AVNET

Summary Plan Description

Avnet, Inc.
HSA 70, HSA 80, Classic 70, and Out-of-Area Medical Plan

Effective: January 1, 2026
Group Number: 905940

UnitedHealthcare

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 ensure the benefits described.

This booklet serves as both the Plan document and Summary Plan Description for the Avnet, Inc. HSA 70, HSA 80, Classic 70, and Out-of-Area 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 **1**

SECTION 2 - INTRODUCTION **3**

Eligibility 3

Cost of Coverage 4

How to Enroll 4

When Coverage Begins 4

Changing Your Coverage 6

SECTION 3 - HOW THE PLAN WORKS **7**

Accessing Benefits 7

Eligible Expenses 11

Annual Deductible 15

Coinsurance 16

Copayment 16

Out-of-Pocket Maximum 16

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION **18**

Care Management 18

Prior Authorization 19

Covered Health Services which Require Prior Authorization 20

Special Note Regarding Medicare 21

SECTION 5 - PLAN BENEFITS **22**

Covered Health Services 22

Additional Coverage Details 23

Acupuncture Services 24

Ambulance Services 24

Cellular and Gene Therapy 25

Clinical Trials 25

Congenital Heart Disease (CHD) Surgeries 28

Dental Services - Accident Only 29

Diabetes Services 30

Durable Medical Equipment (DME), Orthotics and Supplies 31

Emergency Health Services - Outpatient 33
Enteral Nutrition 33
Fertility Preservation for Latrogenic Infertility 33
Fertility Services 34
Gender Dysphoria (Gender Identity Disorder) 35
Hearing Aids 35
Home Health Care 36
Hospice Care 37
Hospital - Inpatient Stay 37
Lab, X-Ray and Diagnostics - Outpatient 38
Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient 39
Men's Family Planning Services 39
Mental Health Services 40
Neurobiological Disorders - Autism Spectrum Disorder Services 41
Non-Preventive Nutritional Counseling 42
Obesity Surgery 42
Ostomy Supplies 43
Pharmaceutical Products - Outpatient 43
Physician Fees for Surgical and Medical Services 44
Physician's Office Services - Sickness and Injury 45
Pregnancy - Maternity Services 45
Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services 46
Preventive Care Services 47
Private Duty Nursing - Outpatient 48
Prosthetic Devices 48
Reconstructive Procedures 49
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment 50
Scopic Procedures - Outpatient Diagnostic and Therapeutic 52
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services 52
Substance-Related and Addictive Disorders Services 54
Surgery - Outpatient 55

Temporomandibular Joint (TMJ) Services 55
Therapeutic Treatments - Outpatient 56
Transplantation Services 57
Travel and Lodging Assistance Program 58
Urgent Care Center Services 59
Urinary Catheters 59
Virtual Behavioral Therapy and Coaching 60
Virtual Care Services 60
Vision Examinations (For Dependent Children Age 18 and under) 60
Wigs 61
Women's Family Planning Services 61

SECTION 6 - OUTPATIENT PRESCRIPTION DRUG PLAN – OptumRx 62

Pharmacy Benefits 62
Accessing Covered Pharmacy Benefits 63
Identification Card (ID Card) - Network Pharmacy 63
Prescription Drug Products which Require Prior Authorization 63
Benefit Levels 64
Specialty Prescription Drug Products 65
Retail 65
Mail Order 66
Step Therapy 66
Preventive Care Medications 67
Price Edge Program 67
Split Fill Program 67
Designated Pharmacy 68
Assigning Prescription Drugs to the PDL 68
Prior Authorization Requirements 69
Limitation on Selection of Pharmacies 70
Supply Limits 70
If a Brand-name Drug Becomes Available as a Generic 70
Rebates and Other Discounts 70
Coupons, Incentives and Other Communications 71

SECTION 7 – CLINICAL PROGRAMS AND RESOURCES 72
Consumer Solutions and Self-Service Tools 72
Complex Medical Conditions, Programs and Services 75
Bariatric Resource Services (BRS) 75
Congenital Heart Disease (CHD) Resource Services 75
Diabetes Management Program 75
Disease Management Services 76
Wellness Program 77
SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL/ PRESCRIPTION PLAN WILL NOT COVER 79
Alternative Treatments 79
Dental 79
Devices, Appliances and Prosthetics 80
Drugs 81
Experimental or Investigational or Unproven Services 83
Foot Care 83
Gender Dysphoria (Gender Identity Disorder) 83
Medical Supplies and Equipment 84
Nutrition 84
Personal Care, Comfort or Convenience 85
Physical Appearance 86
Prescription Drugs 87
Procedures and Treatments 89
Providers 91
Reproduction 91
Services Provided under Another Plan 93
Transplants 93
Travel 93
Types of Care, Supportive Services, and Housing 94
Vision and Hearing 94
All Other Exclusions 95
SECTION 9 - CLAIMS PROCEDURES 97
Network Benefits 97

Non-Network Benefits....97
If Your Provider Does Not File Your Claim....97
Payment of Benefits....99
Health Statements....100
Explanation of Benefits (EOB)....100
Medical Claim Denials and Appeals - UnitedHealthcare....100
Federal External Review Program....102
Prescription Drug Benefit Claims – OptumRx....110
Prescription Claims Denials and Appeals – OptumRx....111
Legal Action....113

SECTION 10 - COORDINATION OF BENEFITS (COB)....116
Benefits When You Have Coverage under More than One Plan....116

SECTION 11 - SUBROGATION AND REIMBURSEMENT....123
Right of Recovery....127

SECTION 12 - WHEN COVERAGE ENDS....128
Cancellation of Coverage for Submitting False or Fraudulent Claims....128
Other Events Ending Your Coverage....129
Coverage for a Disabled Child....129
Leave of Absence....130
Family and Medical Leave Act of 1993 (FMLA)....130
Continuing Coverage Through COBRA....130
When COBRA Ends....135
Uniformed Services Employment and Reemployment Rights Act....135

SECTION 13 - OTHER IMPORTANT INFORMATION....137
Qualified Medical Child Support Orders (QMCSOs)....137
Your Relationship with UnitedHealthcare and Avnet, Inc.....137
Relationship with Providers....138
Your Relationship with Providers....139
Interpretation of Benefits....139
Information and Records....140
Incentives to Providers....141
Incentives to You....141

Rebates and Other Payments 142
Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies 142
Workers' Compensation Not Affected 143
Future of the Plan 143
SECTION 14 - GLOSSARY 143
Medical Benefits 144
Prescription Drugs 163
SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA 167
ATTACHMENT I - HEALTHCARE REFORM NOTICES 172
Patient Protection and Affordable Care Act ("PPACA") 172
ATTACHMENT II - LEGAL NOTICES 173
Effect of Section 125 on This Plan 173
Group Plan Coverage Instead of Medicaid 174
Group Plan Coverage Instead of SCHIP 174
Newborns' and Mothers' Health Protection Act 174
Privacy Rights under the Health Insurance Portability and Accountability Act ("HIPAA") 175
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 175
Women's Health and Cancer Rights Act of 1998 177
ATTACHMENT III – HSA 70 PLAN DETAILS 178
Payment Terms and Features 178
Schedule of Benefits 180
Pharmacy Benefit Information – OptumRx 192
ATTACHMENT IV – HSA 80 PLAN DETAILS 194
Payment Terms and Features 194
Schedule of Benefits 196
Pharmacy Benefit Information – OptumRx 206
ATTACHMENT V – CLASSIC 70 PLAN DETAILS 208
Payment Terms and Features 208
Schedule of Benefits 210
Pharmacy Benefit Information – OptumRx 225

ATTACHMENT VI – OUT-OF-AREA PLAN DETAILS 226

Payment Terms and Features 226

Schedule of Benefits 228

Pharmacy Benefit Information – OptumRx 237

ATTACHMENT VII - HEALTH SAVINGS ACCOUNTS 238

About Health Savings Accounts (HSAs) 238

HSA Contributions and Distributions 238

About Flexible Spending Accounts (FSAs) 241

ATTACHMENT VIII – NONDISCRIMINATION 242

ATTACHMENT IX – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUSILIARY AIDS AND SERVICES 244

ATTACHMENT X - HIPAA PRIVACY PLAN AMENDMENT 251

HIPAA Privacy Plan Amendment 251

Avnet Group Benefits Plan and Avnet Insured Plan Components and Designated Avnet Employees 258

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Services 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. HSA 70, HSA 80, Classic 70, and Out-of-Area 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 HR Now at 888-99-HR-NOW (994-7669), 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 HR Now at 888-99-HR-NOW (994-7669).
- 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 a regular Employee of the Employer who works an average of at least 20 hours per week and is currently in Active Service. An Employee must live and/or work in the United States. 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 HR Now at 888-99-HR-NOW (994-7669).

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.
- 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 HR Now 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 HR Now 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 HR Now 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.

Use Your Prior Health Care Coverage

If you have prior coverage that extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. Benefits for that particular condition or disability are subject to your prior coverage.

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 HR Now 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, Designated Network Benefits, or Non-Network Benefits.

Important Note: Covered Health Services for preventive care are only covered in the Plan when provided by a Network provider.

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

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that has been identified as a Designated Facility. Only certain Physicians and providers have been identified as a Designated Facility. Designated Network Benefits are available only for specific Covered Health Services as identified in Attachments (Attachment III – HSA 70, Attachment IV – HSA 80, Attachment V – Classic 70, or Attachment VI – Out-of-Area Plan). When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

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. In general health care

terminology, Non-Network Benefits may also be referred to as out-of-network-benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described at the end of this section.

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 a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **myuhc.com**.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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

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 UnitedHealthcare's 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 31 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 the Plan will pay for Benefits.

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

- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.

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

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

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

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

provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:

  - The reimbursement rate as determined by a state *All Payer Model Agreement*.

  - The reimbursement rate as determined by state law.

  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.

  - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:

  - The reimbursement rate as determined by a state *All Payer Model Agreement*.

  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.

  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:

  - The reimbursement rate as determined by a state *All Payer Model Agreement*.

  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.

  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment,

Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expense are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

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

Recognized Amount

- The amount that is applied to the Annual Deductible is calculated on the basis of the Eligible Expenses or the Recognized Amount when applicable.
- The Out-of-Pocket Maximum does not include charges that exceed eligible expenses, when applicable.
- Coinsurance includes the charge stated as the percentage of the Recognized Amount when applicable.
- When a Copayment applies, the covered person is responsible for paying the lesser of the co-payment, or the eligible expense or the Recognized Amount when applicable.
- When a per occurrence deductible applies, the covered person is responsible for paying the lesser of the per occurrence deductible, or the eligible expense or the recognized amount when applicable.

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, or the Recognized Amount when applicable, 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, or the Recognized Amount when applicable.	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 HR Now at 888-99-HR-NOW (994-7669). 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

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

- **Admission Counseling** – Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient Care Management** - If you are hospitalized, a Personal Health Support 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

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

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.
- Clinical Trials.
- Congenital heart disease surgery.
- Diabetes services – Durable Medical Equipment.
- Durable Medical Equipment.
- Gender Dysphoria – surgical and non-surgical treatment.
- Home health care – nutritional foods and skilled nursing.
- 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.
- Lab, x-ray and diagnostics - sleep studies and designated testing, including CT, PET scans, MRI, etc. (see Section 5, *Plan Benefits*).

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment/High Intensity Outpatient and services at a Residential Treatment Facility).
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day treatment/High Intensity Outpatient, Intensive Outpatient Programs, psychological testing, and services at a Residential Treatment Facility).
- Obesity Surgery.
- Physician's office services – Genetic Testing.
- Prosthetic devices.
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery.
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day/High Intensity Outpatient Treatment, Intensive Outpatient Programs, psychological testing, and services at a Residential Treatment Facility).
- Surgery – designated procedures (see Section 5, *Plan Benefits*).
- Temporomandibular joint (TMJ) services – Hospital Inpatient Stay.
- Therapeutic Treatments – Outpatient.
- Transplantation Services

Notification is required within 24 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 – *HSA 70,* Attachment IV – *HSA 80,* Attachment V – *Classic 70,* or Attachment VI – *Out-of-Area Plan.*

- Acupuncture Services
- Ambulance Services
- Cellular and Gene Therapy
- Clinical Trials
- Congenital Heart Disease (CHD) Surgeries
- Dental Services – Accident Only
- Diabetes Services
- Durable Medical Equipment (DME)
- Emergency Health Services – Outpatient
- Enteral Nutrition
- Fertility Preservation for Latrogenic Infertility
- Fertility Services
- Gender Dysphoria (Gender Identity Disorder)
- Hearing Aids
- Home Health Care
- Hospice Care
- Hospital – Inpatient Stay
- Lab, X-Ray and Diagnostics – Outpatient
- Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient
- Men’s Family Planning Services

- Mental Health Services
- Neurobiological Disorders – Autism Spectrum Disorder Services
- Nutritional Counseling
- Obesity Surgery
- Ostomy Supplies
- Pharmaceutical Products – Outpatient
- Physician Fees for Surgical and Medical Services
- Physician's Office Services – Sickness and Injury
- Pregnancy – Maternity Services
- Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related 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-Related and Addictive Disorders Services
- Surgery – Outpatient
- Temporomandibular Joint (TMJ) Services
- Therapeutic Treatments – Outpatient
- Transplantation Services
- Travel and Lodging Assistance Program
- Urgent Care Center Services
- Urinary Catheters
- Virtual Office Visits
- Vision Examinations (for Dependent Children Age 18 and Under)
- Wigs
- Women's Family Planning Services

Additional Coverage 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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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 non-Emergency 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.

Eligible Expenses for Air Ambulance transport provided by a Non-Network provider will be determined as described in Section 3, *How the Plan Works*.

Prior Authorization Requirement
In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. For Non-Network Benefits, if you are requesting non-Emergency ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office. If services are not received from a Designated Facility, Benefits will not be paid.

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

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.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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 Assistance Program* 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, Benefits will be subject to a $750 reduction.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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

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. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps that are not fully implanted into the body and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- Insulin pumps that are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*
- Blood glucose meters including continuous glucose monitors. (For questions about which glucose monitors are covered, call the number on the back of your ID card.)
- Insulin syringes with needles.
- Blood glucose and urine test strips.

- Ketone test strips and tablets.
- Lancets and lancet devices.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

Durable Medical Equipment (DME), Orthotics and Supplies

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.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* 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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these 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 dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). To receive Network Benefits, you must purchase or rent the DME from the vendor the Claims Administrator or Personal Health Support identifies or purchase it directly from the prescribing Network Physician. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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 24 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*.

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Emergency room Copay, Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.

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

Enteral Nutrition

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

Fertility Preservation for Latrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible Infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under Section 6, *Outpatient Prescription Drug Plan* or under *Pharmaceutical Products – Outpatient* in this section.

Benefits are not available embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

Limited to $20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This Benefit limit will be the same as and combined with those stated under Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services, and Fertility Services. Benefits are further limited to one cycle of fertility preservation for Latrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan.

Fertility Services

The Plan pays Benefits for the below fertility treatments:

- 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 fertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office or in a Covered Person's home.
- Any combination of Network Benefits and Non-Network Benefits for fertility services is limited to $20,000 per Covered Person during the entire period you are covered under the Plan with this or any previous Claims Administrator. This Benefit limit will be the same as and combined with those stated under Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services, and Fertility Preservation.

Charges for the following apply toward the fertility lifetime maximum:

- Hospital outpatient facility.
- Surgeon's and assistant surgeon's fees.
- Anesthesia.
- Lab and x-ray.
- Diagnostic services.
- Physician's office visits.
- Consultations.
- Durables.

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 fertility lifetime maximum.

Gender Dysphoria (Gender Identity Disorder)

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

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

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.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or soon as is reasonably possible for non-scheduled admissions.

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health 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.

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.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services or as soon as is reasonably possible for nutritional foods and skilled nursing. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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 $750 reduction.

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 $750 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.
- Mammography.

Benefits under this section include:

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

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.

Important Note: In the *Classic 70 plan*, services that are rendered at a Network Hospital or Affiliated Facility for outpatient lab or radiology services are subject to the plan deductible/coinsurance. Services covered under your office visit copay must be rendered at a Network Facility that is not affiliated with a Hospital. This does not apply to preventive mammograms performed at a Network Hospital.

Prior Authorization Requirement
For Non-Network Benefits for Genetic Testing and sleep studies you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $750 reduction.

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.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

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.

Important Note: In the *Classic 70 plan*, services that are rendered at a Network Hospital or Affiliated Facility for outpatient lab, radiology or major diagnostic services are subject to the plan deductible/coinsurance. Services covered under your office visit copay must be rendered at a Network Facility that is not affiliated with a Hospital. This does not apply to preventive mammograms performed at a Network Hospital.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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 , Pks).

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. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

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

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy360 provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for the initial consultation, Covered Persons with a high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles or Coinsurance for the initial consultation.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Mental Health Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing and transcranial magnetic stimulation.

If you do not obtain prior authorization as required, Benefits will be subject to a $750 reduction.

Neurobiological Disorders - Autism Spectrum Disorder Services

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

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

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the Enhanced Autism Spectrum Disorders benefit below.

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment, and treatment and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits]you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization as required, Benefits will be subject to a $750 reduction.

Non-Preventive Nutritional Counseling

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

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

Any combination of Network Benefits and Non-Network Benefits for non-preventive nutritional counseling services is limited to 3 visits per calendar year. Limits do not apply to nutritional counseling services for mental health and substance-related and addictive disorders.

Obesity Surgery

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

- You have a minimum a 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 services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Benefits are limited to one surgery per lifetime the entire period you are covered under the Plan, unless there are complications to the covered surgery.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product is under the corresponding Benefit category in this SPD. 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.

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

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

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

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs 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.

Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.

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 freestanding, 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.

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 $750 reduction.

Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

Limited to $20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for related services as described under *Fertility Preservation for Latrogenic Infertility* and *Fertility Services*.

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.

Important Note: Covered Health Services for preventive care are only covered in the Plan when provided by a Network provider.

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

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.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceeds $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be subject to a $750 reduction.

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 $750 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

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

- Physical Therapy.
- Occupational Therapy, including cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke.
- Manipulative Treatment (e.g., chiropractic).
- Speech Therapy.
- Post-cochlear implant aural therapy.
- 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. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly or following the placement of a cochlear implant.

Habilitative Services

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

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

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

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

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, educational/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 that does not help the covered Person to meet functional goals is not a habilitative service.

The Plan may require the following to be provided:

- medical records.
- other necessary data to allow the Plan to prove medical treatment is needed.

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

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*.

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 diagnostic 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 60 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 $750 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Substance-Related and Addictive Disorders Services

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

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment, and treatment and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Substance-Related and Addictive Disorders Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing.

If you do not obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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.

Prior Authorization Requirement
For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, sleep apnea surgeries, cochlear implant, and orthognathic surgeries, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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.

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.

Prior Authorization Requirement
For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy, and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

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Transplantation Services

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

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

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

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

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 Assistance Program* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Prior Authorization Requirement
For Non-Network Benefits (only Out-of-Area Plan covers Non-Network Benefits) you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

If you fail to obtain prior authorization as required, Benefits will be subject to a $750 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

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 Assistance Program

The Plan may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Facility (when required) and the requisite distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

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

Travel and Lodging Expenses

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

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Facility for care related to one of the programs or Covered Health Services discussed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.

- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Facility, except where otherwise noted below.
- Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The Plan also provides a Covered Person with a travel and lodging allowance related to the Covered Health Service when such Covered Health Service that is not available within 50 miles of your address and that the Covered Health Service is not available in the Covered Person's state of residence due to law or regulation when such services are received in another state, as legally permissible. There is no requirement to have Covered Health Service performed at a Designated Facility. The annual maximum is $2,000.

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

Lodging

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

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*.

Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

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

- Irrigation tubing set.

Virtual Behavioral Therapy and Coaching

- Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo") for Covered Persons with certain co-occurring behavioral and medical conditions.
- AbleTo provides behavioral Covered Health Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.
- There are no deductibles, Copayments or Coinsurance for the initial consultation.
- If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Virtual Care Services

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

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

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

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

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

Vision Examinations (For Dependent Children Age 18 and under)

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility every calendar year.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

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.

The Plan provides you with Travel and Lodging assistance under certain circumstances. Refer to the Travel and Lodging Assistance Program in Section 5, *Plan Benefits*.

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 – *HSA 70,* Attachment IV – *HSA 80,* Attachment V – *Classic 70,* or Attachment VI – *Out-of-Area Plan*, 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 or its designee, Briova. 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 Section 9, *Claims Procedure*s 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 HR Now.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. 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 Product 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 Product 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

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail. 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.**

Step Therapy

Certain Prescription Drug Products for which Benefits are described in this section are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting **myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products that are Chemically Equivalent

If two drugs are Chemically Equivalent (they contain the same active ingredient) and you or your Physician choose not to substitute for this lower priced Chemically Equivalent drug for the higher priced drug, you will pay the difference between the higher priced drug and the lower priced Chemically Equivalent drug, in addition to the Coinsurance. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower price.

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.

Important Note: Medications listed on the OptumRx Select Preventive Drug List (posted on HR Now) are available in the HSA 70 and HSA 80 plan options for a Copay (not subject to the Plan Deductible).

Price Edge Program

Price Edge is a plan feature designed to help ensure that members receive a competitive price for certain eligible generic prescription drugs, whether such drugs are covered or not covered under the terms of the Plan. Under this program, the member's applicable cost-sharing amount is compared at the point of sale to available pricing obtained from third-party cash discount programs. Where permitted and available, and if such pricing results in a lower amount than the member's applicable cost-sharing obligation, the member will pay the lower amount.

The availability of lower pricing through this program is not guaranteed and may vary based on drug, pharmacy, and other factors. This program is intended to reduce member out-of-pocket expenses where applicable and to support the overall value of the pharmacy benefit; however, it does not alter the terms of coverage, formulary status, or benefit limitations under the Plan.

Split Fill Program

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product.

Designated Pharmacy

If you require certain Prescription Drug Products (including, but not limited to, Specialty Prescription Drug Products), OptumRx may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

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 may occur up to 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 a. 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, including those drugs that you purchase prior to meeting any applicable deductible. As determined by OptumRx, the Plan may pass a portion of these

rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or 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

At various times, OptumRx may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may contain offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-OptumRx entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

SECTION 7 – CLINICAL PROGRAMS AND RESOURCES

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

- Consumer Solutions and Self-Service Tools.
- Complex Medical Conditions, Programs and 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.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and 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 of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

UnitedHealthcare provides you tools to help you be an educated health care consumer. To that end, UnitedHealthcare 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 health care system.

Health Survey

You and your Spouse are invited to learn more about your health and wellness at **optumengage.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.

If you need any assistance with the online survey, please call the number on the back of your ID card.

Reminder Programs

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

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

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

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

Conditions for which this program is available include:

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

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

- Receive personalized messages that are posted to your own website.
- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Choice Plus Network providers available in your Plan through the online provider directory.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on 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.

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

Complex Medical Conditions, Programs and Services

Bariatric Resource Services (BRS)

The Plan offers Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Participants and Enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Congenital Heart Disease (CHD) Resource Services

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

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on your ID card or you can call the *CHD Resource Services* Nurse Team at 888-936-7246.

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

The Plan provides you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program* in Section 5, Plan Benefits.

Diabetes Management Program

The Diabetes Management program helps members control blood sugar, A1c levels and comorbidities. The diabetes program includes:

- Member counseling
- Provider engagement
- Digital technology (cloud-based meter and app to improve glucose monitoring)
- Education (verbal and written) for ongoing condition management

All members with diabetes receive:

- Medication adherence monitoring
- Retrospective interventions to close gaps in care
- Member education on disease and adherence

Members who require higher touch care consult with pharmacists who are diabetes experts. These members receive:

- Connected care through a cloud-based meter and digital technology (app) Retrospective interventions to close gaps in care
- One-on-one coaching

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.

- Access to educational and self-management resources on a consumer website.

- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.

- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.

- Preparation and support for upcoming Physician visits.
- Review of psychosocial services and community resources.
- Caregiver status and in-home safety.
- Use of mail-order pharmacy and Network providers.

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

Transplant Resource Services (TRS) Program

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

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

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

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program* in Section 5, Plan Benefits.

Wellness Program

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life®
program employes an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addition to tobacoo use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based ocaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.

- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.
- If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card or visit **www.myuhc.com** for additional information.

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.
5. Rolfing.
6. 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 preventive care for which Benefits are provided under the *United States Preventive Services Task Force requirement* or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 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), Orthotics and Supplies* in Section 5, *Plan Benefits*. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria (In-network only).

   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. The following items are excluded, even if prescribed by a Physician:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Trusses.
    - Ultrasonic nebulizers.
4. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
5. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
6. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 5, Plan Benefits.
7. Oral appliances for snoring.
8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.
9. Powered and non-powered exoskeleton devices.
10. Over-the-counter continuous glucose monitors.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another *Pharmaceutical Product*, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

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. Routine foot care. Examples include the cutting or removal of corns and calluses.
2. Nail trimming, nail cutting, or nail debridement.
3. 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.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes, shoe orthotics, shoe inserts, and arch supports except if prescribed by a physician and In-network.

Gender Dysphoria (Gender Identity Disorder)

1. Cosmetic Procedures, including the following:
   - Abdominoplasty.
   - Blepharoplasty.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.

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

2. Treatment received outside of the United States.

Medical Supplies and Equipment

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

   This exclusion does not apply to:
   - 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 for which Benefits are provided as described under *Urinary Catheters* in Section 5, *Plan Benefits*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section* 5, *Plan Benefits*.

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 (including high protein foods and low carbohydrate foods).
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized food products for which Benefits are provided as described under *Enteral Nutrition* in Section 5, Plan Benefits.

3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

4. Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to Benefits provided under *Non-Preventive Nutritional Counseling* as described in *Section 5, Plan Benefits*.

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 and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.

- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. 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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 5, *Plan Benefits*.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - 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.

1. Pharmaceutical Products for which Benefits are provided in the medical portion of the Plan. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

2. The following over-the-counter drugs and products:
   - Drugs or products available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Claims Administrator has designated the over-the-counter drug or product as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.
   - Over-the-counter continuous glucose monitors

3. The following Prescription Drug Products with over-the-counter alternatives:
   - Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year.
   - Certain Prescription Drug Products that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Claims 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.) Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

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 Prescription Drug Products and/or new dosage forms, until the date they are reviewed and placed to a tier by the Claims Administrator's 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 or Pharmaceutical Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

14. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available to another covered Prescription Drug Product or Pharmaceutical Product, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

15. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.
16. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
17. Typically administered by a qualified provider or licensed health professional in an outpatient setting.

18. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as a unit dose or unit doses.
19. 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).
20. Prescription Drug Products used for Cosmetic purposes.
21. Used to enhance athletic performance.
22. Replacement of Prescription Drugs due to loss or theft.
23. Immunizations and medications used for travel prophylaxis.
24. Prescription Drugs that are designed to adjust sleep schedules, such as for jet lag or shift work.
25. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
26. Treatment for toenail Onychomycosis (toenail fungus).
27. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.
28. A Prescription Drug Product with either:

    An approved biosimilar.

    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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. Speech therapy to treat stuttering, stammering, or other articulation disorders.
5. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition.
6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty except when deemed medically necessary.
7. Psychosurgery (lobotomy).
8. 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.
9. Chelation therapy, except to treat heavy metal poisoning.
10. 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.
11. The following treatments for obesity:
    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Plan Benefits*.
12. Medical and surgical treatment of excessive sweating (hyperhidrosis).
13. 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.
14. Breast reduction surgery except as coverage is 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*. This exclusion does not apply to breast reduction surgery for treatment of gender dysphoria.
15. General population-based Genetic Testing performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
16. Intracellular micronutrient testing.

17. Cellular and Gene Therapy services not received from a Designated Facility.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services ordered or delivered by a Christian Science practitioner.
4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. The following Infertility treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials except as described under Fertility Services, Fertility Preservation for Latrogenic Infertility, and Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described in Section 5 : Plan Benefits.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as 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 congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.
2. The following services related to Gestational Carrier or Surrogate:

- Fees for the use of a Gestational Carrier or Surrogate.
- Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier except as provided under Section 5: Plan Benefits for Reciprocal IVF or Partner IVF.
- Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

- Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
- Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
- Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
- Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

5. Invitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility. This exclusion does not apply to InVitro fertilization for which Benefits are provided as described under Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services in *Section 5, Plan Benefits*.
6. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
7. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
8. Infertility treatment following unsuccessful reversal of voluntary sterilization.
9. Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

10. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.
11. Elective fertility preservation.

Important Note: See eligibility requirements under *Fertility Services, Fertility Preservation for Latrogenic Infertility, and Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related 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. Under workers' compensation, no-fault automobile coverage similar legislation if you could elect it, or could have it elected for you.
3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
4. While on active military duty.
5. 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 animal organs.
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 Assistance Program* in Section 5, *Plan Benefits*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician or other Network Provider 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*.

Types of Care, Supportive Services, and Housing

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 Inpatient.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in Section 5, *Plan Benefits*.
6. Rest cures.
7. Services of personal careaids.
8. Independent living services.
9. Assisted living services
10. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the Individual with Disabilities Education Act.
11. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
12. Transitional Living services (including recovery residences).

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. Eye exercise or vision therapy.
5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
6. Over-the-counter hearing aids.

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, 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).
   - That exceed Eligible Expenses or any specified limitation in this SPD.
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 unless Medically Necessary.
    - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work.
- 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:

1. Your name and address.
2. The patient's name, age and relationship to the Employee.
3. The number as shown on your ID card.
4. The name, address and tax identification number of the provider of the service(s).
5. A diagnosis from the Physician.
6. The date of service.
7. 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. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the OptumRx claims address noted 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.

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. 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.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 10: Coordination of Benefits*.

Eligible expenses due to a Non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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.

*For purposes of this Section 9 – Claims Procedures, "urgent care" means any claim for medical care or treatment that, if not delivered before the time periods for making non-urgent care determinations, (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without such care or treatment.

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. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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 and if necessary, for any additional information needed to conduct the external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

Upon receipt of a Final External Review Decision reversing UnitedHealthcare’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

*UnitedHealthcare may require a one-time extension for the initial claim determination of no more than 15 days only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, 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.

Limitation of Action

You cannot bring any legal action against Avnet, Inc. or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Avnet, Inc. or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Avnet, Inc. or the Claims Administrator.

You cannot bring any legal action against Avnet, Inc. or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Avnet, Inc. or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Avnet, Inc. or the Claims Administrator.

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.

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan Sponsor's Self-Funded group medical benefit plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, “Allowable Expense,” is further explained below.

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

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another

Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

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

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

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

   1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

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

      a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
         (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
      b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

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

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

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

a) The Plan covering the Custodial Parent.
b) The Plan covering the Custodial Parent's spouse.
c) The Plan covering the non-Custodial Parent.
d) The Plan covering the non-Custodial Parent's spouse.

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

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

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

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does

not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

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

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

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

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

Determining the Allowable Expense If this Plan is Secondary

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

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan’s network rate. When the provider is a

network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

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

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely

enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

Right to Receive and Release Needed Information?

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

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

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

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

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

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

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

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

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

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

SECTION 11 - SUBROGATION AND REIMBURSEMENT

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

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

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

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

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers’ compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical

payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

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

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

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without 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 death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of 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 any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any 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.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant/employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your

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

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of 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 or Fraudulent 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 at least 30 days prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

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 UnitedHealthcare 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 UnitedHealthcare'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.

Leave of Absence

If your Active Service ends due to a leave of absence, your coverage will be continued until the earlier of (a) the last day of the month after 12 months from the start of your leave or (b) the last day of the month after the termination of your employment. Coverage is continued up to two years for military leave (for more details, see "Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)," below).

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 HR Now at 888-99-HR-NOW (994-7669), 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 HR Now at 888-99-HR-NOW (994-7669), 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 HR Now 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
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
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

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

Getting Started

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

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

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

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

- During 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; coverage is retroactively terminated).
- 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 HR Now 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 Claims Administrator has agreements in place that govern the relationships between it and Avnet and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

Avnet and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, Avnet and the Claims Administrator arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Avnet's employees nor are they employees of the Claims Administrator. Avnet and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator 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 is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq*., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You 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.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.
- The relationship between you and Avnet, Inc. is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

Avnet, Inc. and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs 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 including UnitedHealthcare's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and UnitedHealthcare's discretion. In order to receive Benefits, you must cooperate with those service providers.

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, including provider billing and provider payment records 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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your Schedule of Benefits.

UnitedHealthcare uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with UnitedHealthcare includes any financial incentives, UnitedHealthcare encourages you to discuss those questions with your provider. You may also call UnitedHealthcare at the telephone number on your ID card. UnitedHealthcare can advise whether your Network provider is paid by any financial incentive, including those listed above.

Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek

care in a more cost effective setting and/or from Designated Facilities. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays and/or Coinsurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally in accordance with one or more of the following methodologies:

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

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

or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use comparable methodology(ies). 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 methodology.

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

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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

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

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders 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.

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

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

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 for each Plan option is shown in the Attachments (Attachment III – HSA 70, Attachment IV – HSA 80, Attachment V – Classic 70, or Attachment VI – Out-of-Area Plan).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

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 or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 6, *Outpatient Prescription Drug*.

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 set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 6, *Outpatient Prescription Drugs*.

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

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable.

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:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Benefits and* Section 6 – *Outpatient Prescription Drug Plan.*
- 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 or* Section 6 – *Outpatient Prescription Drug Plan.*

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.

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

Dependent - an individual who meets the eligibility requirements specified in the Plan, 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 Dispensing Entity - a pharmacy, provider, or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

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 through live audio with video technology or audio only.

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 or as required by law as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. 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 accepts.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency Health Services – with respect to an Emergency, both of the following:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

  a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

  b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

  c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

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

Employee - a regular Employee of the Employer who works an average of at least 20 hours per week and is currently in Active Service. An Employee must live and/or work in the United States.

An eligible Employee does not include any employee who:

- is temporary (e.g., a seasonal intern) or 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 covered by a collective bargaining agreement, unless the collective bargaining agreement provides for eligibility under this Plan;
- 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.

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 as appropriate for the proposed use in any of the following:

- AHFS D*rug Information (AHFS DI)* under therapeutic uses section;
- *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
- *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; *or*
- *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.
-

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 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.

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.
- Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

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

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

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.

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

Latrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Independent Freestanding Emergency Department – a health care facility that:

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

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavioral Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Program(s) - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided 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 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 service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

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

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Delegate – the organization or individual designated by ABC Co. who provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services.

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

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network. 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/High Intensity Outpatient - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator 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 medications or products administered in connection with a Covered Health Service by a Physician.

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. 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.

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

Primary Care Physician (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 an inpatient or home setting when any of the following are true:

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

- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.

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

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

1) An *All Payer Model Agreement* if adopted,

2) State law, or

3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

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

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

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.

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

Residential Treatment – A program of Mental Health Services or Substance-Related and Addictive Disorders Services that 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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

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

SCHIP - See State Children's Health Insurance Program (SCHIP).

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

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health 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.

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

Skilled Care - skilled nursing, 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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

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

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

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

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

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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. Please note: these living arrangements are also known as supportive housing (including recovery residences).

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

- Well-designed system reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case control studies cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

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** and liveandworkwell.com.

Please note:
If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Unproven Services - health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, 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. (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. (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 - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. For purposes of Section 9 – *Claims Procedures*, a different definition of "urgent care" applies.

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

Prescription Drugs

Ancillary Charge – a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a Chemically Equivalent Prescription Drug Product is available**.**

Annual Deductible (or Deductible) – the amount you must pay for Prescription Drug Products in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible for each Plan option is shown in the Attachments (Attachment III – HSA 70, Attachment IV – HSA 80, Attachment V – Classic 70, or Attachment VI – Out-of-Area Plan).

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

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

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**.

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

Prescription Drug Charge - the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to 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 or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is generally appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain injectable medications and vaccines/immunizations administered in a Network pharmacy.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters including continuous 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 (PPACA Zero Cost Share) - 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 and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting the Claims Administrator at **myuhc.com** or the telephone number on your ID card.

For the purpose of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

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.

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

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
888-99-HR-NOW (994-7669)
HRNow@avnet.com

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.

In addition to the requirement under federal law, Massachusetts law requires that Massachusetts residents, eighteen (18) years of age and older, have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 877-MA-ENROLL or visit the Connector website (**mahealthconnector.org**). This Plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health coverage under the Massachusetts Health Care Reform Law as of January 1, 2022. If you enroll in this plan, you will satisfy the statutory requirement that you have health coverage meeting these standards.

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 Practices when you first enrolled in the Plan and you will be provided with a copy following any material revisions. You can also request a copy of the Notice of Privacy Practices 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 X* 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). You and your eligible Dependent(s) must be covered under the same Plan option (e.g., HSA 70, HSA 80, etc.). 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 – HSA 70 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 (Employee enrolled in single coverage). ■ Family (Employee + one or more dependents). ■ All family members contribute toward the family Deductible. An individual cannot have claims covered under the Plan until the total family Deductible has been satisfied. ■ The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$3,000 $6,000	$6,000 $12,000
Calendar Year Out-of-Pocket Maximum (combined Medical/Pharmacy) ■ Individual (Employee enrolled in single coverage). ■ Individual (Employee enrolled in family coverage). ■ Family (Employee + one or more dependents). ■ The Plan Sponsor may not permit certain coupons or	$6,000 $6,000 $12,000	$12,000 $12,000 $24,000

Plan Features	Network Amounts	Non-Network Amounts
offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.		
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 *Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	Unlimited	

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in in Section 14, *Glossary*.

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.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance. Eligible Expenses for ground and Air Ambulance transport provider by a non-Network Provider will be determined as described in Section 3, *How the Plan Works.* ■ Non-Emergency Ambulance. Eligible Expenses for ground and Air Ambulance transport provided by a Non-Network provider will be determined as described in Section 3, *How the Plan Works*.	*Ground and/or Air Ambulance* 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible	*Ground and/or Air Ambulance* 70% after you meet the Network Annual Deductible 40% after you meet the Annual Deductible
Cellular and Gene Therapy	70% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
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.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Congenital Heart Disease (CHD) Surgeries Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Dental Services - Accident Only See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Diabetes Self-Management Items ■ Diabetes equipment.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this Schedule of Benefits.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this Schedule of Benefits.
■ Diabetes supplies. ■ ■ See Section 5, *Plan Benefits*, for limits.	For diabetes supplies the Benefit is 70% after you meet the Annual Deductible	For diabetes supplies the Benefit is 40% after you meet the Annual Deductible
Durable Medical Equipment (DME) See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Emergency Health Services - Outpatient	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**
Enteral Nutrition	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Fertility Preservation for Latrogenic Infertility See Section 5, Plan Benefits for limits	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Fertility Services See Section 5, Plan Benefits, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Gender Dysphoria (Gender Identity Disorder) See Section 5, *Plan Benefits*, for limits.	**Non-surgical and Surgical treatments:** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	**Non-surgical treatments:** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. **Surgical treatments:** Not Covered
Hearing Aids One per ear every 3 years. See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Home Health Care	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospice Care	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospital - Inpatient Stay	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient (includes pre-admission testing)		
■ Lab Testing - Outpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing - Outpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Men's Family Planning Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Mental Health Services		
■ Inpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ Outpatient.	Office Visit 70% after you meet the Annual Deductible	Office Visit 40% after you meet the Annual Deductible
	All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 70% after you meet the Annual Deductible	All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 40% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
■ Outpatient. ■

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
	nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.	nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.
Obesity Surgery Bariatric services must be received at a Designated Facility. See Section 5, *Plan Benefits*, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Not Covered
Ostomy Supplies	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Pregnancy – Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Preimplantation Genetic Testing (PGT) and Related Services See Section 5, *Plan Benefits*, for limits	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	 100% 100% 100%	 Not Covered Not Covered Not Covered
Private Duty Nursing - Outpatient	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Prosthetic Devices See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 5, *Plan Benefits*, for visit limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Limit of 60 days per calendar year. See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
■ Inpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ Outpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Surgery - Outpatient	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Temporomandibular Joint (TMJ) Services See Section 5, *Plan Benefits*, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Therapeutic Treatments - Outpatient	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Facility. Services provided by a Non-Network facility are not covered.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Travel and Lodging Covered Health Services must be received at a Designated Facility (when required). See Section 5, *Plan Benefits*, for limits.	For patient and companion(s) of patient undergoing treatment for certain illnesses	
Urgent Care Center Services	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Urinary Catheters	70% after you meet the Annual Deductible	40% 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 Care 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 contacting the UnitedHealthcare at **myuhc.com** or the telephone number on your ID card.	70% 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.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Women's Family Planning Services		
■ Contraceptives (devices and procedures).	100%	40% after you meet the Annual Deductible
■ Abortion.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible

[1]Please obtain prior authorization from the Claims Administrator before you receive certain Covered Health Services as described in Section 5, *Plan Benefits*.

Pharmacy Benefit Information – OptumRx

Covered Health Services	Benefit (the Amount the Plan Pays) *Important Note:* **Plan Deductible applies to all Prescription Drugs not on the OptumRx Select Preventive Drug List.**
Prescription Drug from a Retail Network Pharmacy for up to a 30-day supply, the Plan pays:	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $75 per Prescription after Plan Deductible). For a Tier 1 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $10 Copay per Prescription.
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $100 per Prescription after Plan Deductible). For a Tier 2 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $25 Copay per Prescription.
■ **Tier-3**	For a Tier 3 Prescription Drug Product9 70% after Plan Deductible (Member cost not to exceed $150 per Prescription after Plan Deductible).
Mail Order	For up to a 90-day supply, the Plan pays:
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $187.50 per Prescription after Plan Deductible). For a Tier 1 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $25 Copay per Prescription.

Covered Health Services	Benefit (the Amount the Plan Pays) ***Important Note:*** **Plan Deductible applies to all Prescription Drugs not on the OptumRx Select Preventive Drug List.**
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $250 per Prescription after Plan Deductible). For a Tier 2 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $62.50 Copay per Prescription.
■ **Tier-3**	For a Tier 3 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $375 per Prescription after Plan Deductible).
Specialty Prescription Drug Products - up to a 30-day supply, the Plan pays: (Transplant and HIV specialty drugs can be dispensed in a 90-day supply at a Member cost of 3x the monthly cost)	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $75 per Prescription after Plan Deductible). For a Tier 1 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $10 Copay per Prescription.
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $100 per Prescription after Plan Deductible). For a Tier 2 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $25 Copay per Prescription.
■ **Tier-3**	For a Tier 3 Prescription Drug Product: 70% after Plan Deductible (Member cost not to exceed $150 per Prescription after Plan Deductible).

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 – HSA 80 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 (Employee enrolled in single coverage). ■ Family (Employee + one or more dependents). ■ All family members contribute toward the family Deductible. An individual cannot have claims covered under the Plan until the total family Deductible has been satisfied. ■ The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$2,000 $4,000	$4,000 $8,000
Calendar Year Out-of-Pocket Maximum (combined Medical/ Pharmacy) ■ Individual (Employee enrolled in single coverage). ■ Individual (Employee enrolled in family coverage). ■ Family (Employee + one or more dependents).	$5,000 $5,000 $10,000	$10,000 $10,000 $20,000

Plan Features	Network Amounts	Non-Network Amounts
■ The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.		
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-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	Unlimited	

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in in Section 14, *Glossary*.

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	60% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance. Eligible Expenses for ground and Air Ambulance transport provider by a non-Network Provider will be determined as described in Section 3, *How the Plan Works.* ■ Non-Emergency Ambulance. Eligible Expenses for ground and Air Ambulance transport provided by a Non-Network provider will be determined as described in Section 3, *How the Plan Works*.	*Ground and/or Air Ambulance* 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	*Ground and/or Air Ambulance* 80% after you meet the Network Annual Deductible 60% after you meet the Annual Deductible
Cellular and Gene Therapy	80% after you meet the Annual Deductible	Not Covered
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.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgeries Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Diabetes Self-Management Items ■ Diabetes equipment. ■ Diabetes supplies. ■ See Section 5, *Plan Benefits*, for limits.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this Schedule of Benefits. 80% after you meet the Annual Deductible	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this Schedule of Benefits. 60% after you meet the Annual Deductible
Durable Medical Equipment (DME) See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services - Outpatient	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible
Enteral Nutrition	80% after you meet the Annual Deductible	60% after you meet the Network Annual Deductible
Fertility Preservation for Latrogenic Infertility *See Section 5, Plan Benefits for visit limits*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Fertility Services *See Section 5, Plan Benefits, for limits.*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Gender Dysphoria (Gender Identity Disorder) See Section 5, *Plan Benefits*, for limits.	**Non-surgical and Surgical treatments:** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	**Non-surgical treatments:** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. **Surgical treatments:** Not Covered
Hearing Aids One per ear every 3 years. See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient (includes pre-admission testing) ■ Lab Testing - Outpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
■ X-Ray and Other Diagnostic Testing - Outpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Men's Family Planning Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient.	Office Visit 80% after you meet the Annual Deductible	Office Visit 60% after you meet the Annual Deductible
	All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 80% after you meet the Annual Deductible	All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 60% 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 Office Visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 80% after you meet the Annual Deductible Intensive Behavioral Therapy 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Office Visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 60% after you meet the Annual Deductible Intensive Behavioral Therapy 60% after you meet the Annual Deductible
Nutritional Counseling See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery Bariatric services must be received at	Depending upon where the Covered	Not Covered

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
a Designated Facility. See Section 5, *Plan Benefits*, for limits.	Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Preimplantation Genetic Testing (PGT) and Related Services See Section 5, *Plan Benefits*, for limits	80% after you meet the Annual Deductible	60% 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%	Not Covered Not Covered Not Covered
Private Duty Nursing - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 5, *Plan Benefits*, for visit limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Limit of 60 days per calendar year. See Section 5, *Plan Benefits*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services See Section 5, *Plan Benefits*, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Facility. Services provided by a Non-Network facility are not covered.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
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 treatment for certain illnesses	
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Virtual Care 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 contacting the UnitedHealthcare at **myuhc.com** or the telephone number on your ID card.	80% after you meet the Annual Deductible	Not Covered
Vision Examinations (For Dependent Children Age 18 & 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	60% after you meet the Annual Deductible
Women's Family Planning Services ■ Contraceptives (devices and procedures).	100%	60% after you meet the Annual Deductible
■ Abortion.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]Please obtain prior authorization from the Claims Administrator before you receive certain Covered Health Services as described in Section 5, *Plan Benefits*.

Pharmacy Benefit Information – OptumRx

Covered Health Services	Benefit (the Amount the Plan Pays) *Important Note:* **Plan Deductible applies to all Prescription Drugs not on the OptumRx Select Preventive Drug List.**
Prescription Drug from a Retail Network Pharmacy - up to a 30-day supply, the Plan pays:	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $75 per Prescription after Plan Deductible). For a Tier 1 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $10 Copay per Prescription.
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $100 per Prescription after Plan Deductible). For a Tier 2 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $25 Copay per Prescription.
■ **Tier-3**	For a Tier 3 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $150 per Prescription after Plan Deductible).
Mail order - up to a 90-day supply, the Plan pays:	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $187.50 per Prescription after Plan Deductible). For a Tier 1 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $25 Copay per Prescription.

Covered Health Services	Benefit (the Amount the Plan Pays) ***Important Note:*** **Plan Deductible applies to all Prescription Drugs not on the OptumRx Select Preventive Drug List.**
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $250 per Prescription after Plan Deductible). For a Tier 2 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $62.50 Copay per Prescription.
■ **Tier-3**	For a Tier 3 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $375 per Prescription after Plan Deductible).
Specialty Prescription Drug Products - up to a 30-day supply, the Plan pays: (Transplant and HIV specialty drugs can be dispensed in a 90-day supply at a Member cost of 3x the monthly cost)	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $75 per Prescription after Plan Deductible). For a Tier 1 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $10 Copay per Prescription.
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $100 per Prescription after Plan Deductible). For a Tier 2 Prescription Drug Product on the OptumRx Select Preventive Drug List: 100% after a $25 Copay per Prescription.
■ **Tier-3**	For a Tier 3 Prescription Drug Product: 80% after Plan Deductible (Member cost not to exceed $150 per Prescription after Plan Deductible).

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 V – CLASSIC 70 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 (Medical)		
■ Individual.	$2,000	$4,000
■ Family.	$4,000	$8,000
■ 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.		
■ The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		

Plan Features	Network Amounts	Non-Network Amounts
Calendar Year Out-of-Pocket Maximum (combined Medical/Pharmacy) ■ Individual. ■ Family. The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.	 $5,000 $10,000	 $10,000 $20,000
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 -related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	Unlimited	

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in in Section 14, *Glossary*.

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.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance. Eligible Expenses for ground and Air Ambulance transport provider by a non-Network Provider will be determined as described in Section 3, *How the Plan Works.*	*Ground and/or Air Ambulance* 70% after you meet the Annual Deductible	*Ground and/or Air Ambulance* 70% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance. Eligible Expenses for ground and Air Ambulance transport provided by a Non-Network provider will be determined as described in Section 3, *How the Plan Works*.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Cellular and Gene Therapy	70% after you meet the Annual Deductible	Not Covered
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.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgeries Benefits under this section include only the inpatient facility charges for the congenital heart disease surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Dental Services - Accident Only See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Diabetes Services		
Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Diabetes Self-Management Items		
■ Diabetes equipment.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this Schedule of Benefits.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this Schedule of Benefits.
■ Diabetes supplies.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Durable Medical Equipment (DME) See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Emergency Health Services - Outpatient	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Enteral Nutrition	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Fertility Preservation for Latrogenic Infertility *See Section 5, Plan Benefits for limits*	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Fertility Services *See Section 5, Plan Benefits, for limits.*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Gender Dysphoria (Gender Identity Disorder) See Section 5, *Plan Benefits*, for limits.	**Non-surgical and Surgical treatments:** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	**Non-surgical treatments:** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. **Surgical treatments:** Not Covered

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Hearing Aids One per ear every 3 years. See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Home Health Care	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospice Care	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospital - Inpatient Stay	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Lab, X-Ray and Diagnostics - Outpatient (includes pre-admission testing) ■ Lab Testing - Outpatient. ■	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing – Outpatient.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible
■ See Section 5, *Plan Benefits*, for limits.		

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible
Men's Family Planning Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Mental Health Services ■ Inpatient. ■ Outpatient.	70% after you meet the Annual Deductible Office Visit 70% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 70% after you meet the Annual Deductible	40% after you meet the Annual Deductible Office Visit 40% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 40% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
■ Outpatient. ■ See Section 5, *Plan Benefits*, for limits.	Office Visit 70% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 70% after you meet the Annual Deductible Intensive Behavioral Therapy 70% after you meet the Annual Deductible	Office Visit 40% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 40% after you meet the Annual Deductible Intensive Behavioral Therapy 40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Nutritional Counseling See Section 5, *Plan Benefits*, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible
Obesity Surgery Bariatric services must be received at a Designated Facility. See Section 5, *Plan Benefits*, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Not Covered
Ostomy Supplies	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	100% after you pay the $25 Primary Care Physician or $60 Specialty Care Physician per office visit Copay	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Pregnancy – Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Preimplantation Genetic Testing (PGT) and Related Services See Section 5, *Plan Benefits*, for limits	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	 100% 100% 100%	 Not Covered Not Covered Not Covered
Private Duty Nursing - Outpatient	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Prosthetic Devices See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 5, *Plan Benefits*, for visit limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Limit of 60 days per calendar year. See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Substance-Related Addictive Disorders Services		
■ Inpatient.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ Outpatient.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% 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	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services See Section 5, *Plan Benefits*, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Therapeutic Treatments - Outpatient	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Facility. Services provided by a Non-Network facility are not covered.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
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 treatment for certain illnesses	
Urgent Care Center Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible
Urinary Catheters	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Virtual Care 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 contacting the UnitedHealthcare at **myuhc.com** or the telephone number on your ID card.	100% after you pay the $25 Primary Care Physician per office visit Copay	Not Covered
Vision Examinations (For Dependent Children Age 18 and under)	100%	Not Covered
Wigs See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Women's Family Planning Services ■ Contraceptives (devices and procedures).	100%	40% after you meet the Annual Deductible
■ Abortion.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	40% after you meet the Annual Deductible

[1]Please obtain prior authorization from the Claims Administrator before you receive certain Covered Health Services as described in Section 5, *Plan Benefits*.

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, the Plan pays:	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 100% after $15 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, the Plan pays:	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 100% after $37.50 Copay per Prescription.
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 70% (Member cost not to exceed $150 per Prescription).
■ **Tier-3**	For a Tier 3 Prescription Drug Product: 70% (Member cost not to exceed $300 per Prescription).
Specialty Prescription Drug Products - up to a 30-day supply, the Plan pays: (Transplant and HIV specialty drugs can be dispensed in a 90-day supply at a Member cost of 3x the monthly cost)	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 100% after $15 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 VI – OUT-OF-AREA 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 (Medical) ■ 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.	$2,000 $4,000	$2,000 $4,000
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.	$5,000 $10,000	$5,000 $10,000

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 *Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance -related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	Unlimited	

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in in Section 14, *Glossary*.

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.	70% 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. Eligible Expenses for ground and Air Ambulance transport provider by a non-Network Provider will be determined as described in Section 3, *How the Plan Works.*	70% after you meet the Annual Deductible	70% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance. Eligible Expenses for ground and Air Ambulance transport provided by a Non-Network provider will be determined as described in Section 3, *How the Plan Works*.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Cellular and Gene Therapy	70% 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.)	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**
Congenital Heart Disease (CHD) Surgeries See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Accident Only See Section 5, *Plan Benefits*, for limits.	70% 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	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Diabetes Self-Management Items ■ Diabetes equipment.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Diabetes supplies. ■ See Section 5 *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Durable Medical Equipment (DME) See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Enteral Nutrition	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Fertility Preservation for Latrogenic Infertility *See Section 5, Plan Benefits for limits*	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**
Fertility Services *See Section 5, Plan Benefits, for limits.*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.
Gender Dysphoria (Gender Identity Disorder) See Section 5, *Plan Benefits*, for limits.	**Non-surgical and Surgical treatments:** 70% after you meet the Annual Deductible	**Non-surgical treatments:** 70% after you meet the Annual Deductible **Surgical treatments:** Not Covered
Hearing Aids One per ear every 3 years. See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Home Health Care	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	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**
Lab, X-Ray and Diagnostics - Outpatient (includes pre-admission testing)		
■ Lab Testing - Outpatient.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing - Outpatient.	70% 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	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Men's Family Planning Services	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient.	Office Visit 70% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs	Office Visit 70% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient.	Office Visit 70% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 70% after you meet the Annual Deductible Intensive Behavioral Therapy 70% after you meet the Annual Deductible	Office Visit 70% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 70% after you meet the Annual Deductible Intensive Behavioral Therapy 70% after you meet the Annual Deductible
■ See Section 5, *Plan Benefits*, for limits.		

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Nutritional Counseling See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery Bariatric services must be received at a Designated Facility. See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	Not Covered
Ostomy Supplies	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pregnancy – Maternity Services	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Preimplantation Genetic Testing (PGT) and Related Services See Section 5, *Plan Benefits*, for limits	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Preventive Care Services		
■ Physician Office Services.	100%	100%
■ Lab, X-ray or Other Preventive Tests.	100%	100%
■ Breast Pumps.	100%	100%

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Private Duty Nursing - Outpatient	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Prosthetic Devices See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures	70% 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.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Limit of 60 days per calendar year. See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient.	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Surgery - Outpatient	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**
Temporomandibular Joint (TMJ) Services See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	70% 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. Services provided by a Non-Network facility are not covered.	70% 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 treatment for certain illnesses	
Urgent Care Center Services	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Urinary Catheters	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Virtual Care 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 contacting the UnitedHealthcare at **myuhc.com** or the telephone number on your ID card.	70% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Vision Examinations (For Dependent Children Age 18 and under) See Section 5, *Plan Benefits*, for limits.	100%	100%
Wigs See Section 5, *Plan Benefits*, for limits.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Women's Family Planning Services ■ Contraceptives (devices and procedures).	100%	100%
■ Abortion.	70% after you meet the Annual Deductible	70% after you meet the Annual Deductible

[1]Please obtain prior authorization from the Claims Administrator before you receive certain Covered Health Services as described in Section 5, *Plan Benefits*.

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, the Plan pays:	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 100% after $15 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, the Plan pays:	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 100% after $37.50 Copay per Prescription.
■ **Tier-2**	For a Tier 2 Prescription Drug Product: 70% (Member cost not to exceed $150 per Prescription).
■ **Tier-3**	For a Tier 3 Prescription Drug Product: 70% (Member cost not to exceed $300 per Prescription).
Specialty Prescription Drug Products - up to a 30-day supply, the Plan pays: (Transplant and HIV specialty drugs can be dispensed in a 90-day supply at a Member cost of 3x the monthly cost)	
■ **Tier-1**	For a Tier 1 Prescription Drug Product: 100% after $15 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 VII - HEALTH SAVINGS ACCOUNTS

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that is established in your name to complement the HSA 70 and HSA 80 Plans only, which are high-deductible medical plans. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high-deductible health plan that is associated with the "HSA". Benefits available under the Plan are described in this Summary Plan Description (SPD) in Section 5, *Plan Benefits*.

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

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

About Health Savings Accounts (HSAs)

You gain choice and control over your health care decisions and expenditures when you have an HSA to complement the high-deductible medical plans described in this SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax-free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain qualified health expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay for services and items that are not qualified health expenses; however, these amounts are subject to income tax and may be subject to 20% penalty.

To meet your healthcare needs, you have:

- A high-deductible medical plan (HSA 70 or HSA 80) which are discussed in this Summary Plan Description;
- An HSA established in your name; and
- Health information, tools, and support.

HSA Contributions and Distributions

Health Savings Accounts (HSAs) are available to Employees who enroll in the HSA 70 or HSA 80 Plan and satisfy the requirements described below. If you satisfy the eligibility requirements, the Company will make a contribution to your HSA at the beginning of each year (or when you become a participant, if later). You can also make HSA contributions through payroll deductions or by a direct contribution. HSA

contributions will be available for your use only after they have been deposited into your account.

The amount you can contribute annually to your HSA is limited by the Internal Revenue Service and may change from year to year (e.g., the limits for 2022 are $3,650 for Employee Only coverage and $7,300 for Employee + Dependent coverage). The Company's contribution counts toward the annual limit. If you are age 55 or older, you can contribute an additional amount annually (e.g., in 2022 you can contribute an additional $1,000 to your account). Be careful not to exceed the annual contribution limit. If you contribute more than the maximum permitted, or you make or receive HSA contributions when you are not eligible, you will be subject to excise taxes.

You can use your HSA contributions and any earnings to pay out-of-pocket medical, dental, and vision expenses, referred to as "Qualified Expenses." In general, Qualified Expenses for your HSA include any medical, dental and vision expenses for you, your Spouse, or tax dependents that qualify for a medical expense deduction on your federal income taxes. (Note, however, that the same expense cannot be reimbursed from your HSA and deducted from your federal incomes taxes.) For example, Qualified Expenses generally include Coinsurance, amounts that are applied to your Deductible, and the cost of drugs that are prescribed for you.

If you don't use all the money in your HSA account during the Plan Year, the balance is carried over for reimbursement of Qualified Expenses in subsequent years, if certain requirements are met.

To make and/or receive contributions to an HSA:

- You must be enrolled in the HSA 70 or HSA 80 Plan. If you are not enrolled in the Plan but are enrolled in another high-deductible health plan, the Company will not make contributions on your behalf but you might still be eligible to make contributions to an HSA;
- You must not have any other medical coverage (e.g., coverage under your Spouse's plan or a former employer's plan), unless that coverage also qualifies as "high deductible" coverage or the coverage is an excepted benefit under the federal tax laws;
- Neither you nor your Spouse may participate in a flexible spending account (FSA) if the FSA can reimburse expenses other than dental or vision expenses before the minimum deductible determined by the IRS is satisfied. You may participate in Avnet's Limited Purpose FSA (described below), but not Avnet's General Purpose FSA;
- You cannot be enrolled in Medicare, TRICARE, tribal benefits, or other benefit programs. Keep in mind that some disqualifying benefit programs, such as Medicare Part A, require that you take action to avoid being covered; and
- You cannot be claimed as a dependent on someone else's tax return.

If you do not meet the above requirements, you can still enroll in the HSA 70 or HSA 80 Plan for your medical coverage, but you will not be eligible to make or receive HSA contributions. If the Plan Administrator discovers that it mistakenly contributed to your HSA, you will be required to return prior contributions and interest to the extent permissible under IRS rules and regulations.

You will not be allowed to change to a different health plan until the next open enrollment period, unless you qualify under the "Change in Status" rules summarized in *Attachment II – Legal Notices* entitled "Effect of Section 125 on This Plan" or the rules summarized in the section entitled "Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)."

Your HSA is an individual bank account in your name. This account is not maintained, sponsored, or endorsed by the Company, nor is it subject to ERISA. The Company has contracted with HealthEquity to establish an HSA in your name and administer your account. The Company intends to pay the HealthEquity administrative fees as long as you are enrolled in a qualifying Plan. For more information about the HealthEquity HSA, visit the education website at **healthequity.com/ed/avnet**.

You are solely responsible for managing your HSA to ensure that contributions qualify for favorable tax treatment and that funds are used only for Qualified Expenses. HSAs are not subject to a claims process. Making or receiving contributions to an HSA when you are not eligible, or withdrawing HSA funds for expenses that are not qualified, will generally result in tax penalties. You should consult your tax advisor.

If your coverage under the Plan terminates for any reason, you will not forfeit any remaining HSA balance. These funds will be available for Qualified Expenses for you, your Spouse, or tax dependents after your coverage ends. However, discontinuing participation in the Plan (e.g., if you leave the Company mid-year) might result in over-contributions to your HSA. You should review the contribution limits before making any mid-year changes to your coverage.

The Company's annual HSA contribution is as follows (contingent on your Plan participation effective date):

Company Annual HSA Contribution	**HSA 70 Effective Date Before July 1**	**HSA 70 Effective Date On or After July 1**	**HSA 80 Effective Date Before July 1**	**HSA 80 Effective Date On or After July 1**
Employee Only	$200	$100	$400	$200
Employee + Dependents	$400	$200	$800	$400

Your Company contribution will be credited to your account at the beginning of the year or at the time you are eligible, if you enroll mid-year.

If you move to a higher coverage tier during the Plan Year (such as from Employee only coverage to Employee + Dependent coverage), the Company will contribute an additional amount to bring your annual contribution to the dollar amount corresponding

to your new tier level. However, there will be no Company contribution reversal if you move to a lower coverage tier during the Plan Year (such as from Employee + Dependent coverage to Employee only coverage). Again, it is important to review the applicable HSA contribution limits before making any changes to your coverage.

About Flexible Spending Accounts (FSAs)

Employees in the HSA 70 or HSA 80 Plan are not eligible to enroll in a General Purpose Healthcare FSA. Therefore, if you or your Spouse enroll in a Limited Purpose Healthcare Flexible Spending Account ("FSA"), your FSA balance can be used for dental and vision expenses only.

Avnet, Inc. has entered into an agreement with HealthEquity under which HealthEquity will provide certain administrative services to the Plan.

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

Important
Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Avnet, Inc. and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Avnet, Inc. and the Claims Administrator are not responsible or liable for the misuse by Employees of HSA funds by, or for the use by Employees of HSA funds for non-qualified health expenses.

You can obtain additional information on your HSA online at **irs.gov**. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

ATTACHMENT VIII – NONDISCRIMINATION

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc. on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, secual orientation, and gender identity). UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides the Employer free aids and services to help you communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages
- We also provide reasonable modifications for persons with disabilities.

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Employer.

If you believe the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator identified below.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

Employer Civil Rights Coordinator
Avnet, Inc. Civil Rights Coordinator Benefits Department 2211 S. 47th St. Phoenix, AZ 85034 888-99-HR-NOW (994-7669), TTY 711 HRNow@avnet.com

If you need help filing a complaint, the Civil Rights Coordinator identified above is available to help you.

Your can also file a complaint directly with the U.S. Dept. of Health and Human Services, Office for Civil Rights online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT IX – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUSILIARY AIDS AND SERVICES

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0 (TTY 711).

This attachment is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m.

Language¤	Translated·Taglines¤
1.→ Albanian¤	Ju·keni·të·drejtë·të·merrni·ndihmë·dhe·informacion·falas·në·gjuhën·tuaj.·Për·të·kërkuar·një·përkthyes,·telefononi·në·numrin·që·gjendet·në·kartën·e·planit·tuaj·shëndetësor,·shtypni·0.·TTY·711.¤
2.→ Amharic¤	ያለ·ምንም·ክፍያ·በቋንቋዎ·እርዳታና·መረጃ·የማግኘት·መብት·አላቸሁ።··አስተርጓሚ·እንዲቀርብልዎ·ከፈለጉ·በጤና·ፕላን·መታወቂያዎት·ላይ·ባለው·በተጻ·መስመር·ስልክ·ቁጥር·ይደውሉና·0ን·ይጫኑ።·TTY·711¤
3.→ Arabic¤	لك·الحق·في·الحصول·على·المساعدة·والمعلومات·بلغتك·دون·تحمل·أي·تكلفة.·لطلب·مترجم·فوري،·اتصل·برقم·الهاتف·المجاني·الخاص·بالأعضاء·المدرج·ببطاقة·مُعرّف·العضوية·الخاصة·بخطتك·الصحية،·واضغط·على·0.·الهاتف·النصي·(TTY·711)¤
4.→ Armenian¤	Թարգմանիչ·պահանջելու·համար,·զանգահարե՛ք·Ձեր·առողջապահական·ծրագրի·ինքնության·(ID)·տոմսի·վրա·նշված·անվճար·Անդամնէրի·հէռախոսահամարով,·սեղմե՛ք·0:·TTY·711¤
5.→ Bantu-Kirundi¤	Urafise·uburenganzira·bwo·kuronka·ubufasha·n'amakuru·mu·rurimi·rwawe·ku·buntu.·Kugira·usabe·umusemuzi,·hamagara·inomero·ya·telephone·y'ubuntu·yagenewe·abanywanyi·iri·ku·rutonde·ku·karangamuntu·k'umugambi·wawe·w'ubuzima,·fyonda·0.·TTY·711¤
6.→ Bisayan-Visayan·(Cebuano)¤	Aduna·kay·katungod·nga·mangayo·og·tabang·ug·impormasyon·sa·imong·lengguwahe·nga·walay·bayad.·Aron·mohangyo·og·tighubad,·tawag·sa·toll-free·nga·numero·sa·telepono·sa·miyembro·nga·nakalista·sa·imong·ID·kard·sa·plano·sa·panglawas,·pindota·ang·0.·TTY·711¤
7.→ Bengali-Bangala¤	অনুবাদকের·অনুরোধ·থাকলে,·আপনার·স্বাস্থ্য·পরিকল্পনার·আই·ডি·কার্ড·এ·তালিকাভুক্ত·ও·কর·

8.→ Burmese¤	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဝန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9.→ Cambodian-Mon-Khmer¤	[illegible] ID [illegible] 0 TTY 711¤
10.→Cherokee¤	Θ·D4Ꭴ·ᏏP·ᏗCZᏢᏗ·Ꮷ4ᏫᎠᏗ·ᏂᎪᏯᎳᏇ·ᎶᏆᏢ·ᏁᎭ·ᏏR·ᏗJᎪᏁᏗ·ACᏫᎠᏁᏗ·ᎢΘᏂᏫᎠᏗT, ·ᏙᏐ0ᵇᏫᎠᏓ·0. TTY·711¤
11.→Chinese¤	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711¤
12.→Choctaw¤	Chim·anumpa·ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711¤
13.→Cushite-Oromo¤	Kaffaltii mala afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711¤
14.→Dutch¤	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711¤
15.→French¤	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.¤
16.→French Creole-Haitian Creole¤	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711¤
17.→German¤	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an

	und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફ્રેન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono ʻī me ka uku ʻole ʻana. ↵ E kama ʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tsww cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị n'akwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

27.·Japanese¤	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID· カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は·711です。¤
28.·Karen¤	[illegible] 0 [illegible].TTY 711
29.·Korean·¤	귀하는·도움과·정보를·귀하의·언어로·비용·부담없이·얻을·수·있는·권리가·있습니다.·통역사를·요청하기·위해서는·귀하의·플랜·ID카드에·기재된·무료·회원·전화번호로·전화하여·0번을·누르십시오.·TTY·711¤
30.·Kru-·Bassa¤	Ni·gwe·kunde·I·bat·mahola·ni·mawin·u·hop·nan·nipehmes·be·to·dolla.·Yu·kwel·ni·Kobol·mahop·seblana,·soho·ni·sebel·numba·I·ni·tehe·mu·I·ticket·I·docta·I·nan,·bep·0.·TTY·711¤
31.·Kurdish-Sorani¤	[illegible] TTY·711¤
32.·Laotian¤	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ.· ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເວກໂທລະສັບຢ່າງັບ ອະນາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດອະນາຊິກຂອງທ່ານ,ກົດເວກ· 0.·TTY·711¤
33.·Marathi¤	आपल्याला·आपल्या·भाषेत·विनामूल्य·मदत·आणि·माहिती·मिळण्याचा·अधिकार·आहे.·दूभाषकास·विनंती·करण्यासाठी·आपल्या·आरोग्य·योजना·ओळखपत्रावरील·सूचीबध्द·केलेल्या·सदस्यास·विनामूल्य·फोन·नंबरवर·संपर्क·करण्यासाठी·दाबा·0.·TTY·711¤
34.·Marshallese¤	Eor·aṃ·maroñ·ñan·bok·jipañ·im·meḷeḷe·ilo·kajin·eo·aṃ·ilo·ejjeḷọk·wōṇāān.·Ñan·kajjitōk·ñan·juon·ri-ukok,·kūṛọk·nōṃba·eo·emōj·an·jeje·ilo·kaat·in·ID·in·karōk·in·ājmour·eo·aṃ,·jiped·0.·TTY·711¤
35.·Micronesian-Pohnpeian¤	Komw·ahneki·manaman·unsek·komwi·en·alehdi·sawas·oh·mengihtik·ni·pein·omwi·tungoal·lokaia·ni·soh·isepe.·Pwen·peki·sawas·en·soun·kawehweh,·eker·delepwohn·nempe·ong·towehkan·me·soh·isepe·me·ntingihdi·ni·pein·omwi·doaropwe·me·pid·koasoandi·en·kehl,·padik·0.·TTY·711.¤
36.·Navajo¤	T'áá·jíík'eh·doo·baąh·'alínígóó·bee·baa·hane'ígíí·t'áá·ni·nizaád·bee·nikáʼe'eyeego·bee·ná'ahoot'i'.·ʼAta'·halne'í·ła·yíníkeedgo,·ninaaltsoos·nitʻiz7·ʻats'77s·bee·baa'ahay1·bee·n44hozin7g77·bik11'·b44sh·bee·hane'7·t'11·j77k'eh·bee·hane'7·bik1'7g77·bich'8'·hodíilnih·dóó·0·bił·

	'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست خود تماس حاصل بهداشتی برنامه شناسایی کارت در شده قید رایگان مترجم شفاهی با شماره تلفن نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика

	позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan - Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. ↵ TTY 711
50. Sudanic-Fulfulde	Dum hakke maada mballedaa kadin keɓaa habaru nder wolde maada naa maa a yoɓii. To a yidi pirtoowo, noddu limngal mo telefol caahu limtaado nder kaatiwol ID maada ngol njamu, nyo'u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambari ya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	·0 TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంటు మరియు సమాచారం పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลข โทรฟรีที่ อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรหาหมายเลข 711
56. Tongan -	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki

Fakatonga	he fika telefoni ta'etotongi ma'ae kau memipa ʻa ee ʻoku lisi ʻI ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I ʻa e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	اپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט קארטל, דרוקט ID דעם טאל פריי מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן TTY 711 0.
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ʻ0'. TTY 711

ATTACHMENT X - HIPAA PRIVACY PLAN AMENDMENT

HIPAA Privacy Plan Amendment

Avnet, Inc. ("Avnet") has adopted this Plan Document Amendment to the Avnet Group Benefits Plan and the Avnet Insured 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 and Avnet Insured 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 Plan, which provide or pay the cost of Medical Care, including the:

- HSA 70 Medical Plan,
- HSA 80 Medical Plan,
- Classic 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan (NoCal),
- Kaiser Permanente Medical Plan (SoCal),
- Hawaii Medical Plan,
- Employee Assistance Program/Behavioral Health,
- Vision Service Plan,
- PPO Dental,
- Copay Dental,
- Health Care Flexible Benefits,

"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 this HIPAA Privacy Plan Amendment, 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;

(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

[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.

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.

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.

Avnet Group Benefits Plan and Avnet Insured Plan Components and Designated Avnet Employees

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,
- Classic 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan (NoCal),
- Kaiser Permanente Medical Plan (SoCal),
- Hawaii Medical Plan,
- Employee Assistance Program/Behavioral Health,
- Vision Service Plan,
- PPO Dental,
- Copay Dental,
- Health Care Flexible Benefits.

The following 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 Plan:

The following classes of employees and other persons are hereby designated to perform Plan Administration Functions on behalf of the Avnet Group Benefits Plan (the “Plan”):

Designated Employees (Job Title)
Director, Global Benefits
Benefits Specialists
Rewards Advisors

***End of Summary Plan Description