheduled work day.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

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

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in Attachment III – *Plan Details*.

Assisted Reproductive Technology (ART) - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).

- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

BMI - see Body Mass Index (BMI).

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

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates (e.g., OptumRx), who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company - Avnet, Inc.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copay - the charge, stated as a flat dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

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

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Benefits*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions*.

Covered Person - either the Employee 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-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. The term child means a child born to you, a child legally adopted by you, a child for whom you are a legal guardian, or a stepchild.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Facility - a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Physician - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

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

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

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, which is both of the following:

- Arises suddenly.

- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employee - an Employee of the Employer who is currently in Active Service and resides in Hawaii, is an eligible full-time, part-time, on-call or temporary Employee; and has worked at least 20 hours per week for four consecutive weeks.

An eligible Employee does not include any employee who:

- is classified by the Employer as a leased employee or independent contractor;
- is part-time and works an average of less than 20 hours per week for the Employer;
- is employed by a business unit or division that is not eligible to participate in the Plan; or
- does not have U.S.-source income.

If an individual who is classified as ineligible is subsequently reclassified (e.g., an individual classified as an independent contractor is reclassified as an employee), the reclassification will apply prospectively only. Reclassification, whether by Avnet, a court, or otherwise, shall not result in retroactive coverage for any individual.

Employer - Avnet, Inc. or an Avnet company that has been designated as a participating employer. As of January 1, 2016, the only Employer other than Avnet, Inc. is Avnet Government Solutions, LLC.

EOB - see Explanation of Benefits (EOB).

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

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

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

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Plan Benefits*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Plan Benefits,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Copays.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

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

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

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

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

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

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

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **UnitedHealthcareOnline.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator - the organization or individual designated by Avnet, Inc. who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. 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 a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network

providers. Refer to Section 5, *Plan Benefits* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by Avnet, Inc., during which eligible Employees may enroll themselves and their Dependents under the Plan. Avnet, Inc. determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - the Out-of-Pocket Maximum is the maximum amount you pay every calendar year for medical and pharmacy services combined. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works and refer to the Schedule of Benefits for your plan option.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Important Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Avnet, Inc. Hawaii Medical Plan, which is offered as part of the Avnet Group Benefits Plan.

Plan Administrator - Avnet, Inc. or its designee.

Plan Sponsor - Avnet, Inc.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Primary Care Physician (PCP) - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice, or general medicine, and who has been selected by you to provide or arrange for medical care for you or any of your covered Dependents.

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

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.

- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

SCHIP - See State Children's Health Insurance Program (SCHIP).

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Benefits*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by Non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse - a Spouse, for purposes of the Plan, is an individual to whom an Employee is lawfully married. In accordance with IRS Revenue Ruling 2013-17, an individual to whom an Employee is married will be recognized as the Employee's Spouse if (and only if) the marriage to that individual was legal and valid when it was entered into, under the laws of the jurisdiction where it was entered into.

A Spouse does not include a domestic partner or a partner through civil union or other similar formal relationship that is not treated as a marriage under applicable state law.

State Children's Health Insurance Program (SCHIP) - a state program for children's health insurance established under Title XXI of the Social Security Act of 1965, as amended.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Care - Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

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

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **myuhc.com**.

Important Note: If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition. The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- Do not require an appointment.
- Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends.
- Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

Prescription Drugs

Brand-name - a Prescription Drug Product that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer.
- Identified by OptumRx as a Brand-name product based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by OptumRx.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Prescription Drug Products.

Copay - the charge, stated as a dollar amount, that you are required to pay for certain Prescription Drug Products.

Designated Pharmacy - a pharmacy that has entered into an agreement with OptumRx or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product that is either:

- Chemically Equivalent to a Brand-name drug.
- Identified by OptumRx as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by OptumRx.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with OptumRx or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by OptumRx as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by OptumRx's PDL Management Committee.
- December 31 of the following calendar year.

PDL - see **Prescription Drug List (PDL)**.

PDL Management Committee - see **Prescription Drug List (PDL) Management Committee**.

Prescription Drug Charge - the rate OptumRx has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to OptumRx's periodic review and modification (generally quarterly, but no more than four times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting OptumRx at the number on your ID card or by logging onto **myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that OptumRx designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, only be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Pharmacy Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- 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 (e.g., generic contraceptive prescriptions) and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication by visiting **myuhc.com** or by calling OptumRx at the number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by visiting **myuhc.com** or by calling the number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile. Therapeutically Equivalent Prescription Drug Products with similar uses and/or actions may be grouped into therapeutic classes.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under *ERISA*.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by *ERISA* as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Avnet, Inc. is the Plan Sponsor and Plan Administrator of the Avnet Group Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
Avnet, Inc.
2211 S 47th St.
Phoenix, AZ 85034
800-882-8638, Option #4

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator (Medical Benefits only) for Covered Persons who reside within the United States.

The role of UnitedHealthcare is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative services agreement with the Company. UnitedHealthcare shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. UnitedHealthcare shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact UnitedHealthcare by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

OptumRx is the Plan's Claims Administrator (Prescription Drug Benefits only) for Covered Persons who reside within the United States.

The role of OptumRx is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative services agreement with the Company. OptumRx shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. OptumRx shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact OptumRx by phone at the number on your ID card or in writing at:

OptumRx, Inc.
P.O. Box 29044
Hot Springs, AR 71903

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Medical/Prescription Plan
Avnet, Inc.
2211 S 47th St.
Phoenix, AZ 85034

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by *ERISA*.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third-party administrators.

Plan Name:	Avnet Group Benefits Plan
Plan Number:	510
Employer ID:	11-1890605
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	General assets of the Company

Collective Bargaining Agreements

The Plan is not currently maintained pursuant to a collective bargaining agreement. For more information, please contact the Plan Administrator.

Discretionary Authority

The Plan Administrator has discretionary authority to interpret the terms of the Plan, including to resolve ambiguities and inconsistencies. The Plan Administrator delegates to

UnitedHealthcare and OptumRx the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with their review of claims under the Plan. Such discretionary authority is intended to include the determination of the eligibility of persons desiring to enroll in or claim benefits under the Plan, the determination of whether a Covered Person is entitled to benefits under the Plan, and the computation of any and all Benefit payments. The Plan Administrator also delegates to UnitedHealthcare and OptumRx the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his/her duly authorized representative.

Privilege

Avnet and the Plan Administrator may engage attorneys, accountants, actuaries, consultants, and others to advise them on issues related to the Plan. When they do so, the advisor's client is Avnet or the Plan Administrator, as applicable, and not any Covered Person or other individual. Communications between an attorney and a client are "privileged," which means that they may not be disclosed to third parties unless the client waives the privilege. Avnet and the Plan Administrator intend and expect to preserve this attorney-client privilege, and all other rights to maintain confidentiality, to the full extent permitted by law. No Covered Person or other individual will be permitted to review any communications between Avnet or the Plan Administrator (including any of their representatives, agents, or delegates) and any of their attorneys or other advisors with respect to whom a privilege applies, unless mandated by a court order.

Plan Modification, Amendment and Termination

The Company as Plan sponsor reserves the right, at any time, and for any reason, to change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of Employees may be changed or terminated, and by which part or all of the Plan may be terminated, is through the unilateral action of the Avnet Executive Board (AEB) or the Board of Directors of the Company. No consent of any Member is required to terminate, modify, amend or change the Plan. Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any Covered Expenses incurred or approved prior to the date the Plan terminates.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under *ERISA*. *ERISA* provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all documents governing the Plan—including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining

agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue healthcare coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.

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

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court within the timeframe set forth under the Plan. See Section 9, *Claims Procedures*, under the heading *Bringing a Legal Action/Governing Law*. 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 Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the *Employee Benefits Security Administration* at 866-444-3272.

The Plan's Benefits are administered by Avnet, Inc., the Plan Administrator. UnitedHealthcare and OptumRx are the Claims Administrators and process claims for the Plan and provide appeal services; however, UnitedHealthcare, OptumRx, and Avnet, Inc. are not responsible for any decision you or your Dependents make to receive treatment, services, or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare, OptumRx and Avnet, Inc. are neither liable nor responsible for the treatment, services, or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTHCARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card or visit **myuhc.com**.

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

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

Requirement to Have Qualifying Healthcare Coverage

Federal law requires most individuals to have healthcare coverage or pay a tax called a "shared responsibility payment." There are limited exceptions that are not addressed in this document. For more information, see the instructions for IRS Form 8965 (available through **irs.gov**). If you enroll in this Plan, you will satisfy the requirements for qualifying healthcare coverage.

ATTACHMENT II - LEGAL NOTICES

Effect of Section 125 on This Plan

Section 125 of the Internal Revenue Code allows you to make premium payments on a pre-tax basis (subject to certain exceptions), provided that the Plan complies with certain requirements. The Plan is subject to those requirements, which are described below.

Coverage Elections

You are generally allowed to enroll for coverage only within 30 days of your date of hire or change coverage only during the annual Open Enrollment period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

- the date you meet the HIPAA special enrollment criteria described below; or
- the date you qualify to make a change under one of the following sections.

Change in Status

The Section 125 rules allow new enrollment or coverage elections in response to (and consistent with) any of the following changes in status:

- change in legal marital status due to marriage, death of a Spouse, divorce, annulment, or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, legal guardianship of a child, or death of a Dependent;
- change in employment status of you, your Spouse, or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- change in employment status of you, your Spouse, or Dependent resulting in eligibility or ineligibility for coverage (e.g., reduction in hours), as long as the change corresponds to your intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage;
- change in residence of you, your Spouse, or Dependent to a location outside of the Employer's network service area;
- change that causes a Dependent to become eligible or ineligible for coverage;
- change in employment status that causes the average number of hours that you are expected to work to decrease below 30 hours of service per week, and you certify that you (and your Spouse and Dependent, if applicable) will enroll in other minimum essential coverage that is effective by the first day of the second month after the month in which your drop your medical coverage; and
- if you are eligible to enroll in Exchange coverage during a special or open enrollment period, you may drop your coverage, as long as you certify that you (and your Spouse and Dependent, if applicable) will enroll in Exchange coverage that is effective the day after you drop your medical coverage.

Court Order

You may make a change in coverage in order to comply with a court or administrative order (e.g., Qualified Medical Child Support Order; see Section 13 *Other Important Information*).

Medicare or Medicaid Eligibility/Entitlement

You, your Spouse or Dependent may cancel or reduce coverage due to entitlement to Medicare or Medicaid, or enroll or increase coverage due to loss of Medicare or Medicaid eligibility.

Changes to Coverage

If the cost of benefits increases or decreases during a benefit period, the Company may automatically change your elective contribution. When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the Plan of your Spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to special enrollment, change in status, court order, or Medicare or Medicaid eligibility/entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

Group Plan Coverage Instead of Medicaid

If you qualify for Medicaid (which generally means your income and other liquid resources do not exceed certain limits established by law), the state may decide to pay premiums for coverage under the Plan instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Group Plan Coverage Instead of SCHIP

If you qualify for assistance under SCHIP, the state may offer you the option to receive premium assistance subsidies to purchase coverage under this Plan (or another group medical option under the Avnet Group Benefits Plan) in lieu of or in addition to coverage under SCHIP. If SCHIP premium assistance subsidies are available in your state, the Plan will notify you.

Newborns' and Mothers' Health Protection Act

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

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

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

Privacy Rights under the Health Insurance Portability and Accountability Act ("HIPAA")

The Plan is required to provide you with a notice that describes your rights and the Plan's obligations regarding your "protected health information." Generally, "protected health information" is individually identifiable health information, including demographic information, collected from you or created or received by a healthcare provider, a healthcare clearinghouse, the Plan, or your employer on behalf of the Plan. You were provided with a copy of the Plan's Notice of Privacy Policies when you first enrolled in the Plan and you will be provided with a copy following any material revisions to the Plan's privacy policies. You can also request a copy of the Notice of Privacy Policies at any time by contacting the Plan Administrator listed in *Section 15 – Important Administrative Information*. The Plan amendment relating to disclosure of individually identifiable information to a Plan Sponsor is set forth in *Attachment VIII* of this booklet.

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you and/or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option (e.g., change from Employee only to Employee + Dependent coverage). If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). The special enrollment events are as follows:

- If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, or legal guardianship of a child, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; Employee and Spouse; Employee and Dependent child(ren); Employee, Spouse and Dependent child(ren). Enrollment of Dependent children includes newborn or adopted children or children who became your Dependent children due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- If coverage was declined under this Plan due to coverage under another plan (excluding COBRA continuation coverage), and eligibility for the other coverage is lost, you and your eligible Dependent(s) may request special enrollment in this Plan. This provision applies to loss of eligibility as a result of any of the following:
    - divorce or legal separation;
    - cessation of Dependent status (such as reaching the limiting age);
    - death of the Employee;
    - termination of employment;
    - reduction in work hours to below the minimum required for eligibility;

  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.

- If an employer terminates contributions toward group health coverage, other than COBRA continuation coverage, for you or a dependent, the termination of contributions is a special enrollment event. However, termination of employer contributions toward COBRA continuation coverage is not a special enrollment event.
- Special enrollment may be requested due to loss of coverage under another plan only after exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is also considered to have exhausted COBRA or other continuation coverage if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- If you or your eligible Dependent(s) are covered under Medicaid or SCHIP and such coverage is terminated as a result of loss of eligibility for the coverage, you and your eligible Dependent(s) may request special enrollment in this Plan.
- If you or your Dependent(s) are not enrolled in one of the group medical options under the Avnet Group Benefits Plan and become eligible for premium assistance from Medicaid or SCHIP for the purchase of coverage under this Plan, you and your eligible Dependent(s) may request special enrollment in this Plan.

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. However, if the special enrollment event is the termination of Medicaid or SCHIP coverage or the eligibility for premium assistance under Medicaid or SCHIP, the 30-day period is extended to 60 days.

Individuals who timely enroll in the Plan due to a special enrollment event will not be denied enrollment. However, if you miss the deadline, you may not enroll until the next Open Enrollment period (or you have another change in status, as described above).

Women's Health and Cancer Rights Act of 1998

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

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

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

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

ATTACHMENT III – PLAN DETAILS

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.
- Pharmacy Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts
Calendar Year Deductible (combined Medical/Pharmacy) ■ Individual. ■ Family. Family member claims are covered under the Plan Coinsurance starting after the earlier of (a) the individual family member satisfying the individual Deductible or (b) the family satisfying the family Deductible.	 $300 $600	 $300 $600
Calendar Year Out-of-Pocket Maximum (combined Medical/Pharmacy) ■ Individual. ■ Family. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.	 $3,000 $6,000	 $3,000 $6,000

Plan Features	Network Amounts	Non-Network Amounts
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. 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 use disorder 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.	Unlimited	

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Plan Benefits*.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Acupuncture Services See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Ambulance Services	*Ground and/or Air Ambulance*	*Ground and/or Air Ambulance*
■ Emergency Ambulance.	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance. Ground or air ambulance, as the Claims Administrator determines appropriate.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Chemotherapy – Oral	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgeries See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Accident Only See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Diabetes Services		
Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Diabetes Self-Management Items		
■ Diabetes equipment.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Diabetes supplies.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
See Section 5, *Plan Benefits*, for limits.		
Durable Medical Equipment (DME) See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Hearing Aids One per ear every 3 years. See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Home Health Care Calendar year maximum: Unlimited	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Hospice Care	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Infertility Services See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient (includes pre-admission testing)		
■ Lab Testing - Outpatient.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing - Outpatient.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Medical Foods	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Men's Family Planning Services	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient. See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Nutritional Counseling See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	Not Covered
Ostomy Supplies	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pregnancy – Maternity Services	80% after you meet the Annual Deductible.	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	 100% 100% 100%	 100% 100% 100%
Private Duty Nursing - Outpatient	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Prosthetic Devices See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 5, *Plan Benefits*, for visit limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Calendar year maximum: 100 days See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance Use Disorder Services ■ Inpatient. ■ Outpatient.	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Surgery - Outpatient	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Telehealth Services See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Facility.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Travel and Lodging Covered Health Services must be received at a Designated Facility. See Section 5, *Plan Benefits*, for limits.	For patient and companion(s) of patient undergoing Congenital Heart Disease treatment or transplant procedures	
Treatment of Gender Dysphoria (Gender Identity Disorder) See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	Not Covered
Urgent Care Center Services	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Virtual Office Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Not Covered
Vision Examinations (For Dependent Children Age 18 and under) See Section 5, *Plan Benefits*, for limits.	100%	Not Covered
Wigs See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Women's Family Planning Services		
■ Contraceptives (devices and procedures).	100%	70% after you meet the Annual Deductible
■ Abortion.	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible

[1]In general, your Network provider must obtain prior authorization from the Claims Administrator or Personal Health Support, as described in Section 4, *Personal Health Support,* before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization from the Claims Administrator or Personal Health Support. See Section 5, *Plan Benefits,* for further information.

Pharmacy Benefit Information – OptumRx

Covered Health Services	Benefit (the Amount the Plan Pays) *Important Note:* **No Deductible applies to Prescription Drugs.**
Prescription Drug from a Retail Network Pharmacy - up to a 30-day supply	
	For up to a 30-day supply, the Plan pays:
Tier-1	For a Tier 1 Prescription Drug Product: 100% after $10 Copay per Prescription.
Tier-2	For a Tier 2 Prescription Drug Product: 70% (Member cost not to exceed $60 per Prescription).
Tier-3	For a Tier 3 Prescription Drug Product: 70% (Member cost not to exceed $120 per Prescription).
Mail order - up to a 90-day supply	
	For up to a 90-day supply, the Plan pays:
Tier-1	For a Tier 1 Prescription Drug Product: 100% after $20 Copay per Prescription.
Tier-2	For a Tier 2 Prescription Drug Product: 70% (Member cost not to exceed $120 per Prescription).
Tier-3	For a Tier 3 Prescription Drug Product: 70% (Member cost not to exceed $240 per Prescription).
Specialty Prescription Drug Products - up to a 30-day supply (Transplant and HIV specialty drugs can be dispensed in a 90-day supply at a Member cost of 3x the monthly cost)	
	For up to a 30-day supply, the Plan pays:
Tier-1	For a Tier 1 Prescription Drug Product: 100% after $10 Copay per Prescription.
Tier-2	For a Tier 2 Prescription Drug Product: 70% (Member cost not to exceed $60 per Prescription).
Tier-3	For a Tier 3 Prescription Drug Product: 70% (Member cost not to exceed $120 per Prescription).

Important Note: You, your Physician or your pharmacist must notify OptumRx to receive full Benefits for certain Prescription Drug Products. Otherwise, you may pay more out-of-pocket. See Section 6, *Prior Authorization Requirements,* for details.

ATTACHMENT IV - HIPAA PRIVACY PLAN AMENDMENT

HIPAA PRIVACY PLAN AMENDMENT FOR THE AVNET GROUP BENEFITS PLAN AND THE AVNET INSURED MEDICAL/DENTAL PLAN

Avnet, Inc. ("Avnet") has adopted this Plan Document Amendment to the Avnet Group Benefits Plan and the Avnet Insured Medical/Dental Plan, as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), to comply with 45 C.F.R. Parts 160 and 164 (the "HIPAA Privacy Rule"), and specifically 45 C.F.R. sec. 164.504(f), with respect to the portions or components of the Avnet Group Benefits Plan that provide or pay the cost of Medical Care.

1. Definitions

The following underscored terms, when appearing herein with an initial capital will have the meanings indicated for them in this Section 1.

"Covered Plan" or "Plan" means those portions or components of the Avnet Group Benefits Plan and the Avnet Insured Medical/Dental Plan, which provide or pay the cost of Medical Care, including the:

- HSA 70 Medical Plan,
- HSA 80 Medical Plan,
- PPO 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan,
- Hawaii Medical Plan,
- Puerto Rico Medical and Dental Plan,
- Employee Assistance Program/Behavioral Health,
- Vision Service Plan,
- PPO Dental,
- Copay Dental, and
- Health Care Flexible Spending Account.

"Plan" shall not include any portion or component of a plan that solely provides or pays the cost of Excepted Benefits.

"Designated Employees" means the following employees, classes of employees, and other persons who are designed to receive, use and disclose PHI on behalf of the Plan Sponsor:

(a) The individual employees designated in Exhibit A to the Avnet, Inc. HIPAA Privacy Policies and Procedures, to the extent they are designated therein to perform Plan Administration Functions on behalf of the Plan[1];

(b) Anyone under the immediate supervision of the individuals above;

[1] If the individuals identified in Exhibit A leaves the identified position they shall cease to be a Designated Employee and their replacement shall become a Designated Employee upon assuming the identified position.

(c) Individual employees or job categories approved by the above individuals to perform specific tasks on behalf of a Plan.

"Disclosed PHI" means PHI maintained by the Plan Sponsor, to the extent that such PHI is or has been disclosed to the Plan Sponsor by the Plan (or by an Insurer, if the Plan provides for or permits such disclosure to the Plan Sponsor), except that it does not include PHI released to the Plan Sponsor pursuant to Section 2 below.

"Enrollment Information" means information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

"Excepted Benefits" means any one or more of the following:

(a) Coverage for accident, disability income insurance, or any combination thereof.
(b) Coverage issued as a supplement to liability insurance.
(c) Liability insurance, including general liability insurance and automobile liability insurance.
(d) Worker's compensation or similar insurance.
(e) Automobile medical payment insurance.
(f) Credit-only insurance.
(g) Coverage for on-site medical clinics.
(h) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
(i) Coverage for life insurance.
(j) Dependent care reimbursement account features of a Plan.

"Insurer" means either or both of:

(a) An insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, is subject to state laws that regulate insurance, and is providing coverage under the Plan.
(b) A federally-qualified health maintenance organization, an organization recognized as a health maintenance organization under applicable state law, or a similar organization regulated for solvency under applicable state law in the same manner and to the same extent as a health maintenance organization that is providing coverage under the Plan.

"Medical Care" means the diagnosis, cure, mitigation, treatment, or prevention of disease; services and supplies applied for the purpose of affecting any structure or function of the body; transportation primarily for and essential to obtaining any of the foregoing; and insurance covering any of the foregoing.

"Operations Functions" means any of the following activities when carried out with respect to the Payment Functions of the Plan:

(a) Quality assessment and improvement activities.
(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management, disease management, care coordination, and contacting health care providers and enrollees with information about treatment alternatives and related functions.
(c) Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities.

(d) Fraud and abuse detection, and compliance activities.
(e) Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance). Underwriting activities shall not include the use of PHI that is genetic information. For this purpose, "genetic information" includes information about an individual's genetic tests, the manifestation of disease or a disorder in their family members, and genetic counseling and genetic education they have received.
(f) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
(g) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, and development or improvement of payment methods or coverage policies.
(h) Business management and general administrative activities, including:
- Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements.
- Customer service, including the preparation and provision of data analyses for use of the Plan Sponsor, policy holders, or other customers.

(i) Resolution of internal grievances.
(j) Due diligence in connection with the sale or transfer of assets to a potential successor in interest if the potential successor in interest either:
- Is a covered entity for purposes of HIPAA; or
- Will become a covered entity following completion of the sale or transfer.

(k) Subject to restrictions of the Privacy Rules, creating de-identified health information, summary health information, or limited data sets.
(l) Assisting other health plans, health care providers, and health care clearinghouses with their health care operations activities that are like those listed above in this definition, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with the individual whose PHI is involved and the PHI pertains to that relationship.

"Payment Functions" means activities undertaken to obtain premium payments or to determine or fulfill the Plan's responsibility for coverage of, and provision of health benefits with respect to, an individual to whom health care is provided. Payment functions include the following:

(a) Determining individuals' eligibility for coverage under the Plan, including determinations of rights pursuant to COBRA.
(b) Obtaining reimbursement for benefits paid during a period of ineligibility.
(c) Determining whether individuals have coverage in effect under the Plan, and in what capacity.
(d) Determining whether particular expenses are covered under the Plan with respect to individuals (including, without limitation, coordination of benefits determinations, cost sharing determinations, subrogation determinations, medical necessity determinations, and all other determinations necessary or appropriate to determine whether Plan benefits are payable for particular health benefit claims) and making claims payments based on those determinations.

(e) Coordination of benefits, including, without limitation, collecting amounts from another plan covering an individual, and determining order of benefits payment and the extent to which benefits have been paid from another plan.
(f) Activities related to rights of reimbursement the Plan may have with respect to previously-paid benefits, and subrogation activities, including asserting liens against actual or potential recoveries, exercising rights of reimbursement with respect to third parties, and making demand for repayment of Plan benefits.
(g) Determining cost-sharing amounts applicable to particular claims under the terms of the Plan, including determining whether an individual has reached applicable plan limits, satisfied Deductibles or out-of-pocket limits, or is required to make a co-payment or satisfy Coinsurance with respect to a particular claim.
(h) Adjudicating benefit claims under the Plan (including appeals and other payment disputes).
(i) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to enrollees' inquiries about payments.
(j) Billing and collection activities, and related data processing.
(k) Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance), including notification to carriers issuing such insurance of diagnoses or claims that trigger reporting requirements under such policies.
(l) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.
(m) Determining required employee contributions under the Plan.
(n) Risk adjusting amounts due for coverage based on enrollees' health status, claims history, and demographic characteristics, to the extent permissible under applicable law.
(o) Utilization review activities, including pre-certification and preauthorization of services, and concurrent and retrospective review of services.
(p) Disclosure to consumer reporting agencies relating to collection of premiums or reimbursement, limited to any or all of the following:
    - Name and address
    - Date of birth
    - Social security number
    - Payment history
    - Account number
    - Name and address of the Plan
(q) Assisting other health plans (including other health plans sponsored by the Plan Sponsor), health care providers, and health care clearinghouses with their payment activities, which include activities similar to those listed above in this definition with respect to the Plan.

"PHI" means protected health information, as defined in §160.103 of the Privacy Rules.

"Plan Administration Functions" means Payment Functions and Operations Functions.

"Plan Sponsor" means Avnet, Inc. and its related companies that sponsor one or more of the plans identified the definition of "Covered Plan" above, except that with respect to any particular Plan, "Plan Sponsor" means only the entity that sponsors that particular Plan.

"Privacy Rules" means the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, and found at 45 CFR part 160 and part 164, subparts A and E, as amended.

"Secretary" means the Secretary of the Department of Health and Human Services or his designee.

"Summary Health Information" means summary health information as defined in §164.504(a) of the Privacy Rules to the extent disclosed to the Plan Sponsor in accordance with §164.504(f)(1)(ii) of the Privacy Rules.

2. Use and Disclosure of Certain PHI by Plan Sponsor

Except as prohibited by § 164.502(a)(5)(i) of the Privacy Rules, a plan may disclose PHI to the Plan Sponsor: (i) if such information is Summary Health Information and is requested by the Plan Sponsor in order to obtain premium bids from health plans for providing health benefits under the Plan or to modify, amend, or terminate the plan; (ii) if such information is Enrollment Information; or (iii) if such information is disclosed pursuant to an authorization under 45 C.F.R. §164.508.

3. Use and Disclosure of PHI by Plan Sponsor with Limitations

With respect to any Disclosed PHI not described in Section 2 above, the Plan Sponsor may use and disclose such Disclosed PHI only as described in this Section 3.

(a) Plan Sponsor may use and disclose Disclosed PHI:
- For purposes of performing Plan Administration Functions on behalf of the Plan.
- As required by law, as that term is defined in §164.103 of the Privacy Rules.

(b) Plan Sponsor shall not use or disclose Disclosed PHI in a manner that the Plan would not be permitted to use and disclose the Disclosed PHI under the Privacy Rules.

(c) Plan Sponsor shall not use or further disclose the Disclosed PHI other than as permitted or required by the documents setting out the terms of the Plan or as required by law.

(d) Plan Sponsor shall require its agents, including subcontractors, to whom the Plan Sponsor provides Disclosed PHI, to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Disclosed PHI.

(e) Plan Sponsor shall not use or disclose the Disclosed PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(f) Plan Sponsor shall report to the Plan any Security Incident (as that term is defined in 45 C.F.R. §164.403) or any use or disclosure of the Disclosed PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the documents setting out the terms of the Plan.

(g) Plan Sponsor will make the Disclosed PHI available to allow participants access to their PHI in accordance with §164.524 of the Privacy Rules.

(h) Plan Sponsor will make the Disclosed PHI available for amendment, and incorporate any amendments to such Disclosed PHI, in accordance with §164.526 of the Privacy Rules.

(i) Plan Sponsor will make available, in accordance with §164.528 of the Privacy Rules, the information required to provide an accounting of disclosures of the Disclosed PHI made by the Plan Sponsor, its agents or subcontractors.

(j) Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of the Disclosed PHI available to the Secretary for purposes of determining compliance by the Plan with the Privacy Rules.

(k) If feasible, the Plan Sponsor will return to the Plan, or destroy, all Disclosed PHI maintained by the Plan Sponsor in any form, and retain no copies, when such Disclosed PHI is no longer needed for the purpose for which disclosure of it was made to the Plan Sponsor, except that, if such return or destruction is not feasible, the Plan Sponsor shall instead limit further uses and disclosures of the information by the Plan Sponsor, its agents and subcontractors to uses and disclosures required by law and those made for the purposes that make return or destruction of the Disclosed PHI infeasible.

4. Disclosure of PHI to Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor solely through the Designated Employees, and only for the purposes specified in Section 3(a) hereof.

5. Adequate Separation

(a) No one who is an employee, or is otherwise under the control, of the Plan Sponsor, other than the Designated Employees, may have access to the Disclosed PHI.

(b) The Plan Sponsor shall implement appropriate administrative, physical and technical safeguards to prohibit its employees and other persons under its control, other than the Designated Employees, from accessing the Disclosed PHI.

(c) The Designated Employees may have access to and use the Disclosed PHI only for the purposes specified in Section 3(a) hereof.

(d) The Plan Sponsor shall implement appropriate administrative, physical, and technical safeguards to prohibit and/or prevent Designated Employees from accessing the Disclosed PHI for purposes other than those specified in Section 3(a) hereof.

(e) Any employee who intentionally accesses, uses or discloses Disclosed PHI for any purpose not specified in Section 3(a) hereof, and any Designated Employee who acts with respect to the Disclosed PHI in a manner contrary to the provisions of this Section 5 will be subject to disciplinary action at the Plan Sponsor's discretion, which may include termination of employment.

The Plan Sponsor has adopted HIPAA Privacy Policies and Procedures to implement these provisions. This Addendum supersedes any inconsistent provisions in the documents governing the Plans and replaces any prior amendments or addenda dealing with the subject matter hereof.

Exhibit A

Avnet Group Benefits Plan and Avnet Insured Medical/Dental Plan Components and Designated Avnet Employees (Revised January 1, 2016)

The portions or components of the Plans that provide or pay the cost of medical care include:

- HSA 70 Medical Plan,
- HSA 80 Medical Plan,
- PPO 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan,
- Hawaii Medical Plan,
- Puerto Rico Medical and Dental Plan,
- Employee Assistance Program/Behavioral Health,
- Vision Service Plan,
- PPO Dental,
- Copay Dental, and
- Health Care Flexible Spending Account.

The following employees, classes of employees, and other persons are hereby designated to perform Plan Administration Functions on behalf of the Avnet Group Benefits Plan and Avnet Insured Medical/Dental Plan:

Designated Employees (Job Title)	**Current Incumbent***
Vice President, Compensation and Benefits	Roberta Bixhorn
Vice President, Director of Benefits	Jane Smith
Benefits Consultant	Anna Conti
Benefits Consultant	Tammy Halter
Senior Benefits Specialist	Karen Hamacher
Benefits Coordinator	Beth Crothers

*****_The current incumbent is listed as of the date this Exhibit was last revised. If the incumbent subsequently changes, the new employee in the designated position will be automatically designated hereunder._

***End of Summary Plan Description