PetSmart LLC

SmartChoices and Flexible Benefits Plans

Summary Plan Description

Effective January 1, 2023

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OVERVIEW

As a full-time Associate in the U.S., you are eligible to participate in the PetSmart SmartChoices Benefits Plan and the PetSmart Flexible Benefits Plan. This means that you can choose among the benefits and coverage options described below.

This Summary Plan Description describes the basic features of both plans. Throughout it, we refer to the PetSmart SmartChoices Benefits Plan as the "Smart Choices Plan," the PetSmart Flexible Benefits Plan as the "Flex Plan," and the two plans, collectively, as the "Plans."

This Summary Plan Description is part of the official plan document for the SmartChoices Plan. If there is a conflict between the official plan document and this Summary Plan Description, the official plan document is controlling. For those benefits provided under terms of an insurance contract, the provisions of the insurance contract are always controlling in case of a conflict. The Surest Supplemental Plan Description describes the features of the Surest Plan and is effective January 1, 2023.

The official Flex Plan document is separate and apart from the SmartChoices Plan and is controlling if there is any conflict between the Flex Plan and this Summary Plan Description.

Many terms have special meanings for purposes of this Summary Plan Description. To call your attention to the more important defined terms, we have capitalized them. These terms are defined in the Glossary or elsewhere in the Summary Plan Description.

This Summary Plan Description is effective January 1, 2023

BENEFITS AT A GLANCE

SmartChoices Plan Benefits – The SmartChoices Plan actually consists of several component benefit plans and benefit offerings: the Medical Plan, the Dental Plan, the Vision Plan, the Employee Assistance Plan (EAP), the Life Insurance and AD&D Plan, the Short-Term Disability Plan and the Long-Term Disability Plan.

Flex Plan Benefits – The Flex Plan generally allows you to pay for your coverage for benefits under the SmartChoices Plan on a before-tax basis for most plans. Premiums for domestic partner benefits must be paid with after-tax funds, and the value of the employer-paid portion of the coverage will be treated as imputed income. This is not actual cash income but means the value of the employer-paid portion of the coverage is included in the employee's gross income in order to calculate the required tax withholdings. Flexible Spending Accounts are also offered under the Flex Plan.

Company Contribution to the SmartChoices Plan – To help pay for benefits, the Company contributes toward coverage under the Medical Plan (including the EAP), the Dental Plan, Basic Life under the Life Insurance Plan, and the Short-Term Disability Plan. It also contributes toward coverage under the Long- Term Disability Plan for certain Associates and other individuals as more fully described below.

Medical Plan – If you enroll in the Medical Plan, you must generally select coverage for yourself and, if desired, for your Eligible Dependents from among two available PPO options and a High Deductible Health Plan ("HDHP") with a Health Savings Account ("HSA) or the Surest personalized health plan. If a network of PPO doctors is not available in your home area, you'll be offered Out of Network coverage. Depending on which Medical Plan option you select, the Company may establish and allocate benefit dollars to a health reimbursement account ("HRA") in your name as part of your coverage. You may not contribute to the HRA. However, once you have used up any money in your Health Care FSA, you may use benefit dollars credited to your HRA to cover eligible health care expenses, and the balance in your HRA will not be forfeited at year's end. However, see the HRA section below for more information on how enrolling in the HDHP medical option with a Health Savings Account or the Surest Health plan will affect your eligibility for the HRA. Prescription drug coverage is included under all Medical Plan options as is the EAP.

Dental Plan – You can choose Dental Plan I, Dental Plan II, or a Dental Health Maintenance Organization (DHMO), if offered in your area. The Company contributes to Dental Plan I and Dental Plan II.

Vision Plan – If you elect vision coverage, you can obtain vision care services and supplies through a network of participating providers who provide eye exams, prescription glasses and contact lenses or from any out-of-network provider. The Company does not contribute to this plan.

Spending Accounts – The Company offers Flexible Spending Account options ("FSA") to help you save money for certain health care and child care expenses: a Health Care FSA (if you are

enrolled in a non-high-deductible health plan option), a Limited-Purpose FSA (if you are enrolled in the high-deductible health plan option and had up to $500 of unused amounts from your Health Care FSA from the previous Plan Year) to pay for certain dental, vision and preventive care expenses only, and a Dependent Day Care FSA to help you pay for child care expenses. The money you contribute to these accounts is on a before- tax basis. The Company does not make contributions to these accounts.

Health Savings Account (HSA) – The Company offers an HSA to those enrolled in the HDHP medical plan option to help you to cover certain health-related expenses. The money you contribute to your HSA through payroll contributions is on a Pre-Tax basis in most states and is subject to IRS annual limits. The Company may contribute to the associate's HSA account.

Life Insurance & AD&D – The Company provides and pays for a basic level of life insurance to all full-time Associates. You can increase your life insurance, add AD&D (accidental death and dismemberment) coverage, or elect life insurance coverage for your Eligible Dependents at your own expense. AD&D coverage is not available under the Plan for Eligible Dependents.

Short Term Disability – The Company provides this coverage, to all full-time Associates. Associates in some states have access to Short Term Disability benefits through their state. Short-term disability coverage is not available under the Plan for Eligible Dependents.

Long Term Disability – The Company provides this coverage, without cost, to all full-time salaried Associates, full-time hourly Associates assigned to the Phoenix Home Office, full-time Salon Leaders, and full-time hourly store leadership classified as non-exempt manager (NEMG) (this does not include store lead level positions). It is offered on a voluntary, associate-paid basis to other full-time Associates. Long-term disability coverage is not available under the Plan for Eligible Dependents.

ELIGIBILITY & PARTICIPATION

ENROLLMENT RULES

When Do Associates First Become Eligible?

SmartChoices Plan

If you're a full-time salaried Associate, you're eligible to participate in the SmartChoices Plan on the first day of the month following your date of hire except as noted below for the Flexible Spending accounts. If you're a full-time hourly Associate, you must be employed by the Employer for 90 days to be eligible to participate in the Plans, and your coverage begins on your 91st day, assuming you enroll in the first 45 days of employment during your initial enrollment period. Generally, you are "full-time" if you work 32 or more hours per week (30 hours for medical plan coverage—see *Special Rules For the Medical Plan* below) and are classified as a "full-time" associate.

If you're a part-time Associate and change to a full-time salaried position, any coverage under the SmartChoices Plan will begin on the first day of the month following the date you changed from part- time to full-time. If you're a part-time Associate and changed to a full-time hourly position, your coverage will begin on the later of:

- your 91st day of employment (including both part-time and full-time service); or
- the first day of the month following the date you changed from part-time to full time.

If you are enrolled in the HDHP, then you are eligible for the Health Savings Account ("HSA") only if you meet certain criteria. Specifically, you must:

- Elect coverage in the HDHP medical option;
- Not be covered under any medical plan that is not an HDHP (e.g., a spouse's employer's non-HDHP plan);
- Not participate in the Health Care FSA for the Plan Year;
- "Freeze" any existing health reimbursement account (HRA) balances or not participate in the HRA for the Plan Year;
- Not be enrolled in Medicare, TRICARE, or most VA benefits; and
- Not be claimed as a dependent on another person's tax return

If you meet the criteria above and are a full-time salaried Associate, then you are eligible for the HSA on the first of the month following your date of hire. If you are a full-time hourly Associate, you must meet the criteria above and be employed for 90 days to be eligible to participate.

Flexible Spending Account Plan

In the case of the HealthCare Flexible Spending Account Plan, Limited-Purpose Flexible Spending Account, and the Dependent Day Care Flexible Spending Account Plan, full-time salaried and full-time hourly Associates must be employed by the Employer for 90 days to be eligible to participate.

Coverage will begin on your 91st day, assuming you enroll during your 45-day initial enrollment period. If you're a part-time Associate and change to a full-time salaried or full-time hourly position, your coverage for the Flexible Spending Account Plans will begin on the later of:

- your 91st day of employment (including both part-time and full-time service); or
- the first day of the month following the date you changed from part-time to full time.

Temporary, seasonal and part-time Associates who work, on average, less than 32 hours a week are not eligible for coverage under the Plans. This means that if you move from a full-time to a part-time position, you'll no longer be eligible to participate in all the Plans. Your eligibility to participate in the medical plan will be based on the rules set forth in the "When Coverage Ends" section.

Special Rules For the Medical Plan

An Associate who is not classified as full-time but works, on average, at least 30 hours of service per week generally will be eligible for coverage under the Medical Plan as a Part-Time Eligible or ("PTE"). PetSmart has opted to utilize the look-back measurement method and count Associate hours of service for a specific period (referred to as the "Measurement Period") to determine whether an Associate has PTE status and is eligible for medical coverage for a pre-established future period (referred to as the "Stability Period").

In the case of hourly Associates, PetSmart will calculate your actual hours of service from records of hours worked and non-worked hours for which payment is made or due (e.g., vacation, holiday, illness, incapacity, etc.).

PTE status does not make an associate eligible to participate in any other benefits available under the Plan.

When Do Eligible Dependents First Become Covered? Your Eligible Dependents will be covered under the Plan the same date your coverage becomes effective, but only if you affirmatively enroll your Eligible Dependents during your initial enrollment period. The Benefits Department will require documentation verifying the proof of dependent status.

How Do I Select Benefit and Coverage Options? To select benefits and coverage options for yourself and any Eligible Dependents, you must enroll using HR Connect website https://hrconnect.petsmart.com/. Associates are provided 45 days from their hire date if full-time (or from the status change date) to enroll (the "initial enrollment period") to make their benefit and coverage option elections. If you require assistance, please contact the Benefits Team at 1-866-263-8411 or by email at benefits@petsmart.com for assistance. You cannot be covered under the Plans as both an Associate and an Eligible Dependent or as the Eligible Dependent of more than one Associate.

What are the Coverage Categories? For the medical, dental and vision plans, you may elect coverage in the following categories:

- Associate Only
- Associate Plus Spouse

- Associate Plus Domestic Partner
- Associate Plus Eligible Child(ren)
- Associate Plus Family (includes Spouse or Domestic Partner and Eligible Child(ren))

Who Are My Eligible Dependents? "Eligible Dependent" means an Associate's:

- Spouse;
- Eligible Children;
- Domestic Partner:
- Domestic Partner's children.

Dependents not listed above are not eligible for the Plan. Proof of the relationship for any dependent covered may be required to verify eligibility. Fraudulently adding dependents or providing other inaccurate information or misrepresentations to the Plan may result in termination of the Covered Person's benefits (including retroactive termination in certain cases), denial of future benefits, legal action against the Covered Person, set-off from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan, and under certain circumstances, could result in disciplinary action including termination of the Associate's employment.

NOTE: If your Spouse or Domestic Partner is eligible for other coverage with his/her employer and you cover them under a PetSmart Medical Plan, you will pay a spousal surcharge in addition to your regular Associate contribution. See benefits.petsmart.com for details. Prior to coverage, valid proof of the relationship for any Spouse or Domestic Partner will be required to verify eligibility.

Who Qualifies as a "Spouse" for Purposes of the Plan? "Spouse" means a person of the same or opposite sex who is lawfully married to an Associate based on federal law. However, a legally separated spouse is not eligible for coverage under the Plan.

Who Qualifies as a "Domestic Partner" for Purposes of the Plan? "Domestic Partner" means a person of the same or opposite sex who is not married to an Associate, or to any other person, and has been in an exclusive committed relationship, similar to marriage, for at least 12 months, and meets the requirements described in the Affidavit of Domestic Partnership. You must properly complete and file with the Benefits Department the Affidavit of Domestic Partnership if you elect coverage for your Domestic Partner and /or you Domestic Partner's Eligible Children.

Eligiblity for Domestic Partner includes the following and supporting documentation is required:

- Reside together in an exclusive committed relationship, similar to marriage, and intend to continue in the relationship indefinitely;
- Have lived together for at least twelve (12) consecutive months, or twelve (12) consecutive months as of the effective date of coverage;
- Are jointly responsible for each other's basic living expenses;
- Are at least 18 years old and mentally competent to consent to contract; and
- Are not related by blood to a degree of closeness that would prohibit legal marriage in the state where the parties legally reside;

- Neither is legally married to, the civil union spouse of, or a domestic partner of any other person;
- Both are mentally capable of consenting to the domestic partnership and are not consenting to the partnership under force, duress, or fraud;
- The relationship is not in violation of any laws applicable to the benefit;
- There has been at least twelve months since the termination of a previous domestic partnership.

Premiums for domestic partner benefits must be paid with after-tax dollars, and the employer-paid portion of your domestic partner's coverage will be treated as imputed income to the employee. This is not cash income, but the amount of the employer-paid portion of the domestic partner's coverage must be included in the employee's gross income in order to properly calculate tax withholdings.

What happens when a Domestic Partnership ends? An associate must notify PetSmart within forty-five (45) days of the termination of a domestic partnership by filing a Termination of Domestic Partnership with the Benefits Department. An associate cannot file a new domestic partnership for twelve (12) months following the filing of a Notice of Termination of Domestic Partnership. The form can be found at benefits.petsmart.com

Who Qualifies as an "Eligible Child" for Purposes of the Plan? "Eligible Child" or "Eligible Children" means an Associate's or Spouse's or Domestic Partner's child or children (i.e., natural children, adopted children, children placed for Adoption with the Associate or Spouse or Domestic Partner, stepchildren, and children for whom the Associate is a non-temporary legal guardian) who are:

- under age 26; or
- age 26 or older, physically or mentally disabled for the foreseeable future, incapable of self- sustaining employment, and principally dependent on you for support.

Spouses or children of an Eligible Child are not eligible for coverage under the Plan.

To be considered a child's non-temporary legal guardian, you must have a valid court order specifying the guardianship is permanent or non-temporary. Simply having physical custody and control of the child, or temporary guardianship is insufficient.

If you enroll Eligible Dependents in the Medical and/or Dental Plans you will be asked to provide documentation to verify they meet dependent eligibility requirements under these Plans. Failure to provide supporting documentation will result in the dependent being removed from the plan.

What Is Required for Me to Keep 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 beyond the age of 26, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to PetSmart proof of the child's incapacity and dependency within 31 days

of the date coverage would have otherwise ended because the child reached age 26.
- You provide proof, upon PetSmart's periodic request, that the child continues to meet these conditions.

The proof might include medical examinations at PetSmart's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days of PetSmart's request, the child will be disenrolled from coverage under the Plan. Once disenrolled, the child may not be re-enrolled in the Plan.

Provided you comply with any requests for proof of continuing disability, coverage will continue as long as the enrolled Dependent is disabled and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

What Happens If I Don't Enroll On Time? Because we believe it's important for you to have certain coverage, if you do not enroll within your first 45 days of becoming eligible, we automatically enroll you for the default coverage shown below. Default benefits cover only you, not your Eligible Dependents.

Medical Care	No Coverage
Dental Care	No Coverage
Vision Care	No Coverage
Short Term Disability	Coverage
Long Term Disability	Coverage (for Associates who qualify)
Basic Life Insurance	1 x Annual Base Salary (or, for salon leaders, $40,000)
AD&D Insurance	No Coverage
Dependent Life Insurance	No Coverage

May I Waive Medical Coverage? We do not require that you enroll in our Plan. We may require that you complete a waiver of medical coverage.

What Are My Special Enrollment Rights? If an eligible Associate waives medical, dental, or vision coverage, generally the Associate and the Associate's Eligible Dependents can enroll during the year if they become eligible for a "special enrollment."

You and/or your Eligible Dependents are eligible for a special enrollment if, when you waived medical, dental, or vision coverage when it was previously offered to you under the Plan, you did so because you or your Eligible Dependents had other coverage and:

- If that other coverage was COBRA coverage, the continuation period has been exhausted (not voluntarily terminated by you or your Eligible Dependent); or
- If that other coverage was <u>not</u> COBRA coverage, employer contributions for it stopped or the other coverage has ended due to a loss of eligibility caused by:
  - divorce or legal separation;
  - termination of domestic partnership that causes you to loss other coverage;
  - death;
  - termination of employment or reduction in hours of the covered individual; or
  - certain other events that cause loss of eligibility.

Under certain other circumstances, you and your Eligible Dependents may not be eligible for a special enrollment; for example, if other coverage is lost due to nonpayment of premiums or for cause (such as filing fraudulent claims). The Administrator has the right to determine what other circumstances might be included.

You and your Eligible Dependents are also eligible for a special enrollment if you acquire a new Eligible Dependent through:

- marriage;
- birth; or
- adoption or Placement for Adoption of a child under the age of 18.

You must elect special enrollment within 45 days of losing other coverage or acquiring a new Eligible Dependent, whichever is applicable. For marriage, coverage will be effective on the first day of the month following the date of the marriage, provided the Benefits Department receives the required documentation of the special enrollment. The effective date for the birth or adoption of a child will be the child's date of birth or adoption placement date, provided you timely request enrollment. Any premiums owed for the special enrollment are the Associate's responsibility and are collected on a post-tax basis.

To enroll an Eligible Dependent during a special enrollment period, an Associate must already be enrolled in the Plan or must enroll himself/herself at the time enrollment for the Eligible Dependent is sought.

Domestic Partners and your Domestic Partner's children can only be added to your coverage during your initial eligibility enrollment, at annual open enrollment and with the loss of other coverage.

If you and/or your Eligible Dependents are covered under Medicaid or a state Child Health Insurance Program ("CHIP") and lose eligibility for such coverage, you may be able to enroll yourself or your Eligible Dependents who lost such coverage in this Plan, provided that you request enrollment within 60 days after the loss of coverage.

Likewise, if you and/or your Eligible Dependent become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself or your Eligible Dependents who become eligible for premium assistance in this Plan, provided that you request enrollment within 60 days after the date you are determined to be eligible for premium assistance. Coverage will be effective as the date of the special enrollment event.

Special Rule During COVID-19 Emergency: The Plan's existing rules for the time in which you must request special enrollment will be modified to comply with Department of Labor and Internal Revenue Service guidance on the COVID-19 pandemic.

Specifically, if your special enrollment event occurs prior to July 10, 2023, your 45- or 60- day deadline to request special enrollment will not begin to run until July 10, 2023. If your special enrollment event occurs on or after July 10, 2023, the normal 45-day (or 60-day) deadline will apply.

How Are Benefits Paid? – Your portion of the benefit premiums or contributions is paid through automatic deductions from your pay. Deductions are made on a pre-tax basis or a post-tax basis, depending on the plan, and the circumstances.

Premiums for domestic partner benefits must be paid on an after-tax basis and will be subject to imputed income. This is not actual income, but it is included in the employee's gross income in order to assess tax withholdings. If the domestic partner is also a PetSmart associate, it is advised that you compare the cost and applicable tax consequences.

If you are a new Associate and do not make your benefit elections before the enrollment deadline, you will receive the default coverage shown in the chart apreviously listed. Default coverage is provided at no cost to you.

Life Insurance –The Company will provide you with basic life insurance coverage equal to your annual base salary rounded to the next $1,000. For full-time salon leaders, coverage is based on an annual salary of $40,000. You may purchase additional amounts of coverage up to a total of 5 times your salary (or a maximum of $1,000,000, if less). See "Life Insurance Benefits" section.

Use HR Connect to enroll, change benefits or add beneficiary information during your initial enrollment or the annual open enrollment. You may also update your beneficiary for your life insurance at any time during the year by completing a Beneficiary Change Form and submitting the update to the Benefits Department. If you require assistance, contact the Benefits Department at 1-866-263-8411 for assistance.

MAKING CHANGES

If I Have a Change in Status, May I Change My Elections During the Plan Year? Once you have made an election to pay for your coverage under the medical, dental and/or vision benefits on a pre-tax basis for a Plan Year, federal law prohibits changing the election during the Plan Year. However, you can make certain limited changes at other times during the Plan Year if you experience a "qualified change in status" or certain other events affecting eligibility under a plan and the change you want to make is consistent with the change in status. Please note that federal law does not allow changes to your election as a result of a change in your domestic partnership, or events affecting your domestic partner, unless they qualify as your federal tax dependent. In certain instances, you may also make a change to your Health Care FSA or Dependent Day Care FSA (see below for more details). A mid-year change to your elections may be allowed in the following circumstances:

1. FMLA Leaves of Absence *(Applies to Medical, Dental, and Vision Plans, Health FSA, and Dependent Day Care FSA).* You may change an election under the Flexible Benefits Plan upon taking or returning from a leave of absence that is subject to the FMLA.

2. Change in Status *(Applies to Medical, Dental, and Vision Plans, Health FSA (as limited below), and Dependent Day Care FSA).* If one or more of the following Changes in Status occur,

you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status.

Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan or other employee benefit plan of you, your Spouse, or your Dependents: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or
- a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status—Other Requirements *(Applies to Medical, Dental, and Vision Plans, Health FSA (as limited below), and Dependent Day Care FSA).* If you wish to change your election based on a Change in Status event listed above, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will satisfy this "consistency rule" if it is on account of and corresponds with a Change in Status event that affects coverage eligibility. (For the Dependent Day Care FSA, the event may also affect eligibility of dependent care expenses for the dependent care tax exclusion).

Election changes may be made to reduce Health FSA coverage during a Plan Year due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you reduce or cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed.

Elections changes may be made to enroll or increase the health FSA coverage during a Plan Year due to the acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption or a dependent's loss of other medical coverage.

4. Special Enrollment Rights *(Applies Only to Medical, Dental, and Vision Plans).* In certain circumstances, enrollment for the Medical, Dental, and Vision Plans may occur outside the Open Enrollment Period. When a special enrollment right explained the "What Are My Special enrollment Rights?" section of this SPD occurs, you may change your election under the Flexible Benefits Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders *(Applies to Medical, Dental, and Vision Plans and Health FSA, but Not to Dependent Day Care FSA).* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical, Dental, or Vision Plans or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid *(Applies to Medical and Dental Plans, and Health FSA (as limited below), but Not to Dependent Day Care FSA).* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's health coverage under the Medical or Dental Plan and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's health coverage (here, Medical or Dental Plans and/or Health FSA, as applicable).

7. Change in Cost *(Applies to Medical, Dental, and Vision Plans, and Dependent Day Care FSA (as limited below), but Not to Health FSA).* If the cost charged to you for your Medical, Dental, or Vision Benefits or Dependent Day Care FSA benefits significantly increases during the Plan Year, then you may choose to do any of the following:

- make a corresponding increase in your contributions;
- revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer;
- drop your coverage, but only if no other benefit package option provides similar coverage.

If the cost of Medical, Dental, Vision, or Dependent Day Care FSA benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes:

- if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions;
- if you are enrolled in another benefit package option, you may change your election on a prospective basis to elect the benefit package option that has decreased in cost; or

- if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of the Medical, Dental, or Vision Plans; you generally will have to notify the Plan Administrator of increases or decreases in the cost of Dependent Day Care FSA benefits.

The change in cost provision applies to Dependent Day Care FSA Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage *(Applies to Medical, Dental, and Vision Plans, and Dependent Day Care FSA, but Not to Health FSA).* You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Medical, Dental, or Vision Plans or Dependent Day Care FSA benefits coverage is significantly curtailed without a loss of coverage, then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.)

  If your Medical, Dental, or Vision Plans or Dependent Day Care FSA coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical, Dental, or Vision Plan coverage; you generally will have to notify the Plan Administrator of significant curtailments in Dependent Day Care FSA coverage.)

- *Addition or Significant Improvement of Flexible Benefits Plan Option.* If the Flexible Benefits Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage

under any group health coverage sponsored by a governmental or educational institution.

- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Flexible Benefits Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

- *Dependent Day Care FSA Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. If you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider. And if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

9. Change in HSA Elections. If you have enrolled in the Plan during open enrollment and have elected to participate in the HSA, then you may increase, decrease, or revoke your HSA election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA election unless permitted as a result of events otherwise described in this Attachment. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA otherwise applied (such as a change in status).

How do I make changes when I experience a "qualified change in status event"? You must notify the Benefits Department at 1-866-263-8411 of a qualified change in status, in writing, within 45 days of the event. The documentation required to support the change is listed at benefits.petsmart.com, on the back of the form, or you will be instructed on what to provide by the Benefits Department when you call; the documentation must be received before the requested change will be processed. The documentation and the Qualified Status Change Form must be received by the Benefits department within 45 days of the event (60 days if CHIP or Medicaid coverage) or it will not be processed. Your election change will be effective the date the Benefits Department receives required documentation for the qualified change in status, however, the effective date of the change for the birth or adoption of a child will be the child's date of birth or adoption placement date. If you make a mid-year change, it will result in a retroactive premium adjustment, and any premiums that are paid retroactively must be paid on an after-tax basis.

What is a Qualified Medical Child Support Order ("QMCSO")? A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued

as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

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

You can request a free copy of the Plan's QMCSO procedures from the Benefits Department.

What Happens if I Terminate Employment and Then Am Rehired? If you were full-time when you terminated and were rehired full-time, and your period of termination is:

- less than 30 days, your previous elections are reinstated at the same level (e.g., Associate v. Associate plus) the first of the month following the rehire date;
- between 30 and 90 days, you'll be treated like a new Associate with the exception of the medical plan which will be effective the first of the month following your rehire date. All other plans follow the rules of a new Associate. (see "When Do Associates First Become Eligible?").
- After 91 days, you'll be treated like a new Associate, see "When Do Associates First Become Eligible?").

If you are Full-time and move to a Part-time position the medical plan election will continue until the end of your Stability Period. At that time, you will be offered COBRA to continue your coverage at your own expense. Coverage under all other plans will end at the change to Part-time and you will be offered COBRA to continue coverage under the Dental and Vision plan at your own expense (if you were enrolled at the time you changed to Part-Time status).

What is Open Enrollment? During open enrollment you can change your elections for the upcoming Plan Year or continue your current elections. Open enrollment is once a year (generally in the fall), and any changes take effect on January 1 of the upcoming Plan Year.

During open enrollment eligible Associates can:

- enroll or drop coverage in the medical, dental or vision plan;
- choose a different medical or dental plan;
- change their life insurance and AD&D election by one level;
- enroll in voluntary long-term disability, if applicable;
- add or drop Eligible Dependent coverage (unless a QMCSO requires coverage);
- add or drop any of their other Plan choices;
- enroll in the Health Care FSA, HSA, and/or Dependent Day Care FSA;

What Happens if I Do Not Enroll During Open Enrollment? With the exception of your Health Care FSA, and Dependent Day Care FSA elections, all other Plan elections, whether undertaken affirmatively or by default, will remain in place for the next Plan Year so long as the same benefit or coverage option is still available. This may change if a new benefit offering is made that requires a new election.

If you re-enroll in the HDHP with HSA during open enrollment, your previous HSA election will remain the same if you take no action at open enrollment. However, if you are not enrolling in the HDHP with HSA during the next open enrollment (e.g., enroll in the PPO plan), then your HSA election will automatically be dropped.

You must affirmatively re-elect HealthCare FSA and/or Dependent Day Care FSA coverage for those options to be available to you for the next Plan Year.

WHEN COVERAGE ENDS

When Does Coverage End for a Covered Associate or PTE? Coverage for a Covered Associate or PTE ends on the earliest of the following:

- At 11:59 PM on the date the Covered Associate's or PTE's employment is terminated, or he/she fails to return from an approved leave of absence;
- At 11:59 PM on the date the Covered Associate or PTE ceases to be in a class of Associates eligible for coverage (for example, the Covered Associate switched to a part-time position and reaches the end of his/her Stability Period), provided that if the Associate's change in status affects eligibility for only certain coverages offered under the Plan, any coverages in which the Associate is enrolled that are not so affected shall not be terminated.
- At 11:59 PM on the due date of any required contribution that the Covered Associate or PTE fails to make;
- At 11:59 PM on the effective date of the termination of this Plan (or any applicable component benefit of this Plan) by the Company;
- At 11:59 PM on the date this Plan is discontinued with respect to the class of Associates or PTEs to which the Covered Associate or PTE belongs;
- At 11:59 PM on the date the Covered Associate or PTE becomes an active member of the Armed Forces of any country, except as required by USERRA (See "How Does USERRA Continuation Coverage Work?" for more details);
- At 11:59 PM on the effective date of the Covered Associate's or PTE's voluntary election to terminate coverage under the Plan, to the extent permissible under the terms of the Plan; or
- At 11:59 PM, following a determination by the Plan Administrator that the Covered Associate or PTE has engaged in fraudulent activity, made misrepresentations regarding Eligible Dependent Status or made any misrepresentations concerning the Plan as described on page 5.

When Does Coverage End for a Covered Dependent? Coverage for a Covered Dependent ends upon the earliest of the following:

- At 11:59 PM on the date the Covered Associate's or PTE's coverage terminates in accordance with the preceding question and answer;
- At 11:59 PM on the due date of any required contribution for the Covered Dependent's coverage which is not made by the Associate or other individual;
- At 11:59 PM on the effective date of any termination of dependent coverage by the Company;
- At 11:59 PM on the date on which the Covered Dependent ceases to be an Eligible

Dependent under this Plan);

- At 11:59 PM on the date the Covered Dependent becomes an active member of the Armed Forces of any country;
- At 11:59 PM on the date the Covered Dependent becomes eligible for coverage under the Plan as an Associate;
- At 11:59 PM on the date the Covered Dependent was fraudulently enrolled for coverage under the Plan, provided that the Plan Administrator provides the 30 days advance notice before rescinding any medical coverage.

> ***Important Note:*** *It is the Associate's obligation to inform the Administrator within 45 days of the date a Covered Dependent ceases to be an Eligible Dependent (for example, in the event of divorce) in order to revoke payment on a pre-tax basis. If the Associate or the Covered Dependent fails to timely notify the Administrator, any election made by the Associate to pay for the eligible Covered Dependent's coverage on a pre- tax basis under the terms of the Flex Plan may not be revoked or otherwise changed until the next annual enrollment period under the terms of the Flex Plan.*

When your (or your Eligible Dependents') coverage ends, "continuation coverage" may be available under a federal law commonly referred to as COBRA. For further information, refer to the notice that you received when you first became eligible for coverage and see "COBRA Continuation Coverage" below.

COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law -- the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage (i.e., your medical, dental, and vision or health FSA coverage).

This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights.

The Administrator who is responsible for administering COBRA continuation coverage is:

WageWorks Inc., a HealthEquity Company
PO Box 226101 Dallas TX 75222-6101 (877)722-2667
mybenefits.wageworks.com

What is COBRA Continuation Coverage? COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage must be offered to each Covered Person who is a "Qualified Beneficiary." You, your Spouse, and your Eligible Children could become Qualified Beneficiaries if coverage under the Plan is lost because of a Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Domestic Partners are not Qualified Beneficiaries under COBRA, however, the Plan will treat Domestic Partners the same as Spouses for COBRA purposes, giving Domestic Partners COBRA-like rights.

COBRA coverage and the amount of the premium will not be conditioned upon evidence of insurability and will not discriminate on the basis of a lack of evidence of insurability.

Which Qualifying Events Will Cause an Associate to be a Qualified Beneficiary? If you are an Associate, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

Which Qualifying Events Will Cause an Associate's Spouse or Domestic Partner to be a Qualified Beneficiary? If you are the Spouse or Domestic Partner of an Associate, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your Spouse or Domestic Partner dies;
2. Your Spouse's or Domestic Partner's hours of employment are reduced;

3. Your Spouse's or Domestic Partner's employment ends for any reason other than his or her gross misconduct;
4. Your Spouse or Domestic Partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse or your Domestic Partnership ends.

Which Qualifying Events Will Cause an Associate's Eligible Children to be a Qualified Beneficiary? Your Eligible Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent Associate dies;
2. The parent Associate's hours of employment are reduced;
3. The parent Associate's employment ends for any reason other than his or her gross misconduct;
4. The parent Associate becomes entitled to Medicare benefits (under Part A, Part B, or both);
5. The parent Associate and Spouse become divorced or legally separated; or
6. The child ceases to be eligible for coverage under the Plan as an Eligible Child.

An Eligible Child of the Covered Associate who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Administrator during the Covered Associate's employment with the Employer is entitled to the same rights to elect COBRA as an Eligible Child of the Covered Associate.

When is COBRA Continuation Coverage Available? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Administrator has been notified that a Qualifying Event has occurred.

When Am I Required to Provide Notice of a Qualifying Event? When the Qualifying Event is the end of employment or reduction of hours of employment, the death of the Associate, or entitlement of the Associate in Medicare (Part A, Part B or both) the Company must notify the Administrator of the Qualifying Event within 30 days.

However, if the Qualifying Event is divorce or legal separation of the Associate and Spouse or a child losing eligibility for coverage as an Eligible Child, the Associate or Covered Dependent must notify the Company of the Qualifying Event within 60 days after the later of the Qualifying Event or the date coverage ends.

Contact the Benefits Department within the time allowed for the qualified event at 866-263-8411 or by mail to PetSmart, LLC. Attn: Benefits Department19601 N. 27th Ave. Phoenix AZ 85027.

What if I Fail to Provide Notice within the time allowed based on the Qualified Event? If you fail to provide notice to PetSmart Benefits Department within the time stated above based on the Qualifying Event or, if later, the date coverage ends, you, your Spouse, and your Eligible Children will not be offered the option to elect COBRA coverage.

What Happens When the Administrator is Notified of a Qualifying Event? When the Administrator is notified that a Qualifying Event has happened, you will be sent a notice within 14 days explaining that you have the right to choose COBRA continuation coverage.

What Happens If I Request COBRA Coverage and I am Not Entitled to COBRA Coverage? The Administrator will provide a notice of unavailability within 14 days after receiving a request for COBRA continuation coverage if the Administrator determines that the individual requesting COBRA is not entitled to coverage. The notice will include an explanation as to why the individual is not entitled to COBRA coverage. The notice will be provided regardless of the basis of the denial.

Can I Waive COBRA Coverage? A Qualified Beneficiary may waive COBRA coverage. The waiver may be withdrawn prospectively anytime during the 60-day election period.

Is COBRA Coverage the Same As the Coverage I Currently Have? If you choose COBRA continuation coverage under the Plan, the Company is required to give you or your qualifying family members coverage that is the same coverage that you or your qualifying family members had on the day before the Qualifying Event. Therefore, a person not covered under the Plan on the day before the Qualifying Event is generally not entitled to COBRA coverage. The coverage provided will be identical to the coverage provided under the Plan to similarly situated Associates or family members. If the coverage for similarly situated Associates is modified, COBRA coverage will be modified the same way.

Any Qualified Beneficiary who elects COBRA coverage under the Plan may, during his/her COBRA coverage period, make any election changes on the same basis as similarly situated Covered Persons with respect to whom a Qualifying Event has not occurred (*e.g.*, during a special or annual enrollment period).

How Long Does COBRA Coverage Last? COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in "Can COBRA Coverage Ever Terminate before the End of the Maximum Coverage Period?"

36 Months. If a Spouse, Domestic Partner, or Eligible Child loses coverage under the Plan because of the Associate's death, divorce or legal separation, the Associate becoming entitled to Medicare, or a child ceasing to be an Eligible Child under the Plan, the maximum coverage period (for Spouse, Domestic Partner, and/or Eligible Child) is 36 months from the date of the Qualifying Event. This means that COBRA coverage will automatically end at midnight on the last day of the 36-month period.

18 Months. If an Associate, Spouse, Domestic Partner, or Eligible Child loses coverage under the Plan because of the Associate's termination of employment (other than for gross misconduct) or reduction in hours, the maximum continuation coverage period (for the Associate, Spouse, Domestic Partner, and Eligible Child) is 18 months from the date of termination or reduction in hours. This means that COBRA coverage will automatically end at midnight on the last day of the 18-month period.

See "How Does USERRA Continuation Coverage Work?" for the maximum coverage period if you take qualifying military leave.

Do Any Special Rules Apply to the Health Care FSA and Limited-Purpose FSA? There is a shorter maximum COBRA coverage period for the Health Care FSA and Limited-Purpose FSA. If coverage under the Health Care FSA or Limited-Purpose FSA is lost due to a Qualifying Event, you, your Spouse, or Eligible Child may be eligible to elect COBRA coverage under the Health Care FSA or Limited-Purpose FSA for the remainder of the Plan Year if you have an under-spent account (i.e., a positive balance).

COBRA coverage for the Health Care FSA or Limited-Purpose FSA can only be elected for the remainder of the Plan Year during which coverage is lost. For example, if you lose coverage due to a Qualifying Event in August and you elect COBRA coverage under the Health Care FSA or Limited-Purpose FSA, your continuation coverage cannot extend beyond December 31 of the same year. You cannot elect coverage for the next Plan Year.

Are the Maximum Coverage Periods Ever Extended? In the following three situations, the maximum coverage periods described above (except for the Health Care FSA continuation coverage) may be extended. These extensions are only available if the qualifying event was the Covered Associate's termination of employment or reduction in hours. In order to qualify for an extension, you must meet all the requirements described below.

- **Disability Extension.** If a Qualified Beneficiary is determined by the Social Security Administration to be disabled, all the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage due to a Qualifying Event that was the covered employee's termination of employment or reduction of hours. Further, the disability must have started at some time during the first 60 days of continuation coverage and must last at least until the end of the 18 months of COBRA coverage that would be available without the disability extension. For the 29-month continuation coverage period to apply, written notice of the determination of disability must be provided to the Administrator both within the 18-month coverage period and within 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; (2) the date of the Covered Associate's reduction of hours or termination of employment; and (3) the date on which the Qualified Beneficiary loses or would lose coverage under the terms of the Plan as a result of the Covered Associate's reduction of hours or termination of employment.

  Your notice must comply with the requirements described herein and be sent to the street address or web page address noted on page 17. In addition, your notice must include the following information: (1) the name and address of the Covered Associate; (2) a description of the initial Qualifying Event and the date it happened; (3) the names and addresses of the Qualified Beneficiaries who lost coverage due to the initial Qualifying Event and who are still receiving COBRA continuation coverage; (4) the name and address of the disabled Qualifying Beneficiary; (5) the date of the Social

Security Administration's determination; (6) the date the Qualified Beneficiary became disabled (according to the Social Security Administration's determination); (7) a copy of the Social Security Administration's determination; and (8) a statement whether the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled.

If you fail to provide timely notice to the Administrator, there will be no disability extension of COBRA continuation coverage.

- **Second Qualifying Event Extension.** If a second Qualifying Event that gives rise to a 36-month maximum coverage period (for example, the Associate dies or divorces, or a child ceases to be an Eligible Child) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours. This extension applies only to Spouses and Eligible Children who are Qualified Beneficiaries receiving COBRA at the time of the second event, and not to the Covered Associate.

  This extension due to a second Qualifying Event is available only if you notify the Administrator in writing of the second Qualifying Event within 60 days of the later of: (1) the date of the second Qualifying Event; and (2) the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan.)

  Your notice must comply with the requirements described herein and be sent to the street address or web page address noted on page 17. In addition, your notice must include the following information: (1) the name and address of the Covered Associate; (2) a description of the initial Qualifying Event and the date it happened; (3) the names and addresses of the qualified beneficiaries who lost coverage due to the initial Qualifying Event and who are still receiving COBRA continuation coverage; and (d) a description of the second Qualifying Event and the date it happened.

  If you fail to provide notice to the Administrator during this 60-day notice period, there will be no extension of COBRA continuation coverage due to a second Qualifying Event.

- **Medicare Extension.** If a termination of employment or reduction in hours occurs within 18 months after the Associate becomes entitled to Medicare, the maximum coverage period (for the Spouse and Eligible Child) ends 36 months from the date the Associate became entitled to Medicare. This COBRA coverage period is available only if the Covered Associate becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

What Happens if I Have a Child or Adopt a Child While I Have COBRA Coverage? A child born to, adopted by, or Placed for Adoption with a Covered Associate during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the Covered Associate is a Qualified Beneficiary, the Covered Associate has elected COBRA coverage for

himself or herself. The Eligible Child's COBRA coverage begins when the Eligible Child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Associate. To be enrolled in the Plan, the Eligible Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Can COBRA Coverage Ever Terminate Before the End of the Maximum Coverage Period? COBRA continuation coverage of the Associate, Spouse, Domestic Partner and/or Eligible Child will automatically terminate at 11:59 PM on the day:

- The Company no longer provides group health coverage to any of its Associates;
- The date coverage ends for failure to make the first required premium (first premium is not paid within 45 days);
- The premium for continuation coverage is not paid within 30 days of its due date;
- The date, after electing COBRA, that coverage is first obtained under any other group health plan (coverage will end only for the person who becomes covered by another group health plan);
- The date you become entitled to Medicare after electing COBRA (coverage will end only for the person entitled to Medicare);
- You extend coverage for up to 29 months due to the Qualified Beneficiary's disability and there has been a final determination that he or she is no longer disabled; or
- Occurrence of any event that permits termination of coverage for cause with respect to non- COBRA Covered Associates and qualified family members.

If your COBRA coverage is terminated before the end of the maximum coverage period, you will be notified as soon as possible but not necessarily before the termination takes effect.

If I (or a Family Member) Become Covered Under Another Group Health Plan or Entitled to Medicare, What Should We Do? You must notify the Administrator in writing within 45 days if, after electing COBRA, a Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage.

Your notice must comply with the requirements described herein and be sent to the street address or web address noted on page 14. In addition, your notice must include the following information: (1) the name and address of the Covered Associate; (2) a description of the initial Qualifying Event; (3) a statement that other group health plan coverage became available or the Qualified Beneficiary became entitled to Medicare; (4) the name and address of the Qualified Beneficiary who has become covered under the other group health plan or who became entitled to Medicare; and (5) the date the other group health plans coverage is effective or entitlement to Medicare began.

If Social Security Decides I (or a Family Member) Am No Longer Disabled, What Should We Do? If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Administrator of that fact within 30 days after the Social Security Administration's determination.

Your notice must comply with the requirements described herein and be sent to the street address or web page address noted on page 17. In addition, your notice must include the

following information: (1) the name and address of the Covered Associate; (2) a description of the initial Qualifying Event; (3) name and address of the disabled Qualified Beneficiary; (4) the date the disability ended (according to the Social Security Administration's determination); (5) the date of the Social Security Administration's determination; and (6) a copy of the Social Security Administration's determination.

If the Social Security Administration subsequently determines that the Qualified Beneficiary is no longer disabled, COBRA coverage will automatically end at the later of the end of the initial 18-month maximum period or midnight on the first day of the month that begins more than 30 days after the date of the Social Security Administrator's final determination.

What If I Change Address, Marital Status, Dependent Status, or Disability Status while on COBRA? If you or your Spouse's address changes, you must promptly notify the Administrator in writing, so important information can be sent. Also, if your marital status changes or if a dependent ceases to be an Eligible Dependent for coverage under the Plan, you, your Spouse, your Domestic Partner or dependent must promptly notify the Administrator. This notification is necessary to protect COBRA rights. You must also notify us if a disabled Associate or family member is determined to no longer be disabled.

How Does USERRA Continuation Coverage Work? The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain Associates who are involved in the uniformed services. In addition to the rights that you have under COBRA, during a period of qualifying military leave you are entitled under USERRA to continue your health coverage that you (and your Covered Dependents, if any) have under the Plan.

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your Covered Dependents) different rights or protections, the law that provides the greater benefit will apply.

The administrative policies and procedures described in "COBRA Continuation Coverage" (for example the procedures how to elect COBRA coverage and paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you elect to continue your health coverage, or your Covered Dependent's coverage pursuant to USERRA:

- you will be required to pay 102% of the premium for USERRA coverage (the same rate as COBRA coverage). However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay as an active Associate for that coverage.
- your coverage may continue for up to 24 months from the date your qualifying military leave began. This is 6 months longer than the 18-month period required by COBRA. If

you fail to return to work as scheduled, your USERRA coverage will terminate on midnight of the day you fail to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Are there other options besides COBRA when I lose group health coverage? You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance marketplace or be eligible for Medicaid or coverage through a spouse's plan. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Special Rule During COVID-19 Emergency: The Plan's existing rules regarding certain deadlines under COBRA will be modified to comply with Department of Labor and Internal Revenue Service guidance on the COVID-19 pandemic.

Specifically, if an event that gives rise to certain deadlines under COBRA occurs prior to July 10, 2023, the applicable COBRA deadline will not begin to run until July 10, 2023.

If the event that gives rise to certain deadlines under COBRA occurs on or after July 10, 2023, the normal COBRA deadline will apply.

The rules described above will apply to the following COBRA deadlines:

(1) the 60-day election period for COBRA continuation coverage;

(2) the deadlines for making COBRA premium payments; and

(3) the date by which you must notify the Plan of a qualifying event (e.g., a divorce), or a determination of disability.

MEDICAL BENEFITS UnitedHealthcare PPO and HDHP Plans

Eligible Associates can enroll in medical coverage for themselves only or for themselves and their Eligible Dependents, without regard to any other coverage elected under the Plan.

The Company has contracted with UnitedHealthcare, which provides access to a Physician network under a preferred provider organization ("PPO") arrangement to provide Covered Services to Covered Persons enrolled in the PPO medical plan or the High Deductible Health plan medical coverage.

If you enroll in the Medical Plan, you must generally select coverage for yourself (and your Eligible Dependents, if enrolled) from among available PPO options and the High Deductible Health plan with Health Savings Account. If a network of PPO doctors is not available in your home area, you'll be offered Out of Network coverage. You can get a directory of health care professionals and facilities in UnitedHealthcare's Network at no charge by calling toll-free 1-866-501-3061 or by visiting their member website at www.myuhc.com. While network status may change from time to time, myuhc.com has the most current source of Network information. Use www.myuhc.com or the UnitedHealthcare mobile application to search for Physicians available in your Plan.

HOW THE PLAN WORKS-ACCESSING BENEFITS

PPO1, PPO2 and HDHP w/ HSA (Choice Plus)

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

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

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

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

Network Benefits.

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.

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, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

The Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of PetSmart or UnitedHealthcare.

The Claims Administrator 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 www.myuhc.com or by calling the telephone 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 Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider 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 Provider, 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 Provider or other provider chosen by UnitedHealthcare.

Limitations on Selection of Provider

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

If you don't make a selection within 31 days of the date you are notified, 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 PPO1, PPO2 and HDHP w/ HSA

PetSmart 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 Plan 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 the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

For **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 UnitedHealthcare's contracted fee(s) with that provider.

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

- **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 Service Act with respect to a visit as defined by the Secretary, 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).
  - 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.
This includes when there is no network provider who is reasonably accessible or available to provide Covered Health Servicess**.** Eligible Expenses are an amount negotiated by UnitedHealthcare 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.

Eligible Expense are determined as follows: an amount negotiated by the Claims Administrator or a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. 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

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, 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 the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Employees (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Out-of-Area Plan (Options PPO with no Differential)
As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay.

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

UnitedHealthcare arranges for health care providers to participate in a Network. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

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

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under the Plan.

Non-Network Benefits Exception
You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30-mile radius of your home zip code.
You can check a provider's Network status by visiting **www.myuhc.com** or by calling the Claims Administrator at the number on your ID card. The Claims Administrator must approve any Benefits payable under this exception before you receive care.

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 Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in the SPD. 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.

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

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 non-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.

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.

Network Providers

The Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of PetSmart or the Claims Administrator. It is your responsibility to select your provider.

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

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

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

Designated Network Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider 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 Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

Eligible Expenses Out-of-Area Plan

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

Eligible Expenses are the amount the Claims Administrator 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.

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates, or subcontractors, at UnitedHealthcare's discretion.

  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:

    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS) for Medicare* for the same or similar service within the geographic market.

- ♦ When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third-party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

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

- For Covered Health Services provided by laboratory or durable medical equipment providers, Eligible Expenses are determined based on a methodology developed by UnitedHealthcare or UnitedHealthcare's vendor which calculates the non-Network provider's reimbursement by utilizing the median amount negotiated with Network providers for the same type of equipment or service in the same *CMS* locality.

Advocacy Services Out-of-Area Plan

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 it was determined. Please call UnitedHealthcare at the number on your ID card to access these advocacy services. 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 reimbursement for that particular claim in accordance with the limits set forth in its service agreement with the designee.

Interpretation of Benefits

PetSmart 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.

PetSmart and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator'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 the Claims Administrator'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, PetSmart may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that PetSmart does so in any particular case shall not in any way be deemed to require PetSmart to do so in other similar cases.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies 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 a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare’s website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and PetSmart 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.

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

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

PetSmart 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 UnitedHealthcare.
- 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.

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 in 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.

Incentives to Providers

Network providers may be provided financial incentives by the Claims Administrator 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*.

The Claims Administrator 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 the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

HDHP Deductible and HSA

A high-deductible health plan (HDHP) is a type of consumer-driven medical plan that has a higher deductible and a lower premium than a traditional medical plan. In a HDHP, you take responsibility for covering minor or routine health care expenses until the deductible is met. Once the deductible is met, co-insurance applies. "Co-insurance" means that the medical plan shares costs with you; the medical plan pays a percentage of each eligible charge and you pay the rest. The HDHP has a combined deductible for both medical and prescription drug expenses. See the "Prescription Drug Program" section for more information.

The Company offers a Health Savings Account (HSA) to those enrolled in the HDHP medical plan option to help cover certain medical expenses. The money you contribute to these accounts is on a before- tax basis in most states. For more information see the "How Does the HSA Work" section of the SPD.

PLAN TERMS

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. There are separate Network and non- Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Eligible expenses charged by non-Network providers apply toward Network individual and family deductibles; eligible expenses charged by Network providers apply toward non-Network individual and family deductibles

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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. Copays 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.

Coinsurance

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

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

Eligible Expenses charged by Network providers apply toward Network and non-network individual and family out-of-pocket maximums. Non-Network Eligible Expenses apply only toward the Non-Network individual and family out-of-pocket maximums

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

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

HEALTH REIMBURSEMENT ACCOUNT

As part of your coverage under the Medical Plan (PPO or Out of Network options), the Company may credit Benefit Dollars to what is known as a health reimbursement account or HRA, for short.

What is an HRA? An HRA is an account established in your name to help pay for eligible medical and prescription drug expenses such as copays or deductibles. The Company will credit a specified amount of HRA Benefit Dollars to your HRA each Plan Year, the amount of which depends on the Medical Plan option you select:

Medical Plan Option	Annual Allocation of HRA Benefit Dollars
PPO 1	$0
PPO 2	$250 individual/$500 family
Out of Network Plan	$0

You are not permitted to make contributions to your HRA, whether on a before-tax or after-tax basis. Your HRA is an "unfunded" account (i.e., the Company does not set aside actual dollars in an account), and Benefit Dollars (essentially, a bookkeeping entry) are payable solely from the Company's general assets.

How Does an HRA Differ From an FSA? An HRA and an FSA (discussed under the *Flexible Spending Account (FSA)* section of this Summary Plan Description) are similar in that both are tax-free accounts, the funds of which can be used to pay for unreimbursed eligible out-of-pocket health care expenses for you or your Eligible Dependents. However, while you can make contributions to a Healthcare FSA or Dependent Day Care FSA, you cannot make contributions to an HRA. In fact, actual dollars are not contributed to the HRA; instead, the Company allocates a prescribed amount of HRA Benefit Dollars (i.e., a bookkeeping entry) to the account.

Further, amounts in your FSA must be used before the end of the Plan Year (under what is known as the "use-it-or-lose-it rule") with the exception of an amount determined by IRS rule for carryover, any balance remaining in your HRA at the end of the Plan Year may be carried forward to the next Plan Year (and subsequent Plan Years) to pay for future eligible health care expenses as long as you are enrolled in a medical plan that qualifies you for HRA (PPO2) in the next plan Year.

What Happens If You Terminate Employment? If you terminate employment for any reason before using all of your HRA Benefit Dollars, those unused HRA Benefit Dollars are forfeited and revert back to the Company. If you elect COBRA coverage and pay the required COBRA premiums, any HRA Benefit Dollars remaining in your account will be available to assist you in paying your medical expenses while COBRA coverage remains in effect. Additionally, you will be eligible to accrue new allocations of HRA Benefit Dollars during your COBRA coverage period. To elect COBRA for the HRA, you must also elect COBRA for your PPO or Out of Network medical option.

If you are rehired by the Company within 30 days following your termination and within the same Plan Year and you are re-enrolled in the Medical Plan, the Company will allocate HRA Benefit Dollars to your account equal to the balance you held in your HRA on the day preceding your termination date less any amounts paid in the interim. If you are rehired after 30 days following your termination date, the Company will allocate to your HRA the lesser of: (1) HRA

Benefit Dollars equal to the balance in your account on the day preceding your termination date less any amounts paid in the interim; or (2) HRA Benefit Dollars equal to the amount for which a newly-hired employee would be eligible.

How Does My HRA Work? Your HRA works in a manner similar to your FSA. When you first enroll in the PPO or Out of Network options under the Medical Plan, the Company allocates a specified amount of HRA Benefits Dollars to your account in accordance with the coverage option you have selected. Your provider may submit a covered expense to UnitedHealthcare prior to collecting the amount you are responsible for. In this instance, UnitedHealthcare will pay your doctor directly when you have available HRA Benefit Dollars in your account. When you pay an eligible medical or prescription drug expense out of your pocket, you simply submit a claim form and proof of payment to UnitedHealthcare, and you will be reimbursed. Alternatively, you can pay for eligible expenses with your UnitedHealthcare Consumer Accounts card. If you also participate in the Health Care FSA, those funds will be used first provided your account settings are set this way. For further information about how your FSA works, including the date by which you must submit claims to have them credited for a particular Plan Year, you should refer to the section of this Summary Plan Description describing the *Flexible Spending Account (FSA).*

How Do My HRA and Health Care FSA Interact? If you choose to establish a Health Care FSA in addition to an HRA, UnitedHealthcare will automatically reimburse your eligible health care expenses from your Health Care FSA first before reimbursing you from your HRA. For more details and scenarios of how the two interact, go to the Health Care FSA section on the benefits web site at benefits.petsmart.com. After you deplete the Health Care FSA balance and incur additional eligible health care expenses in a Plan Year, your HRA Benefit Dollars may be used and at that time, UnitedHealthcare will reimburse 100% of your eligible expenses for up to the allocation in your HRA. Once your HRA benefit dollars are exhausted, you are responsible for any remaining expenses under your Medical Plan coverage up to the amount of the deductible and any out-of-pocket limits. There are other options to set up the reimbursement from the HRA/FSA on myuhc.com.

How Do My HRA and HSA Interact? If you enroll in the HDHP plan with the HSA and have an HRA balance from a prior plan year, you will not be eligible to continue the use of the HRA. Therefore, when you elect to enroll in the HDHP during open enrollment, your HRA balance will be automatically "frozen" beginning at the end of the Plan Year to ensure that you remain eligible for the HSA for the following Plan Year. By "freezing" your HRA, this means that you agree to forgo reimbursements from your HRA for eligible medical expenses incurred during that Plan Year by electing to participate in the HSA; you will not forfeit your existing HRA balance, and your remaining balance will be carried over to future Plan Years in which you are not enrolled in the HDHP. Also, PetSmart will not contribute to your HRA once you elect to freeze your HRA for the duration of the freeze. Eligible medical expenses incurred in the Plan Year before the freeze may be reimbursed by the HRA, so long as there was no freeze in effect for that prior Plan Year. You may not change or revoke your election until the next open enrollment period.

For a future plan year, you may lift the freeze on your HRA by electing not to participate in the HDHP and enrolling in one of the non-HDHP medical plan options. Once your HRA is no longer

frozen, you may use the HRA to be reimbursed for your health care expenses and PetSmart will begin making contributions to your HRA again. Once your HRA is unfrozen, you will not be able to contribute to an HSA, but you may use any existing HSA funds to pay for qualified medical expenses.

In lieu of freezing your HRA, you may elect to permanently opt out of and waive any right to reimbursements from your HRA for expenses incurred after the election takes effect. This opportunity will be offered to you at least annually.

How Do My HRA and Limited-Purpose FSA Interact? Because the Limited-Purpose FSA is only available to those enrolled in the HDHP medical option with the HSA, your HRA balance will be "frozen" (see the question above). This means that you agree to forgo reimbursements from your HRA for eligible medical expenses incurred during the Plan Year in which you are enrolled in the HDHP medical option with the HSA. During this time, you may use your Limited-Purpose FSA to pay for certain dental, vision, and preventive care expenses only. See Health Care and Limited Purpose FSA section.

For a future year, the freeze on your HRA will be removed if you enroll in a medical plan other than the HDHP and you may use the HRA to be reimbursed for your health care expenses (see the question above). Once your HRA is unfrozen, your Limited-Purpose FSA will convert back to a Health Care FSA for the next plan year and you may carryover a maximum of $500.

What Are Eligible HRA Health Care Expenses? Eligible HRA health care expenses generally include health care expenses that are not covered, or only partly covered, by your health plan and include:

- health care expenses that you could deduct on your federal income tax return (but do not actually deduct), except for those specifically listed as not eligible below;
- deductibles and Copays under any medical or prescription drug plan;
- expenses in excess of annual medical plan limits;
- over the counter drugs needed for medical care;
- hearing care expenses, including hearing exams and hearing aids
- Menstrual care products
- Personal protective equipment such as gloves, face masks, and sanitizing wipes for the prevention of spreading disease.

What Expenses Are Not HRA-Eligible? These include but are not limited to:

- expenses for medical services or supplies not covered by your health plan;
- vision care expenses covered by your health or vision plan;
- dental care expenses covered by your health or dental plan;
- cosmetic surgery;
- weight loss programs (unless prescribed by your doctor for the treatment of a medical condition/illness);
- health club dues;

- electrolysis;
- premiums for a health plan;
- health care aids and supplies that are used for general health care, such as toothbrushes;
- vitamins;
- expenses you incur before you begin participating in the HRA or after your participation ends;
- expenses incurred by your Domestic Partner who is not a tax dependent under Section 152 of the Internal Revenue Code determined without regard to the gross income limit under that Section.

PERSONAL HEALTH SUPPORT-CARE MANAGEMENT

CARE MANAGEMENT

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

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

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

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

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

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.

- **Inpatient care management** - If you are hospitalized, 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.
- **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

PPO1, PPO2 and HDHP w/ HSA (Choice Plus)

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

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed in *Additional Coverage Details* have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the toll-free telephone number on your ID card.

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

To obtain prior authorization, call the toll-free telephone number on 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.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

Can I Get a Second or Third Opinion? UnitedHealthcare may require, or a Covered Person may request, a second or third opinion concerning the necessity or advisability of a Covered Service. Second or third opinions must be given by a Physician who is certified by the American Board of Medical Specialists in a field related to the proposed treatment. The Physician giving the second or third opinion cannot perform the service and must be independent of the Physician who first advised the service (or in the case of a third opinion, who gave the second opinion). UnitedHealthcare will only require second or third opinions in non-emergency situations, and its decision will be made in a nondiscriminatory, uniform manner.

Pre-existing conditions

The Medical Plan does not exclude treatment, services or supplies relating to a pre-existing condition that is provided prior to the effective date of coverage on our plans.

BEHAVIORAL HEALTH BENEFITS

Mental and behavioral health, and substance use disorder benefits are provided through OptumHealth Behavioral Services in accordance with the Schedule of Medical Benefits. You can see an in-network or out-of-network provider. You can get a list of OptumHealth network providers by calling toll-free 1-800-788-5614 or by visiting www.liveandworkwell.com and choosing the “Find a Provider” quick link.

Some services (whether Inpatient or Outpatient) require notification to OptumHealth to be covered at the highest benefit level. Contact OptumHealth directly at 1-800-788-5614. In a life-threatening situation, go directly to the Hospital and report any Hospital admission to OptumHealth by the next scheduled workday.

Employee Assistance Program (EAP) Ally

The EAP program is called Ally and it provides three free visits. If you want to see a counselor or mental health therapist, Ally will match you with a counselor that is experienced in helping people with problems similar to yours. Whether or not you enroll in the Medical Plan, the Ally plan is available for all Associates and their Spouses and Eligible Dependents.

Ally can provide counseling and help for issues such as:

- Marital or relationship problems
- Parenting issues
- Drug or alcohol problems
- Physical or emotional abuse
- Financial problems
- Legal problems
- Health issues or concerns
- Day care information
- Elder care information

Ally provides at no cost to you:

- **Assessment and Counseling -** for short-term mental health and substance use disorder services include up to three face-to-face counseling visits covered at 100%.
- **Financial Assistance** – Free phone consultations with credentialed financial professionals on financial planning, debt management, investments or other financial matters.
- **Legal Assistance** – Legal services include one 30-minute consultation per personal legal matter with an attorney, plus a 25% discount for ongoing services. Legal services address issues like landlord/tenant disputes, personal injury, or bankruptcy.
- **Family Mediation** – Access to information and/or referral to a mediator to resolve family disputes in lieu of pursuing litigation.
- **LiveandWorkWell.com** – A robust website where you can download health and wellness articles, use financial calculators and health tools, search for a mental health clinician and much more.

You can contact EAP directly at 1-800-788-5614 for counseling and information. Or log onto lifeandworkwell.com using access code 12347. Services provided by EAP advisors are strictly confidential. The EAP program provides 3 free visits per issue. If you want to see a counselor or mental health therapist, the EAP will match you with a counselor that is experienced in helping people with problems similar to yours.

Schedule of Medical Benefits

Medical benefits for Covered Persons will be paid in accordance with the Schedule of Benefits that is attached as *Appendix A and B.* For more detailed information on a covered health service, contact UnitedHealthcare at the phone number on your ID card.

ADDITIONAL COVERAGE AND PRIOR AUTHORIZATION

While the Schedule of Medical Benefits (see *Appendix A and B)* provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. Services that are not covered are described in the *Exclusions and Limitations* section.

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.

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

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

- Chemotherapy.
- Pregnancy.
- Related to surgery.

Any combination of Network Benefits and Non-Network Benefits is limited to 30 treatments per year.

Ambulance Services - Emergency Only

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services.

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.

Ambulance Services - Non-Emergency

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.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Non-Network Benefits, if you are requesting non-Emergency Air Ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport.

If you fail to obtain prior authorization as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

Obesity Surgery Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You are enrolled in the Bariatric Resourse Servcices (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.
- You have a 3-month physician supervised diet documented within the last 2 years.

You have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in the Glossary, for obesity surgery.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling 1-888-936-7246.

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with obesity-related services received by a Designated Provider.

Cellular and Gene Therapy

The Plan covers Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office. Benefits must be received from a Designated Provider.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 do not obtain prior authorization as required, Benefits will be subject to a $300 reduction and paid at 50%.

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

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare 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 Service under the Plan.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 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).

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

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.

COVID-19 Diagnostic Testing
In vitro diagnostic tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) are covered at 100%, Deductible waived, as provided in the Families First

Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act), and notwithstanding any otherwise-applicable Medical Necessity or experimental and/or investigational requirements, and do not require Prior Authorization, provided the test satisfies one of the following conditions:

- it is approved, cleared, or authorized by the FDA;
- the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
- it is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
- it is deemed appropriate by the Secretary of Health and Human Services.

***Over-the-Counter Diagnostic Tests*:** Diagnostic tests for COVID-19 purchased over-the-counter are covered at 100%, Deductible waived, and do not require Prior Authorization. This benefit covers a maximum of eight (8) over-the-counter tests, per participant, per month. You do not need a doctor's order for over-the-counter tests to be covered. However, to be eligible for coverage under the Plan, the tests must be for personal use and not for employment purposes. Refer to the "Prescription Drug Program" section of this SPD for information on how to access this benefit.

The benefits described in this section will be provided as required by the FFCRA and the CARES Act and are effective through the end of the Public Health Emergency that was declared in 2020 as a result of the COVID-19 pandemic, or such longer time as may be required under applicable law. The declared Public Health Emergency ended May 11. 2023 and the benefits described in this section end as of May 11, 2023.

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

Diabetic Self-Management Items
Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

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

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 the cost exceeds $1,000 and you fail to obtain prior authorization as required, Benefits will be subject to a $300 reduction to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

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

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

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor the Claims Administrator identifies or from the prescribing Network Physician.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.
Examples of DME include but are not limited to:

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

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

Benefits also include 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.

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.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization 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 $300 reduction to 50% of Eligible Expenses Benefits.

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 one business day 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*.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Gender Dysphoria

Transgender surgery must be performed by a qualified provider. Physician must obtain authorization prior to services being rendered or services will not be covered. There are no dollar or lifetime limits. Patients must be at least 18 years of age.

What's Covered

Health care expenses related to the change of one's gender from male to female or female to male are covered subject to an individual's Plan Provisions (i.e. copay, deductible and coinsurance).

This benefit is intended to assist with, but not fully cover, costs incurred with health procedures and services related to Gender Identity Disorder (GID). The types of care, procedures, and services this policy intends to cover are outlined below.

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services in your SPD.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider
- Cross-sex hormone therapy dispensed from a pharmacy is provided as described under Prescription Drugs.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis

- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of urethra)
- Vaginectomy (removal of vagina)
- Vaginoplasty (creation of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements – The Covered Person must provide documentation of the following for breast surgery: a written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery – a written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

- The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence- based professional society guidance.

What's Excluded from Coverage?

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.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

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 do not obtain prior authorization as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

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 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.

Hearing Aids

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

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

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.

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 the *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to the *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 Home HealthCare:

For Non-Network Benefits you must obtain prior authorization. If you do not obtain prior authorization as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

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 contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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*.

Fertility Services

Therapeutic services for the treatment of fertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to InVitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection - ICSI.
  - Assisted hatching.
  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization and ovarian cystectomy.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic (PGT_M) or Surgical Rearrangement (PGT-SR)- when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

Treatment for the diagnosis and treatment of the underlying cause of infertility is covered as described in the SPD.

Enhanced Benefit Coverage

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).
- Embryo biopsy for Pre-implantation Genetic Testing for Aneuploidy (PGT-A**)** used to select embryos for transfer in order to increase the chance for conception.
- Donor Coverage: The plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The plan will not pay for donor charges associated with compensation or administrative services.
- 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).

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This Benefit limit also includes services as described under *Fertility Preservation for Iatrogenic Infertility*.

Benefits for Assisted Reproductive Technology (ART) for related services as described under *Infertility Services* do not include the Preimplantation genetic testing for the specific genetic disorder.

Fertility Preservation for Medical Reasons

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.

- Long-term storage costs (anything longer than 12 months) are not covered.

Benefits for medications related to the treatment of fertility preservation are provided as described under Outpatient Prescription Drugs or under Injections in the Physician Services Grid.

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

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

Limited to $25,000 medical lifetime maximum per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit includes Benefits as described under Fertility Preservationand for related services under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services*.

Charges for the following apply to the fertility maximum:

- Surgeon's and assistant surgeon's fees.
- Anesthesia.
- Lab and x-ray.

Certain criteria to be eligible for Benefits may be waived for Fertility Preservation for medical reasons.

Criteria to be eligible for Benefits

You do not need to have a diagnosis of Infertility in order to be eligible to receive services described above. To be eligible for the fertility services Benefit you must meet the following requirements;

- You are a female:
    - under age 44 and using own oocytes (eggs), or
    - under age 55 and using donor oocytes (eggs).

Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- You have infertility that is not related to voluntary sterilization or failed reversal of a voluntary sterilization.
- You are not a Child Dependent.

Lab, X-Ray and Diagnostic – Outpatient

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

- Lab and radiology/X-ray.
- Mammography.
- Benefits include:
- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests limited to 18 tests per calendar year for each test.

Benefits for other Physician services, Lab, X-ray and diagnostic services are described in the Schedule of Benefits Appendix in the SPD.

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.

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.

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 reduced to 50% of Eligible Expenses. For Non-Network Benefits for Genetic Testing and sleep studies, you must obtain prior authorization five days before scheduled services are received. If you fail to obtain prior authorization, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

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 ther licensure.

Prior Authorization Requirement
Required for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility for Partial Hospitalization/Day Treatment) you must obtain prior authorization from the Claims Administrator five business days before admission.
- In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received;
    - Mental Health or Substance Use Disorder Residential Treatment
    - Outpatient Electro-Convulsive Treatment
    - Applied Behavioral Analysis (ABA) for the treatment of Autism
    - Transcranial Magnetic Stimulation (TMS)
    - Psychological Testing
- A non-scheduled admission you must provide notification as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.Benefits include the following levels of care:

- Inpatient treatment
- Residential Treatment
- Partial Hospitalization/Day Treatment
- Intensive Outpatient Treatment physician
- 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 planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

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 under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

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

Services include the following:

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

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care. You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
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 authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission () you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; ; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleToTheraphy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy360Program 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.

PPO plans there are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

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, 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

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.

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 from or provide notification to the Claims Administrator as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

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. The following Preventive care items and services are covered at 100%, with no cost-sharing, as required under applicable law, when received from a Network Provider:

- 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*.

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 **www.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. These Benefits are described under the Appendix A Schedule of Medical Benefits PPO and Out of Network Plan or Appendix B Schedule of Medical Benefits HDHP.

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

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

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

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is 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 when both of the following are true:

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

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

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

When a test is performed, or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient*.

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.

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining a prosthetic device that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

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

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. 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. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Habilitative Services

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

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

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

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

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

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

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

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

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.

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

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 $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

Specialist Management Solutions

Specialist Management Solutions (SMS) is a holistic outpatient surgery solution that opens the door to affordable, quality specialty care. SMS connects employees and their eligible family members to surgical specialists in their communities who help them choose the most appropriate setting for their procedures. Specialists in the SMS alliance use ambulatory surgery centers (ASC) for outpatient procedures and surgeries, which could result in cost savings for the member. Specialties include:

- Cardiovascular
- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine
- Ophthalmology
- Orthopedic
- Pain Management
- Podiatry
- Urology
- Women's Health

For more information: www.specialistmanagementsolutions.com or call 833-381-2223

Important information about the PetSmart outpatient surgery or specialty care coverage

Beginning January 1, 2023, outpatient surgical procedures and speciality care procedures will require a prior consultation with Specialist Management Solutions (SMS). To complete the consultation before scheduling your surgery, please call SMS at 833-381-2223. PetSmart is requiring members to engage with Specialist Management Solutions (SMS) prior to receiving elective outpatient surgery. Failure to go through SMS will result in a $300 penalty. The penalty will NOT apply to the INN and OON Deductible. The penalty will apply to the INN and OON OOP Max

Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

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

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

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 authorization from the Claims Administrator five business days before admission.
■ A non-scheduled admission you must provide notification as soon as is reasonably possible.
In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; Partial Hospitalization/Day Treatment with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

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*.

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

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

If you do not obtain prior authorization as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

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

If you do not obtain prior authorization as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses. reduction

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 by a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.
- Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Prior Authorization Requirement
For 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 don't obtain prior authorization as required, Benefits will be subject to a $300 reduction and Benefits will be reduced to 50% of Eligible Expenses.

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

Telehealth/Telemedicine

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 schedule of benefits.

Virtual Care Services

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

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

Benefits are available for the following:

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

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

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

Vision Examinations

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*.

CLINICAL PROGRAMS AND RESOURCES

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

- Consumer Solutions and Self-Service Tools.
- Disease Management Services.
- Complex Medical Conditions Programs and Services.
- Wellness Programs.
- Women's Health/Reproductive.

CONSUMER SOLUTIONS AND SELF-SERVICE TOOLS

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

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

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

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

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

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

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

- Access to 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

Second Opinion Service
The Plan offers a second opinion service.

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.

www.myuhc.com
UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips

anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.
With **www.myuhc.com** you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

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

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copays and 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 **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

DISEASE 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.

COMPLEX MEDICAL CONDITIONS PROGRAMS AND SERVICES

Congenital Heart Disease (CHD) Resource Services

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

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare 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 Service under the Plan.

Bariatric Resource Services (BRS)]

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

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

You must access the Bariatric Resource Services program by calling 1-888-936-7246.

- Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

- You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program for obesity surgery services.
- For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling 1-888-936-7246.

Note: The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with obesity-related services received by a Designated Provider.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

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. For more information on the Complex Medical Conditions *Travel and Lodging Assistance Program*, refer to the provision below.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services
Travel and Lodging assistance is available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the 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 1-800-842-0843.

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

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If a 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 Provider.
- Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, 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 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, 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.

WELLNESS PROGRAMS

Quit For Life Program

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

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

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

- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card.

Real Appeal Program

The Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but is not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through **www.realappeal.com**, or at the number shown on your ID card.

WOMEN'S HEALTH/REPRODUCTIVE

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.

- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

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

As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

Fertility Solutions

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates made available to you by the Plan Sponsor. The Fertility Solutions program provides:

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

The Plan pays Benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions program provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics. For Designated Network Benefits, you must enroll in the Fertility Solutions Program to receive services from a Designated Provider. To enroll you can call the telephone number on your ID card or you can call the *Fertility Solutions Program Nurse Team* at 888-936-7246.

Covered Persons who do not live within a 60-mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment. For infertility services and supplies to be considered Covered Health

Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.
You or a covered Spouse or Domestic Partner may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-888-936-7246. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Health Management Virtual Behavioral Therapy and Coaching Programs

The Virtual Behavioral Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health. You can visit the site by going to https://www.ableto.com/uhc.

The program is provided through AbleTo, Inc. 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.

LIMITS & EXCLUSIONS – MEDICAL BENEFITS

What this section includes:
Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in the Medical Benefits Section, including the Schedule of 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, they are described in the Medical Benefits Section, including the Schedule of Benefits. 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 limiting to", it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism, hypnosis, or hypnotherapy.
4. Massage therapy.
5. Rolfing (holistic tissue massage).
6. Art therapy, music therapy, dance therapy, animal-assisted therapy, wilderness, adventure, camping, outdoor, or other similar programs and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care.

Dental

1. Dental care, except as identified under *Dental Services* in the *Schedule of Benefits*.
   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 cares resulting from dry mouth after radiation treatment or as a result of medication.
   Endodontics, periodontal surgery and restorative treatment are excluded.
2. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:
   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided.
3. Dental implants, bone grafts, and other implant-related procedures; however, this exclusion does not apply to accident-related dental services for which Benefits are provided.
4. Dental braces (orthodontics).
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available limited

to:

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

6. Treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

1. Powered and non-powered exoskeleton devices
2. Devices used specifically as safety items or to affect performance in sports-related activities
3. Orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME) in *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding
4. Orthotic appliances and devices, except when all of the following are met:
   - prescribed by a Physician for a medical purpose; and
   - custom manufactured or custom fitted to an individual Covered Person.
   - Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics, and some types of braces availabe over the counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.
5. The following items are excluded, even if prescribed by a Physician:
   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses; and
   - ultrasonic nebulizers.
6. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.
7. The replacement of lost or stolen prosthetic devices.
8. 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)* in *Additional Coverage and Prior Authorization*.
9. Oral appliances for snoring.
10. Dental devices, dentures, bridges, teeth.

Experimental or Investigational or Unproven Services

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* on section.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided. Routine foot care services that are not covered include:
   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue).
2. Hygienic and preventive maintenance foot care. Examples include:
   - cleaning and soaking the feet; and
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
3. Treatment of flat feet.
4. Treatment of subluxation of the foot.
5. Shoe inserts.
6. Arch supports.
7. Shoes (standard or custom), lifts and wedges, (except as shown in the Schedule of Benefits).
8. Shoe orthotics and insoles.

Gender Dysphoria

Cosmetic Procedures, including the following:

1. Abdominoplasty.
2. Blepharoplasty.
3. Body contouring, such as lipoplasty.
4. Brow lift.
5. Calf implants.
6. Cheek, chin, and nose implants.
7. Injection of fillers or neurotoxins.
8. Face lift, forehead lift, or neck tightening.
9. Facial bone remodeling for facial feminizations.
10. Hair removal, except as part of a genital recontruction procedure by a Physician for treatment of Gender Dysphoria.
11. Hair transplantation.
12. Lip augmentation.
13. Lip reduction.
14. Liposuction.
15. Mastopexy.
16. Pectoral implants for chest masculinization.
17. Rhinoplasty.
18. Skin resurfacing.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
   - compression stockings.
   - ace bandages.
   - diapers.
   - diabetic strips and syringes.
   - urinary catheters (except for ostomy & colostomy supplies).

   This exclusion does not apply to:
   - ostomy bags and related supplies for which Benefits are provided as described under *Non-Durable Supplies* in the *Schedule of Benefits.*
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described in the *Schedule of Benefits.*
2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.
3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.
4. The replacement of lost or stolen Durable Medical Equipment.
5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Non-Durable Supplies* in the *Schedule of Benefits.*

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

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy.
2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion does not apply to medical or behavioral/mental health related education services as described in *Physician Office Service's – Sickness and Injury*.
3. Food of any kind. Foods that are not covered include:
   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) unless they are the only source of nutrition– infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals (it may qualify as Preventive care under ACA; see the *Affordable Care Act Preventative Drugs* section under the *Prescription Drug Program* below for more information);
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements.
4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidentals for personal comfort. Examples include:
   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;

- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps (exclusion does not apply to the in-network rental of breastfeeding equipment in conjunction with a birth);
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners;
- electric scooters;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- hot and cold compresses
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in the *Glossary of Defined Terms* are excluded from
2. pharmacological regimens. coverage. 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.
   - nutritional procedures or treatments.
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherpy 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.
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
   - breast augmentation.
3. Physical conditioning programs such as athletic training, bodybuilding, exercise,

fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.
5. Wigs regardless of the reason for the hair loss.
6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Prescription Drugs

The exclusions listed below are limited to the medical component of the Medical Plan. Prescription Drug coverage is available through the Prescription Drug Program component of the Medical Plan. See *Prescription Drug Section* for coverage details and exclusions.
1. Prescription Drugs 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. Growth hormone therapy.
4. Non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office.
5. Over-the-counter drugs and treatments.
6. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.
7. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

Procedures and Treatments

1. Biofeedback.
2. Intracellular micronutrient testing.
3. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).
4. 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 but not limited to routine, long-term or maintenance/preventive treatment.
5. Speech therapy to treat stuttering, stammering, or other articulation disorders.
6. Speech therapy, except when required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders.
7. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.
8. Excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and

brachioplasty).
9. Psychosurgery (lobotomy).
10. Treatment of tobacco dependency (other than tobacco-use counseling and interventions through QuitPower). 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.
11. Chelation therapy, except to treat heavy metal poisoning.
12. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies.
13. 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.
14. Expenses related to weight loss program, dietary instructions and complications thereof (without regard to why prescribed). However, obesity screening and counseling is covered as a preventive service.
15. Medical and surgical treatment of hyperhidrosis (excessive sweating).
16. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.
17. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Services and Special Rights Following Mastectomy.*
18. Diagnosis or treatment of the jawbones, including:
    - orthognathic surgery (procedure to correct underbite or overbite), except as treatment of obstructive sleep apnea;
    - upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, tumor or cancer; and
19. Expenses for services or supplies not prescribed or recommended by a Physician.
20. Treatment of benign gynecosmastia (abnormal breast enlargement in males).
21. Reconstructive Surgery or procedures, except those required to correct or repair damage caused by trauma, injury, birth defect or disease. This exclusion does not include services required by the Women's Health and Cancer Rights Act of 1998.
22. Any service, supply, or treatment that is not a Covered Health Service as determined by UnitedHealthcare or its designee.
23. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

Providers

Services:

1. Performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child.
2. Performed by Covered Person on himself or herself.

3. Performed by a provider with your same legal residence.
4. Ordered or delivered by a Christian Science practitioner.
5. Performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
6. Provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider.
7. Which are self-directed to a free-standing or Hospital-based diagnostic facility.
8. Ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care prior to ordering the service or after the service is received.
9. Supplies that are not prescribed or recommended by a physician (doesn't apply to mammography testing.

Reproduction

1. The following treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Non-medical costs of oocyte or sperm donation such as donor agency fees.
   - 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 embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
   - Donor, Gestational Carrier or surrogate administration, agency fees or compensation.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. 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 under *Fertility Preservation for Iatrogenic Infertility.*
4. IVF for a traditional Surrogate. Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.Costs of donor eggs and donor sperm.
5. The reversal of voluntary sterilization.
6. Infertility services not received from a Designated Provider.
7. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.
8. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

9. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
10. Infertility treatment following unsuccessful reversal of voluntary sterilization.
11. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in the *Plan Administration Section*.
2. Under workers' compensation or similar legislation if you could elect it or could have it elected for you.
3. 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 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 accessible.

Transplants

1. Health services for organ and tissue transplants, except as identified in the *Schedule of Benefits*, unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).
3. Health services for transplants involving animal organs.
4. Donor-related expenses for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).
5. Expenses related to nonhuman organ or tissue transplants and implants.

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 Program described in Complex Medical Conditions.
3. Additional travel expenses related to Covered Health Services received from a Designated Provider 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.

Types of Care

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

Vision and Hearing

1. Routine vision examinations, including refractive examinations to determine the need for vision correction. However, vision screening for children between the age of 3-5 years to detect the presence of amblyopia or its risk factors is covered as a preventive service.
2. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
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; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Medical Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in the Medical 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. Purchase cost and associated fitting charges for eyeglasses or contact lenses.
5. Eye exercise or vision therapy.
6. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.
2. Charges for:
   - missed appointments;
   - room or facility reservations;
   - completion of claim forms;
   - record processing
3. Charges prohibited by federal anti-kickback or self-referral statutes.
4. Diagnostic tests that are:
   - delivered in other than a Physician's office or health care facility; and

- self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests. Excludes over-the counter Covid tests for the duration of the declared health emergency. See Prescirption Drug coverage section in this SPD.

5. Expenses for health services and supplies:
   - that do not meet the definition of a Covered Health Service in the *Glossary of Defined Terms*;
   - that are sustained 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 before your coverage starts or after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
   - that exceed Eligible Expenses or any specified limitation in this SPD;
   - for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;
   - that are over the Usual, Reasonable and Customary charges or contracted allowances established for the Medical Plan (considering geographic location, provider similarity and/or unusual circumstances); and
   - that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
6. Foreign language and sign language services.
7. Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products with the exception of the Fertility Solutions program and storage of embryos for up to 12 months.
8. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - required solely for purposes of education, sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders;
   - required to obtain or maintain a license of any type;
   - services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective; and
9. Expenses that exceed any specific Plan benefit limitation or maximum allowable payment.
   - Expenses related to the medical or surgical treatment of sexual dysfunction or inadequacy and complications thereof.
   - Facility charges if the Covered Person leaves a health care facility against the medical advice of the attending Physician within 72 hours of the admission.
   - Expenses related to collection or administration of blood, blood products or biological serum.

- Expenses for education, job training or vocational rehabilitation.
- Expenses related to physical examinations and testing necessary for employment, government, insurance, school, camp, recreation, sports or other third-party requests.

10. 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.

FLEXIBLE SPENDING ACCOUNTS

What Are the Tax Advantages of Participating in the Flexible Spending Accounts? With a Flexible Spending Account (FSA), you can elect to contribute amounts from your pay on a before- tax basis for use in paying certain health care and/or dependent care expenses. The money you contribute is not subject to federal income taxes or Social Security taxes. Please note your future Social Security benefits may be lower because Social Security (FICA) taxes are based on your reduced pay. Expenses incurred by your Domestic Partner, who is not a tax dependent under Section 152 of the Internal Revenue Code, are not eligible for reimbursement.

How Does the FSA Work? To be eligible to participate in the Health Care FSA, you can not be enrolled in a HDHP medical plan. To be eligible to participate in the Limited-Purpose FSA, you must be enrolled in the HDHP medical plan option with an HSA and have up to $500 of unused amounts in your Health Care FSA from the last Plan Year that will be carried over to the Limited-Purpose FSA during the following Plan Year. To participate in the Dependent Day Care FSA, you must be a full-time salaried or full-time hourly Associate.

If you are eligible for the Limited-Purpose FSA, you will be automatically enrolled, and you cannot contribute additional funds to the Limited-Purpose FSA. If you have a Limited-Purpose FSA and enroll in a non-HDHP medical plan option in a future plan year, your Limited-Purpose FSA may be converted to a Health Care FSA if there is any applicable carryover amount (see the carryover question below).

To open a Health Care FSA or Dependent Day Care FSA, you must sign up during your initial enrollment period or any subsequent open enrollment period. Your participation continues until the end of the calendar year or, if earlier, when your coverage ends (see “Eligibility & Participation”). If you decide to participate, amounts are automatically deducted from your gross pay as FSA contributions to your Health Care FSA and/or Dependent Day Care FSA. Whenever you pay an eligible expense, you simply submit an FSA claim form and proof of payment to UnitedHealthcare to receive a tax-free reimbursement. Alternatively, you can pay for eligible expenses using your UnitedHealthcare Consumer Accounts MasterCard. Note that no amounts are actually held in your account(s); but rather, any Health Care FSA, Limited-Purpose FSA, or Dependent Day Care FSA is simply a bookkeeping account.

What Happens if I leave the Company or am no longer eligible to participate in the FSA Plan? You, your Spouse, or Eligible Child may elect COBRA coverage under the Health Care FSA or Limited-Purpose FSA for the remainder of the Plan Year if you have an under-spent account. The Health Care FSA or the Limited-Purpose FSA can only be elected for the remainder of the Plan Year during which coverage is lost. For example, if you lose coverage due to a Qualifying Event in August and you elect COBRA coverage under the Health Care FSA, your coverage will end on December 31 of the same year. You cannot elect coverage for the next Plan Year.

You may claim payment or reimbursement for expenses incurred before your termination or ineligibility, provided you submit your claim for payment or reimbursement no later than 90 days after your termination or change to ineligible status.

If you are no longer eligible for the Health Care FSA due to enrollment in the HDHP medical plan and your Health Care FSA is under-spent at the end of the previous Plan Year, then up to $500 will be carried over into a Limited-Purpose FSA that can be used during the next Plan Year.

HEALTH CARE AND LIMITED PURPOSE FSAs

If you open a Health Care FSA, you can use tax-free dollars to reimburse yourself for eligible health care expenses that you or your eligible family members incur while you are participating in the Health Care FSA. With a Limited Purpose FSA, you can use tax-free dollars to reimburse yourself only for eligible dental, vision, or preventive care expenses that you or your eligible family members incur while you are participating in the Limited-Purpose FSA.

Who Are My Eligible Dependents for purposes of the Health Care FSA and Limited-Purpose FSA? Your eligible dependents are limited to the following individuals:

- Your Spouse;
- Your child who has not attained age 27 by the end of the plan year (even if he or she is no longer eligible for coverage under the medical, dental and vision components of the Plan);
- Your unmarried child of any age who is permanently and totally disabled, has the same principal residence as you for more than half of the tax year and does not provide for more than half of his or her own support; and
- Any other child, relative or individual (including a grandchild, sibling, niece or nephew) for whom you provide more than half of his or her support and can claim as a dependent for federal income tax purposes (disregarding any income limitation used to determine whether that individual is a tax dependent).

However, a special rule applies for children of parents who are divorced or legally separated under a divorce decree or written separation agreement or live apart during the last six months of the calendar year. Such child satisfies any support and residency requirements if he or she is in the custody of one or both parent(s) for more than half of the calendar year and receives

over one-half of his or her support from his or her parents.

For purposes of the Health Care FSA and Limited-Purpose FSA, the term your "child" means your natural child, stepchild, adopted child, a child placed with you for adoption or a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

How Much May I Contribute Each Year to the Heath Care FSA? You can contribute a minimum of $100, but not more than the IRS limit, a year in a Health Care FSA. The limit for the Plan for 2023 is $2,750.

What Are Eligible Health Care Expenses Under the Health Care FSA? Eligible expenses generally include the portion of health care expenses that are not covered by your health plan and include:

- any health care expense that you could deduct on your federal income tax return.
- deductibles and Copays under any medical, dental, vision or prescription drug plan.
- over the counter drugs needed for medical care.
- expenses for medical services or supplies not covered by your health plan.
- vision care expenses not covered by your vision plan, including eye exams, frames, lenses and contact lenses.
- hearing care expenses.
- expenses in excess of medical, dental or vision plan limits (e.g., orthodontic expenses greater than the limit set by your dental plan).
- transportation expenses related to medical care
- Menstrual care products

What Expenses Are Not Eligible Under the Health Care FSA? Expenses not eligible for reimbursement under the Health Care FSA include:

- Cosmetic surgery.
- weight loss programs (unless prescribed by your doctor for the treatment of a medical condition/illness).
- health club dues.
- Electrolysis.
- after-tax premiums for a health plan.
- health care items used for general health care, such as toothbrushes and vitamins.
- expenses you incur before you begin participating in the Health Care FSA or after your participation ends.
- expenses incurred by your Domestic Partner who is not a tax dependent under Section 152 of the Internal Revenue Code determined without regard to the gross income limit under that Section.

What Are Eligible Expenses Under the Limited-Purpose FSA? Eligible expenses under the Limited Purpose FSA include only:

- Services or treatments for dental care (excluding premiums).
- Services or treatments for vision care (excluding premiums).

- Preventive care, as defined under IRS rules.

You may not use the Limited Purpose FSA to be reimbursed for any other medical expenses except for those listed above. Otherwise, you will no longer be eligible to contribute to an HSA.

What Happens to Unused Amounts?
You can carry over up to $500 of unused amounts remaining in your Health Care FSA or Limited-Purpose FSA at the end of a Plan Year to be used for eligible health care expenses incurred during a future Plan Year. Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit and do not count toward the annual contribution limit. Even if you do not elect to contribute amounts to a Health Care or Limited-Purpose FSA for the following year, you can still use any carried over amounts for reimbursement of eligible health care expenses incurred during a future Plan Year. Unused carryover amounts will not be forfeited during the next Plan Year, except when any prior carryover amount plus the unused amount from the current Plan Year exceeds $500. The maximum total amount that can be carried over to the next Plan Year (from the prior Plan Years combined) remains subject to the $500 limit.

Contribution amounts for the current Plan Year will be utilized prior to amounts carried over from a prior Plan Year.

In order to take advantage of the carryover feature, you must be a participant in the Health Care FSA as of the last day of the Plan Year. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.

Below are examples of how the carryover applies.

- If you had a Health Care FSA during the current year and enroll in the PPO or Out of Network Plan option for next year, then your Health Care FSA for next year will contain any applicable carryover amount plus your elected Health Care FSA contribution for next year.
- If you had a Health Care FSA during the current year and enroll in the HDHP for the next year, then your Health Care FSA will automatically convert to a Limited-Purpose FSA for next year containing any applicable carryover amount.
- If you had a Limited-Purpose FSA during the current year and enroll in the HDHP for the next year, then your Limited-Purpose FSA will continue for next year and will contain any applicable carryover.
- If you had a Limited-Purpose FSA during the current year and enroll in the PPO or Out of Network Plan option for next year, then your Limited-Purpose FSA will automatically convert to a Health Care FSA for next year containing any applicable carryover plus your elected Health Care FSA contribution for next year.

DEPENDENT DAY CARE FSA

If you open a Dependent Day Care FSA, you can use the tax-free dollars to reimburse yourself for eligible dependent care expenses that you incur while you are participating in the Dependent Day Care FSA.

How Much May I Contribute Each Year to the Dependent Day Care FSA? You can contribute a minimum of $100, but not more than $5,000 a year (or $2,500 if you're married but file separate income tax returns) or if less, the amount of your earned income for the year (or that of your Spouse, if married) in your Dependent Day Care FSA. If your Spouse also has a Dependent Day Care FSA at work, your total combined contribution cannot exceed $5,000 a year. If married, your Spouse is deemed to be gainfully employed and to have an earned income of not less than $250 each month (or $500 per month if there are more than one Eligible Dependent) during which he or she is a full- time student or is incapable of self-care and has the same principal place of abode as you for more than half the year.

In certain cases, if you are deemed a highly compensated employee (HCE) or a "Key Employee" by the Internal Revenue Service, your annual limit may be reduced to comply with certain nondiscrimination testing requirements. If such is the case, you will be notified by the Benefits Department.

Who Are My Eligible Dependents? For purposes of the Dependent Day Care FSA, the following are eligible dependents:

- Your biological child, stepchild, adopted child, child placed for adoption, or foster child (or a descendant of your child), or your brother, sister, stepbrother or stepsister (or a descendant of either), whose primary residence is your household for more than half of the calendar year, who is under age 13, and who has not provided more than one-half of his or her own support that year. In the case of divorced or separated parents, a child is treated as a dependent only of the parent who has custody for the greater portion of the calendar year.
- Your Spouse or other relative you claim as a dependent on your taxes (without regard to the gross income limit under Code Section 152(d)(1)(B)) including relatives such as a parent, parent in-law, or sibling, who lives with you for more than half the year, spends at least eight hours a day in your household, and is physically or mentally incapable of caring for himself or herself.

What Are Eligible Dependent Day Care Expenses? Eligible expenses are the same expenses that would give you a dependent care tax credit on your federal income tax return. Namely, expenses incurred for the care of one or more of your Eligible Dependents so that you (and your Spouse, if married) can be gainfully employed. You will need to decide if you want the tax advantages of the Dependent Day Care FSA or if you want to take the federal dependent care tax credit. **Note:** You cannot use the Dependent Day Care FSA and the federal dependent care tax credit for the same expense.

Eligible expenses may include:

- Childcare at a day camp, nursery school, day care center or by a private sitter in your

home.
- Before and after-school care (other than tuition expenses).
- Care of an incapacitated adult who is your Eligible Dependent as defined above, who lives with you at least eight hours a day.
- Late pick-up fees.
- Expenses for household services where attributable in part to the care of an Eligible Dependent.
- Summer or holiday day camps.
- Placement fees for a dependent care provider, such as an au pair.

Examples of ineligible expenses include:

- Education or tuition fees.
- Expenses for children over age 13.
- Late payment fees.
- Overnight camps.
- Payment for services not yet provided (payment in advance).
- Sports lessons, field trips, clothing.
- Transportation to and from the dependent care provider.

You can use a relative to provide dependent care services. However, you may not reimburse expenses for care that was provided by your Spouse, your own children who are under age 19 at the end of the calendar year, or any other individual who qualifies as your dependent for federal income tax purposes.

Eligible childcare providers must provide you with their Social Security Number or Tax Identification Number, and the caregiver must declare your payment as taxable income. Failure to satisfy this requirement may result in your having to pay taxes on the redirected amount. If your dependent care is provided by a dependent day care center, the center must comply with all applicable state and local laws and regulations. A dependent care center is defined as a facility that provides care for more than six individuals and receives a fee, payment, or grant for providing such services.

For a complete list of eligible and ineligible expenses, see IRS Publication 503, "Child and Dependent Care Expenses," available online at www.irs.gov. You can also request a copy of this publication from the IRS or from the Benefits Department.

What Happens to Unused Amounts?

You have three months after December 31 to submit claims for that year's expenses (or if earlier, three months after the termination of your participation in the Dependent Day Care FSA). After that you will forfeit any balance remaining in your account. Unlike the Health Care FSA, IRS rules do not permit the carryover of any unused amounts credited to your Dependent Day Care FSA so it's very important to carefully estimate the amount you will be contributing to your account.

Is There Any Other Important Information about the FSAs?

Read These Rules Before You Elect to Participate in an FSA – Because FSAs offer tax advantages, the IRS has strict rules that govern these plans. To make an informed decision, review the restrictions and limitations below before completing your FSA election.

No Changes – Once you make your FSA election for the year, you cannot change it until the next annual open enrollment. You cannot increase, decrease or stop your contributions during the year unless you have an approved status change (see "Eligibility & Participation").

Separate Accounts – The Health Care FSA, Limited Purpose FSA, and Dependent Day Care FSA are separate accounts. You cannot use your Health Care FSA or Limited Purpose FSA to reimburse yourself for dependent day care expenses, or vice versa, even if you have excess contributions in one account and have a shortage in the other.

Contributions – Generally, FSA contributions must be made through payroll deduction. You cannot deposit cash directly into your account. Special payment rules apply for COBRA and unpaid leaves of absence.

Reimbursable Expenses – Reimbursements from the account must be incurred in the same tax year in which contributions are made. You can only be reimbursed for expenses incurred while you are a participant in the FSA.

FILING CLAIMS FOR FSA REIMBURSEMENT

To request reimbursement from your FSA, you must submit a completed form and evidence of payment to UnitedHealthcare or for certain medical and prescription expenses, you can use the Consumer Account Card. A claim form can be found at petsmart.benefits.com or by visiting www.myuhc.com. Any claims submitted during the Plan Year must be for at least $50.00 (or, if less, the balance remaining in your account at the end of the Plan Year). If your claim for reimbursement is denied, you can request a review (See "Appeals Procedures").

How Do I File Health Care FSA and Limited Purpose FSA Claims? Claims must be submitted no later than three months after December 31 of the plan year in which you incur the expense (or if earlier, three months after the termination of your participation in the Health Care FSA or Limited Purpose FSA). Claims will be processed up to the total annual election amount. Submit claims as follows:

- First submit expenses to the appropriate claims administrator for medical, dental or vision plans.
- Review the Explanation of Benefits (EOB) you receive for expenses that are not paid or covered by the plan(s).
- Accumulate expenses until you have $50 in expenses.
- Complete the FSA Claim Form at benefits.petsmart.com or myuhc.com; mail or fax it to UnitedHealthcare.

If you have expenses that are eligible for reimbursement from the FSA, and you know they are

not covered under the medical, dental or vision plans, skip the first two steps above. Your claim will be treated as a post-service claim. Refer to the Post-Service Claims Section starting for more details.

If you use your Consumer Account Card to pay for an eligible medical expense, the merchant or service provider will be paid the full amount of the health care expense, unless there is insufficient coverage available in your Health Care FSA or Limited Purpose FSA, and your maximum available coverage remaining will be reduced by such payment. However, every debit card transaction is treated as conditional pending review and substantiation, either automatically without further documentation or manually through submission of merchant or provider receipts. Accordingly, you must acquire and retain sufficient documentation for any expense paid with your Consumer Account Card and make such documentation available upon the request of the claims administrator or the Plan Administrator.

Upon identification of an improper payment, you will be required to reimburse the Plan the amount of the improper payment. Until payment is made, your access to the debit card will be suspended. If you do not reimburse the Plan within 30 days, PetSmart may either withhold the amount of the improper payment from your wages or request that the claims administrator deduct such amount from any substantiated claim(s) you may subsequently submit during the same coverage period.

Are Any Health Care or Limited-Purpose FSA Claims Processed Automatically? For medical expenses processed by UnitedHealthcare that are subject to coinsurance required by you as the patient, these expenses can automatically be reimbursed to you through your Health Care FSA or Limited-Purpose FSA. To set up the automatic processing election, log onto myuhc.com and go to the account settings for FSA.

How Do I File Dependent Day Care FSA Claims? Claims must be submitted no later than three months after December 31 of the plan year in which you incur the expense (or if earlier, three months after the termination of your participation in the Dependent Day Care FSA). Claims will be processed up to the amount of the claim(s) or the balance in your account, whichever is less. If you do not have enough money in your account to pay a claim, your claim will be paid when (and if) your account contains enough money to pay the claim. Remember, your account is increased each payroll with new deposits. Submit claims as follows:

- Obtain from your service provider a paid bill or receipt.
- Complete the FSA Claim Form found at benefits.petsmart.com or myuhc.com, including the provider's tax identification number or Social Security Number.
- Mail or fax the form and evidence of payment to UnitedHealthcare.

After each claim is processed, you will receive an account statement that shows the claim amount, the amount paid-to-date, and the available balance for future claims. After the close of the Plan Year, you will receive a statement of account activity, contributions and the remaining balance.

Claim Denial Process

If your claim under the Health FSA or Limited Purpose FSA is denied, you will receive written notification of the denial with the specific reasons for the denial and citing pertinent Plan

provisions on which the denial is based.

Questions and Appeals
If you have a question or concern about a benefit determination, you may informally contact a UnitedHealthcare Customer Service representative for your claim.

If you wish to request a formal appeal of a denied claim under the Health Care FSA or Limited Purpose FSA, you should follow the instructions and contact UnitedHealthcare. See the "Appeals and Claim Procedures" section of this SPD.
A qualified individual who was not involved in the initial benefit decision being appealed will be designated to decide the appeal. 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.

HEALTH SAVINGS ACCOUNT (HSA)

The HSA described in this section is not an arrangement that is established or maintained by PetSmart. Rather, the HSA is established and maintained by the HSA trustee, UnitedHealth Care. It is the Plan's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan when certain requirements are satisfied.

What Are the Advantages of Participating in the HSA? An HSA is a tax-advantaged account that you can use to pay for any qualified health expenses incurred by yourself or your eligible dependents, while covered under a high deductible medical plan. 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 medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses; however, these amounts are subject to income tax and may be subject to 20% reduction. HSA contributions accumulate over time with interest or investment earnings, are portable after employment, and can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis. Some states do not recognize HSA contributions to be a tax deduction for state income tax purposes. Refer to your states income tax regulations for more information.

How Does the HSA Work? To elect an HSA, you must sign up during your initial enrollment period or any subsequent open enrollment period and be enrolled in the HDHP medical option. All contributions made by you or by PetSmart are placed into your HSA, and are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee. Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the HDHP and have established a Health Savings Account until the earlier of:

- The date on which you file taxes for that year; or
- The date on which the contributions reach the contribution maximum.

Note that if coverage under the HDHP medical option terminates, no further contributions may be made to the HSA.

How Much Can I Contribute to the HSA? The contribution maximum is either the single or family limit set by the IRS and are indexed each year. The maximum annual contribution will include both the associate and the employer contribution amounts for the plan year, not to exceed the IRS limits. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the IRS limits. The maximum limits set by the IRS may be found on the IRS website at www.irs.gov. The Plan will follow IRS indexing for HSA contribution maximums for future plan years. Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

If you enroll in an HSA during the Plan Year (i.e., on a date other than January 1) you will still be allowed to contribute the maximum amount. When you enroll in the HSA after January 1 (for example to due to gaining eligibility under the plan, the amount you can contribute is either:

- Prorated, which means you divide the maximum HSA contribution by 12 months and contribute that amount each month that you are enrolled in the HDHP with the HSA; or
- The maximum HSA contribution amount provided that you are HSA-eligible on December 1 and maintain HDHP coverage throughout a subsequent 13-month testing period (e.g., you are enrolled in HDHP coverage with the HSA December 1, 2022 through December 31, 2023).

What Expenses Can HSA Funds be Used For? The funds in your HSA will be available to help you pay your or your Eligible Dependents' out-of-pocket costs under the medical plan, including Annual Deductibles and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code. "Qualified health expenses" only include the medical expenses of you and your Eligible Dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code. Expenses are not covered if they are incurred by your Domestic Partner, who is not a tax dependent under Section 152 of the Internal Revenue Code.

If you receive any additional medical services not covered by the Plan and you have funds in your HSA, you may use the funds in your HSA to pay for those medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services. The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available at www.irs.gov.

Can HSA funds be Used to Pay for Non-Qualified Health Expenses? HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and an additional 20% tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Can HSA Funds be Used to Pay for Premiums? In general, you may not use your HSA to pay for other health insurance premiums without incurring a tax. However, you may use your HSA to pay for COBRA premiums and Medicare premiums.

Will Unused HSA Funds Rollover and Be Available for Use During Subsequent Plan Years?
Yes. If you do not use all of the funds in your HSA during the Plan Year, the balance remaining in your HSA will roll-over from year to year.

What Happens if I leave the Company or Am No Longer Eligible to Contribute to the HSA? If your employment terminates for any reason, or you are no longer eligible to contribute to the HSA, the funds already in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the HDHP.

If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Can HSA Funds be Transferred? If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds.

When Using My HSA for Qualified Medical Expenses, Do I Need to Keep Receipts and Records of Those Transactions? Yes, please be sure to keep your receipts and medical records. 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. The Company 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.

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

Do I Need to Know My HSA Balance Before Withdrawing Funds?
It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance. Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

PRESCRIPTION DRUG PROGRAM

When you enroll in the Medical Plan, you are automatically enrolled in the Prescription Drug Program. When you use a participating CVS Caremark network Pharmacy your copay or coinsurance amount will depend on the type of prescription. You will generally pay the lowest amount for any generic drug, a mid- level copay or coinsurance for cost-effective, preferred brand-name drugs, a higher copay or coinsurance amount for non-preferred brand- name drugs and the highest copay or coinsurance amount for specialty drugs. Specialty drugs are only available through the CVS Caremark Specialty Pharmacy. To receive your benefit, go to a drug store that accepts your CVS Caremark prescription drug card. To find a participating drug store near you contact CVS Caremark at 1-855-821-0355 or visit their website at www.caremark.com. Prescriptions purchased at out-of-network pharmacies are not covered.

How Does the Prescription Benefits work with the HDHP? The High Deductible Health Plan (HDHP) requires you to pay the full negotiated cost for your care until you reach your deductible for most health care expenses, including most prescription medications. After you meet the deductible, you pay only the coinsurance, and your plan pays the rest. Petsmart understands that some medications can help prevent disease or help manage existing conditions to try and avoid future complications. For this reason, Petsmart now offers a preventive drug list, which reduces your cost for select prescriptions that help prevent chronic health conditions, when taken regularly. If you take medications on the preventive drug list, you will pay only the coinsurance for these medications even if you have not yet met your annual plan deductible. The list of covered preventive drugs can be found at benefits.petsmart.com or at www.caremark.com.

Examples of preventive medications:

- The treatment of high cholesterol with medications such as statins to prevent heart disease
- Using medication such as an ACE inhibitor to prevent heart attack or stroke in members who have already suffered a heart attack or stroke

Information on speciality medications on the HDHP plan are reviewed in the section **PrudentRx Co-Pay Program for Specialty Medications**

What is the CVS Caremark Performance Drug List (PDL)? The Prescription Drug Program has adopted the CVS Caremark's current Advance Control Formulary as its guide within select therapeutic categories for plan members and health care providers. Drugs determined as "non-formulary" based on CVS Caremark's current formulary are not covered by the Plan. Certain products or categories, regardless of their appearance in this document may not be covered by the plan. The Caremark Performance Drug List, aka "Commonly Prescribed Medications List" is included with your card(s) or a copy can also be obtained online at www.caremark.com.

What are Generic Drugs? Generic drugs are approved to be as safe and effective as their brand name counterparts, and on average cost 50% less than brand name drugs. Generic drugs contain the same active ingredients and are available in the same strength and dosage form as their brand-name counterparts. The U.S. Food and Drug Administration (FDA) regulates the

manufacture of all generic drugs, which helps ensure their strength, quality and purity. The FDA also requires generic drugs to be absorbed into the body at the same rate and to the same extent as the branded product, which ensures that generic and branded products provide the same effectiveness in children, adults, and the elderly.

What are Preferred Brand-Name Drugs? Preferred brand-name drugs are a selected list of medicines on the CVS Caremark Performance Drug List that are clinically appropriate and cost- effective to meet individual needs. You can view and download the CVS Caremark Performance Drug List by logging onto Caremark.com. (To register, go to http://www.caremark.com/register and have your participant ID handy.) You may want to print a copy of the drug list and take it to your Physician the next time you need a prescription. If a generic isn't available for your prescription, ask your Physician to prescribe a preferred brand-name drug from the list, if appropriate for your needs.

What are Non-Preferred Brand-Name Drugs? These are brand-name drugs that aren't part of the CVS Caremark Performance Drug List and will require you to pay a higher co-payment than a preferred or generic drug.

How Do I find see if a drug is covered or check the cost once I am enrolled in the plan? If you are already enrolled in a CVS plan, you can register online at Caremark.com to check your drug cost and coverage. After logging in, select red Check Drug Cost and Coverage icon on the upper right-hand side of the landing page. Or, under the header, hover over the "Plan & Benefits" tab and select "Check Cost Drug & Coverage".

You will be prompted to enter in the drug name and strength and the pharmacy you would like to fill at, then select the drug name and strength and hit "Search". You will be brought to the results, which will show you the cost of a 30-day supply and a 90-day supply (if applicable). If your drug is not covered, or requires a prior authorization, or is a specialty medication that must be filled at CVS Specialty®, it will be indicated here.

If you do not already have an account with Caremark.com or have not yet enrolled in the plan, you can find out the cost of medications and plan details by calling your Customer Care number is 855-821-0355.

How does the Out-of-Pocket Maximum work? Once you have reached the prescription Out-of- Pocket Maximum, the Plan pays 100% of eligible prescription drug expenses for claims incurred during the remainder of the calendar year. Items that are not included toward your Out-of-Pocket Maximums are excluded drugs, out of network claims, and the amount you pay over the generic drug cost when you request a brand-name drug when the Physician approves an available generic drug. See the Generic Substitution section listed below for more details.

Note that the copay and coinsurance amounts do not apply to covered FDA-approved contraceptives for women that are obtained with a prescription from a participating CVS Caremark network Pharmacy, including Caremark's mail order program. However, if the prescribed contraceptive has a generic equivalent, the copay or coinsurance will apply if you obtain the brand name version of the contraceptive.

How Much Do I Have to Pay For Prescriptions? Copay, coinsurance and out-of-pocket maximums amounts for retail and mail order pharmacies are shown on the chart below.

	PPO 1, PPO2, SUREST & OON Plan Co-pays	
	Retail*	**Mail Order****
Generic (Tier1)	$7	$18
Preferred Brand (Tier 2)	25% $25 minimum/$150 maximum	$75
Non-Preferred Brand (Tier 3)	40% $50 minimum/$250 maximum	$400
Specialty Drugs with Prudent RX savings plan	$0/ 30% without Prudent RX /Prescription (only through CVS Caremark Specialty Pharmacy)	N/A
	RX Out of Pocket Maximums	
	PPO1, PPO2, SUREST & OON Plan	
Associate only coverage (Individual)	$1,500	
Associate plus spouse/ and/or children (Family)	$3,000	
*Retail prescription – 30-day supply **Mail order prescription – or CVS Pharmacy up to 90-day supply. Through Maintenance Choice Program you may receive a 90-day supply of maintenance medications at a CVS Pharmacy for the mail copay.		
	HDHP with HSA coinsurance	
	RX Deductible is combined with the Medical Deductible. If coverage is more than Individual, the Family deductible must be meet before coinsurance begins.	
	Individual	**Family**
	$2,150	$4,250
Generic-Preventative*	20%	
Preferred Brand Name	20%	
Non-Preferred Brand Name	20%	
Specialty Drugs	0/ 30% without Prudent RX /Prescription (only through CVS Caremark Specialty Pharmacy	
*Whether the deductible has been met or not, these specific generic medications will bypass the deductible and you'll be responsible for the applicable coinsurance. These include drugs that treat chronic conditions such as high blood pressure, high cholesterol, diabetes, etc. To see which drugs are on the list, visit benefits.petsmart.com.		
	RX/Medical Out of Pocket Maximum	
	Individual	**Family**
	$5,000	$10,000
Once you have reached the prescription Out-of-Pocket Maximum, the Plan pays 100% of eligible prescription drug expenses for claims incurred during the remainder of the calendar year.		

How Does Generic Substitution Work? You can save the most money by choosing generic drugs when available. Ask your Physician to authorize generic substitution when medically appropriate. CVS Caremark will never give you a generic instead of a brand-name drug without your Physician's permission.

If a generic drug is not available, you'll pay the brand-name copay or coinsurance. However, when a drug is available in generic form, but your Physician prescribes the brand-name drug, you'll pay the generic copayment or coinsurance plus the difference in cost between the generic and brand-name drugs.

If you or your Covered Dependent requests a brand-name drug when the Physician approves an available generic drug, you must pay the generic copay plus the difference in cost between the prescribed brand-name drug and its generic equivalent.

Important Information for Medicare Part D Eligible Individuals: *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a new voluntary prescription drug benefit (Part D) to the Medicare program for certain individuals. Group health plans that provide prescription drug coverage to individuals who are eligible for coverage under Part D must provide a notice to such individuals whether coverage under the group health plan is "creditable." Such individuals will need this information to decide whether keeping the group health coverage will allow them to delay enrolling in Medicare Part D and still avoid the Part D late enrollment penalty when they finally enroll in Part D. Medicare Part D Eligible Individuals will receive a separate creditable coverage notice at the appropriate time. See Notice at the end of this SPD.*

Affordable Care Act Preventive Drugs

Some medications are covered by the ACA preventative drug list, and with a prescription will be covered with a $0 copayment or coinsurance. This list may be amended or changed based on rules of the ACA. Visit https://benefits.petsmart.com/us/forms-and-resources/ for the most up to date list.

Mail Order Prescription Drug Program

Through the Caremark.com mail order program, you save time and money by ordering up to a 90- day supply of prescription medications taken for ongoing treatment of conditions, such as diabetes, ulcers, arthritis, and heart problems. Some medications may be limited to a 30-day supply. Copay or coinsurance amounts for mail order prescription drugs are shown in the previous chart. Over-the-counter (i.e., nonprescription) drugs cannot be ordered through the Caremark.com mail order prescription drug program.

How Do I Place a Mail Order? Have your doctor write a 90-day supply prescription and indicate the number of refills for your maintenance medication.

- With your first order, use the preaddressed mail order form to mail your prescription, completed order form and your check or money order for your copay or coinsurance amount. You may also pay with your VISA, MasterCard, Discover or American Express card. Do not send cash.
- Caremark.com will mail your medication(s) and reorder instructions to your home address. All orders will be sent FedEx, UPS, or First-Class Mail. You may request next-day or

second-day delivery for an additional charge. Allow 14 days from the day you mail your order until delivery. If you need a covered medication right away, ask your doctor to write two prescriptions – one to be filled by your local pharmacist for a 30-day supply and one to send to Caremark.com for up to a 90-day supply with the number of refills indicated.

- Or use the 90-day supply Maintenance Choice Program at CVS/pharmacy option listed below (availability is subject to state law).

What is the Maintenance Choice Program? For any maintenance medications you may receive two 30-day supply fills at retail. On your third fill you need to receive a 90-day supply either at a CVS/pharmacy or Target/pharmacy or by using Mail Order. Regardless of which option you choose, you will pay the mail copay or coinsurance amount. Members have the ability to fill 90-day supplies through mail order or at a CVS/pharmacy or Target/pharmacy. This provides options to save when filling prescriptions for maintenance medications. To fill your medications by mail, follow the instructions above. To fill your prescriptions at retail, simply take your prescription written for a 90-day supply to any CVS/pharmacy or Target/pharmacy and receive the medication at same mail order copay or coinsurance amount. This program may be limited based on state rules that restrict this type of plan.

How Do I Get Refills? Refills for are permitted only when 75% of the prescribed mediation has been used. There are two easy ways to refill your prescriptions:

- call CVS Caremark at 1-855-821-0355 (as shown on your prescription label); or
- log on to www.caremark.com to order a refill.

You can also mail your refill requests by using the mail order form, but telephone and online orders are processed and delivered faster.

PRESCRIPTION MANAGEMENT PROGRAMS

What is the CVS Caremark Specialty Guideline Management Program?
All specialty agents/medications are subject to Specialty Guideline Management (SGM) review. Specialty Guideline Management is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines. In addition, in order to address the changing marketplace dynamics and maximize appropriate use of generics, the SGM program incorporates specialty generic step therapy that requires the use of a cost-effective generic specialty medication as a first line therapy before targeted brands are covered. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved. Physician may call 1- 866-814-5506 to request an SGM review.

PrudentRx Co-Pay Program for Specialty Medications

Prudent Rx provides a comprehensive and cost-effective prescription drug program for you and your covered family members with the PrudentRx Co-Pay Program for certain specialty medications. The PrudentRx Co-Pay Program assists members by helping them enroll in manufacturer co-pay assistance programs. If you enroll in the PrudentRx Co-Pay Program, your out-of-pocket cost for prescriptions covered under the PrudentRx Co-Pay Program will be $0. Otherwise, medications in the specialty tier will remain subject to a 30% coinsurance.

For the HDHP with HSA, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution, unless the member has a health savings account (HSA). For members with HSAs:

(i) for drugs listed on the plan's HDHP Preventive Drug List, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution; and

(ii) for all other drugs, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution after the member's deductible has been satisfied.

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

Eligible members who choose to decline enrollment would be responsible for the full amount of the 30% co-insurance.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Co-Pay Program, you can reach out to PrudentRx at 800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan

deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your deductible or out-of-pocket maximum (if any), unless otherwise required by law.

A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

True Accumulation
Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Are There Any Managed Drug Limitations? CVS Caremark develops limitations to ensure safe and appropriate medication use. The list below includes those drugs subject to Managed Drug Limitations (MDLs). Regardless of what is prescribed by your Physician, the amount dispensed will be based on the recommended limitation. For more information, call CVS Caremark Customer Care at 1-855-821-0355.

- Migraine medications, including Amerge, Axert, Frova, Imitrex, Maxalt, Migranal, Relpax, Sumavel, Treximet and Zomig.
- Pain/Opiod medications, including Stadol NS and Toradol.
- Sedative/Hypnotics, including Ambien/CR, Dalmane, Doral, Halcion, Lunesta, ProSom, Restoril, Rozerem and Sonata.
- Proton Pump Inhibitors, including Aciphex, Dexilant, Nexium, Prevacid, Prilosec, Protonix and Zegerid.
- Lidocaine products
- Compound Products, A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.

Is Prior Authorization Required? Prior authorization requires a drug's prescribed use to be evaluated against a predetermined set of criteria before the prescription will be covered.

In addition to the MDLs above, certain drugs or drug classes will require prior authorization for you to receive coverage for them. If you're taking one of these drugs ask your doctor to call the CVS Caremark Prior Authorization Department at 1-888-413-2723. The request will be evaluated to determine if you still qualify for Plan coverage of the prescribed therapy.

If you don't meet the criteria standards and still wish to take the medication, you'll be responsible for the entire cost of the drug.

Are there any Step Therapies? This step therapy design requires the use of cost-effective

alternatives, within the same therapeutic class, as first line therapy before targeted brands are covered.

Are there any Generic Step Therapies? Generic step therapy requires that a cost-effective generic alternative is tried first before targeted single-source brands are covered.

When a prescription for a targeted single-source brand is presented, the adjudication system will check for previous generic use. If the history shows generic use, the single source brand claim will pay. For targeted brands with no history of a generic trial, the retail pharmacist receives an electronic message with the generic-first criteria and a toll-free number for the physician to call for more information.

In the event the prescriber determines that a generic alternative is not right for the member, (s)he can call the Prior Authorization Department. Prescribers who call will be assisted by a team of professionals who educate the provider on lower cost covered medications to facilitate a seamless prescription conversion.

Are There Any Exclusions? The following drugs and devices are not covered under the Prescription Drug Program:

- Anabolic Steroids.
- Antiobesity Agents.
- Anti-wrinkle Agents.
- Calcium Supplements.
- For Erectile Dysfunction.
- Fluoride Supplements (except Preventive Service Coverage listed below).
- Hair Growth Stimulants.
- Hair Remover Agents.
- Infertility Agents unless enrolled in a fertility program with UHC or Surest.
- Contraceptives not approved by the Food and Drug Administration (FDA) for women.
- Contraceptives obtained without a prescription.
- Contraceptives for men.
- Abortifacient Drugs.
- Mineral and Nutrient Supplements.
- Pediatric Multivitamins w/Fluoride (tabs and drops).
- Select bulk powders and bases used in compound medications.
- Select Specialty Drugs in the following categories; for Multiple Sclerosis, Rheumatoid Arthritis, Hepatitis C, Psoriasis, Growth Hormone, Pulmonary Arterial Hypertension, and Osteoarthritis. Please note there are covered products in each of these classes and this list is updated quarterly.
- Over-the-counter (OTC) products or OTC equivalents and state restricted drugs, except OTC diagnostic test for Covid-19 as described below.

Over-the-Counter Diagnostic Tests: Diagnostic tests for COVID-19 purchased over-the-counter are covered at 100%, Deductible waived, and do not require Prior Authorization. This benefit covers a maximum of eight (8) over-the-counter tests, per participant, per month. You do not need

a doctor's order for over-the-counter tests to be covered. However, to be eligible for coverage under the Plan, the tests must be for personal use and not for employment purposes.

The benefits described in this section will be provided as required by the FFCRA and the CARES Act and are effective through the end of the Public Health Emergency that was declared in 2020 as a result of the COVID-19 pandemic, or such longer time as may be required under applicable law. The declared Public Health Emergency ended May 11, 2023, and the benefits described in this section for over-the-counter tests covered at 100% ended as of May 11, 2023.

If My Prescription Drug is Denied, How Do I Appeal? If your prescription drug is denied coverage, you have the right to appeal to CVS Caremark. See the Appeals Section for more details.

DENTAL BENEFITS

Eligible Associates can enroll in dental coverage for themselves only or for themselves and their Eligible Dependents, without regard to any other coverage elected under the Plan. Dental coverage is voluntary. You may choose Dental Plan I, Dental Plan II or a Dental Health Maintenance Organization (DHMO), if offered in your area.

If you reside in California, you have the right to review the CIGNA Combined Evidence of Coverage and Disclosure prior to enrollment. If you do not have a copy and want one, please call CIGNA Health Care at 1-800-244-6224.

HIGHLIGHTS – DENTAL PLANS I & II

When you enroll in Dental Plan I or Dental Plan II, you can use any Dentist, but if you use a CIGNA Dentist, you can take advantage of CIGNA's negotiated rates, which means lower out-of-pocket expenses for you.

You may obtain a list of participating Dentists by calling CIGNA at 1-800-244-6224 or visiting CIGNA's website at www.cigna.com. You have the flexibility of using a Dentist outside the network, but at a higher out-of-pocket expense. If you use a Dentist that does not participate in CIGNA's dental network, use the Dental Claim Form located at benefits.petsmart.com.

What Are the Highlights of Dental Plan I?

- Dental Plan I covers preventive, basic, major, implants and orthodontic services.
- Any course of treatment expected to cost more than $250 should be pre-certified to determine the amount the plan will pay and what will be your responsibility.
- Pre-certification is not necessary for Emergency treatment.
- All pre-certifications must be processed in accordance with "Claim Procedures" and "Appeal Procedures."

What Are the Highlights of Dental Plan II?

- Dental Plan II is limited to preventive and some basic services. Services not covered include crowns, bridges, dentures and orthodontics.

How is Orthodontics treatment started prior to participating in Dental Plan I covered?

- Ask your treating healthcare professional to submit a completed claim to Cigna at the address below. The claim should indicate your Total Case Fee (total charges including evaluation, treatment plan, x-rays, study models, therapy and, retention), banding date (date the appliance was installed), total number of months of treatment and, retention.
- Cigna will process the claim, deny all services received prior to your effective date of the Cigna Dental plan, and schedule payments for the remainder of your treatment.

Cigna Dental Claims P.O. Box 188037 Chattanooga TN 37422-8037

- Payments for Orthodontics in Progress continue until 1) the treatment plan is completed, 2) the Orthodontic Lifetime Maximum benefit is exhausted, 3) the patient is no longer eligible for benefits, and whichever comes first.

What is the Oral health Interration Program?

- The program offers enhanced dental coverage for customers we have identified as having certain medical conditions. There is no additional charge for the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health.
- Reimbursements under this program are not subject to the annual deductible but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.

What is Cigna Dental Virtual Care?

- Allows members to consult with a dentist 24/7/365 through myCigna.com. Get help with urgent dental care needs, including antibiotics and guided follow-up care. Virtual visits are covered at 100% so the member does not have any out-of-pocket costs to access the care.
- To learn more about either of these program, visit Cigna.com.

SCHEDULE OF DENTAL BENEFITS

Dental benefits for Covered Persons will be paid in accordance with the Schedule of Dental Benefits which compares the provisions of the three dental choices. See the DHMO Patient Charge Schedule for additional rules that apply to the DHMO.

Benefit Description	Additional Limitations and Explanations	Dental Plan I	Dental Plan II	DHMO
Annual Year Deductible Individual Family	• The applicable annual deductible must be met before the Plan will pay its share of the applicable coinsurance amount. • The individual deductible applies separately to each Covered Person. • The family deductible applies to all Covered Persons in the same family. • If the family deductible is met, the individual deductible will not be applied to any Covered Person in the family for the remainder of the Plan Year.	$50 $150	None	None
Annual Maximum Benefit Per Covered Person		$1,500	$500	N/A
Lifetime Orthodontic Maximum	• Orthodontic is not covered under Dental Plan II.	$1,500	Not covered	Per DHMO Patient Charge Schedule
Preventive Services • Oral examination • Prophylaxis (cleaning of the teeth) • Bite-wing x-rays • Full mouth x-rays • Topical application of sodium or stannous fluoride • Application of sealants on bicuspids and posterior teeth (molars) • Space maintainers • Examination and treatment in connection with Emergency palliative treatment	• Subject to annual maximum benefit. • Oral examination, prophylaxis, x-rays, and fluoride treatment limited to twice a calendar year. • Full mouth x-rays limited to once in a period of 36 consecutive months. • Fluoride treatment limited to Covered Associates and children under age 19. • Application of sealants limited to once in a period of 36 consecutive months. • Coverage for sealants limited to Covered Associates and children under age 19.	100% (no deductible)	100%	100%

Benefit Description	Additional Limitations and Explanations	Dental Plan I	Dental Plan II	DHMO
Basic Services • Examination for consultation purposes • Tooth extractions • Oral surgery, including surgical extractions • Administration of general anesthesia and/or intravenous sedation for oral surgery • Amalgam filling restoration for decayed teeth • Treatment of periodontal and other diseases of the gums and supporting structures of the mouth • Endodontic treatment • Occlusal adjustment, only in connection with periosurgery • Diagnostic x-rays and laboratory procedures required for dental surgery. • Adjusting, relining or rebasing of dentures • Repair or recementing of crowns, inlays and onlays as well as repairs to dentures, crowns and bridges.	• Subject to annual maximum benefit. Benefits for other than amalgam filling for posterior teeth only (*i.e.*, silicate, acrylic, synthetic porcelain, and composite) shall be no more than the amount payable for amalgam. • Dental Plan II does not cover crowns, bridges and dentures.	80% after deductible	80%	Per DHMO Patient Charge Schedule
Major Services • Installation of crowns, bridges, or partials • Initial installation of dentures • Onlays, Inlays and crowns, including porcelain for the front teeth only • Initial installation of fixed bridgework (including wing attachments, inlays, and crowns as abutments) to replace natural teeth extracted while covered under Dental Plan I or the DHMO • Prosthesis Over Implant	• Subject to annual maximum benefit.	50% after deductible	No Coverage	Per DHMO Patient Charge Schedule
Benefit Description	**Additional Limitations and Explanations**	**Dental Plan I**	**Dental Plan II**	**DHMO**

Major Services • Replacement of an existing partial or full removable denture or fixed bridgework; the addition of teeth to an existing partial or removable denture; or bridgework to replace extracted teeth	For replacement of an existing partial or full removable denture: • The addition of teeth is necessary to replace 1 or more teeth extracted after the existing denture or bridgework was installed. • Replacement of a tooth or teeth missing at the time coverage began will only be considered after coverage has been in place 1 year. • The existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date. The existing denture is an immediate temporary denture replacing 1 or more natural teeth extracted while participating in the Dental Plan, replacement by a permanent denture is required, and the replacement takes place within 12 months from the placement of the temporary denture.	50% after deductible	No Coverage	Per DHMO Patient Charge Schedule
Implants	• Subject to annual maximum benefit.	50% after deductible	No Coverage	No Coverage
Orthodontic Services • Necessary services related to an active course of orthodontic treatment including diagnosis, evaluation, and precare • The initial and subsequent, if any, installation of orthodontic appliances for an active course of orthodontic treatment • Adjustment of active orthodontic appliances	• Subject to lifetime orthodontic benefit maximum of $1,500 per person – applies to Dental Plan I only.	50% after deductible	No Coverage	Per DHMO Patient Charge Schedule
Medications • Prescription drugs		As covered by the Medical Plan		

LIMITS & EXCLUSIONS – DENTAL PLANS I & II

The following expenses are not covered by Dental Plan I or II:

- Expenses over the Usual, Reasonable and Customary charges for the geographic area in which services are rendered.
- Any service, supply, or treatment that does not meet the standards of the American Dental Association.
- Services or supplies for which there is no legal obligation to pay, are free, or would not be

made except for the availability of benefits under the Dental Plan.

- Services furnished by or for the U.S. Government or any other government, unless payment is legally required.
- Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.
- Any expense sustained as a result of being engaged in: an illegal occupation; or commission of or attempted commission of an assault, felony, misdemeanor or other illegal act.
- Any expense sustained as a result of: intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime; duty as a member of the armed forces or participation in a civil revolution or a riot of any state or country; or a war or act of war which is declared or undeclared, except if you are on official assignment by the Company in a foreign country.
- Any condition that could entitle the Covered Person to a benefit under (a) the Worker's Compensation Act or similar legislation, or (b) a plan or policy, whether or not statutorily mandated, which provides benefits similar to those provided under the Worker's Compensation Act.
- Services or supplies primarily Cosmetic, Experimental, or investigational in nature, as determined by the Administrator or its designee.
- Expenses for dental reports, itemized bills, claim forms, broken appointments, telephone calls, photocopying, mailing, shipping or handling.
- Professional services by a person who ordinarily resides in your household or who is related to the Covered Person (by blood or law), such as a Spouse, Same-Sex Domestic Partner, parent, child, brother or sister.
- Expenses used to satisfy Plan deductibles.
- Training, educational instruction or materials relating to dietary counseling, personal oral hygiene or dental plaque control.
- Facing crowns or pontics and molars.
- Expenses incurred for services rendered prior to the date of coverage under the Dental Plan.
- Dentures and/or bridgework (including crowns) when the charges are incurred during the first 12 months of coverage for teeth extracted prior to the effective date of coverage under the Dental Plan.
- Replacement of lost, stolen or missing prosthetic devices or duplicate prosthetic devices or appliances.
- Procedures/appliances to increase vertical dimension or restore occlusion.
- Precision or semi-precision attachments.
- Myofunctional therapy.
- Athletic mouth guards.
- Treatment, by any means, of jaw joint problems, including temporomandibular joint dysfunction syndrome and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint.
- Treatment for the correction of any congenital defect or developmental malformation that does not interfere with function.

- Crowns for teeth that are restorable by other means for the purpose of periodontal splinting.
- Charges for any procedure in excess of the charge for the least costly procedure which will (as determined by the Administrator) produce a professionally satisfactory result.
- Hospital charges.
- Expenses for services performed after the date coverage ends under the Dental Plan.
- Study models.
- Injections of antibiotic drugs.
- Expense for silicate, acrylic, and synthetic porcelain and composite fillings that exceed the cost of the amalgam filling for posterior teeth only.
- Veneer (not covered Dental Plan II only)

HIGHLIGHTS – DHMO PLAN

The DHMO will be provided in accordance with the Cigna Dental Care Insurance certificate and policy (the terms and provisions of which are incorporated herein by this reference) to Covered Persons enrolled in such coverage. Below is a summary of benefits provided, but the insurer's documents control.

- Each Covered Person under the DHMO must select a Dentist from the DHMO directory ("in-network Dentist"). Each covered family member can select a different Dentist. Covered Persons can change their choice of Dentist as permitted by the DHMO. You must use the Dentist identified in the Welcome Kit that you will receive from CIGNA after you enroll in the DHMO Plan. To change Dentists, call CIGNA Dental Health 1-800-367-1037.
- You may obtain a list of participating Dentists, by calling CIGNA at 1-800-244-6224 or visiting CIGNA's website at www.cigna.com.
- There are no claim forms. When you visit a DHMO dental office, you pay the applicable Copay (if any). If your Dentist performs a procedure that is not covered, you must pay the Dentist's usual fee. If you disagree with CIGNA's decision, you may follow the claims procedures provided without charge with your Welcome Kit.
- When you call for an appointment, identify yourself as a CIGNA dental health member. If your name isn't on your Dentist's list, ask him/her to call CIGNA to verify membership.
- CIGNA's member services representatives can help you with network Dentist information, arrangements for Emergency care and explanation of patient charges. Second opinion appointments must be coordinated through CIGNA's member services.

DHMO PATIENT CHARGE SCHEDULE

If DHMO coverage is available in your area and you choose DHMO coverage, all dental care must be provided through a participating DHMO Dentist ("in-network Dentist"). Many preventative services are provided at no cost to you.

Important Highlights

- The Patient Charge Schedule applies only when covered dental services are performed by your network Dentist, unless otherwise authorized by CIGNA Dental as described in your Plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- The Patient Charge Schedule applies to specialty care when an appropriate referral is made to a network specialty Periodontist, Orthodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by CIGNA Dental. Prior authorization is not required for specialty referrals for Pediatric and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 13 by calling Member Services at 1-800-CIGNA24 to get a list of Network Pediatric Dentists in your area. Coverage for a Pediatric dentist ends on your child's 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 13th birthday.
- Procedures NOT listed on the Patient Charge Schedule are NOT covered and are the patient's responsibility at the Dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or nitrous oxide is not covered except as specifically listed on the Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- CIGNA Dental considers infection control and/or sterilization to be incidental and part of the charges for services provided and not separately chargeable.
- The Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

The Patient Charge Schedule below lists the benefits of the DHMO Plan including covered procedures and patient charges. This may contain CDT codes and/or portions of, or excerpts from the Nomenclature contained within the Current Dental Terminology, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.

Code	Procedure description	W1-09
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12-consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145).		
D9310	Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0.00
D9430	Office visit for observation – No other services performed	$0.00
D9450	Case presentation – Detailed and extensive treatment planning	$0.00
D0120	Periodic oral evaluation – Established patient	$0.00
D0140	Limited oral evaluation – Problem focused	$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0160	Detailed and extensive oral evaluation - problem focused, by report *(limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$0.00
D0170	Reevaluation – Limited, problem focused (not postoperative visit)	$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	$43.00
D0210	X-rays intraoral – Complete series of radiographic images *(limit 1 every 3 years)*	$0.00
D0220	X-rays intraoral – Periapical – First radiographic image	$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	$0.00
D0240	X-rays intraoral – Occlusal radiographic image	$0.00
D0270	X-rays (bitewing) – Single radiographic image	$0.00
D0272	X-rays (bitewings) – 2 radiographic images	$0.00
D0273	X-rays (bitewings) – 3 radiographic images	$0.00
D0274	X-rays (bitewings) – 4 radiographic images	$0.00
D0277	X-rays (bitewings, vertical) – 7 to 8 radiographic images	$0.00
D0330	X-rays (panoramic radiographic image) – *(limit 1 every 3 years)*	$0.00
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures *(limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$240.00
D0431	Oral cancer screening using a special light source	$50.00
D0460	Pulp vitality tests	$14.00
D0470	Diagnostic casts	$0.00
D0472	Pathology report – Gross examination of lesion (only when tooth related)	$0.00
D0473	Pathology report – Microscopic examination of lesion (only when tooth related)	$0.00
D0474	Pathology report – Microscopic examination of lesion and area (only when tooth related)	$0.00
D1110	Prophylaxis (cleaning) – Adult *(limit 2 per calendar year)*	$0.00

	Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	$45.00
Code	**Procedure description**	**W1-09**
D1120	Prophylaxis (cleaning) – Child *(limit 2 per calendar year)*	$0.00
	Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	$30.00
D1206	Topical application of fluoride varnish – *(limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.*	$0.00
	Additional topical application of fluoride varnish in addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride) per calendar year.	$15.00
D1208	Topical application of fluoride (*limit 2 per calendar year*) *There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.*	$0.00
	Additional topical application of fluoride - In addition to any combination of two (2) D1206s (topical applications of fluoride varnish) and/or D1208s (topical application of fluoride) per calendar year	$15.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant – Per tooth	$17.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$17.00
D1510	Space maintainer – Fixed – Unilateral	$110.00
D1515	Space maintainer – Fixed – Bilateral	$170.00
D1555	Removal of fixed space maintainer	$0.00
Restorative (fillings, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	$17.00
D2150	Amalgam – 2 surfaces, primary or permanent	$22.00
D2160	Amalgam – 3 surfaces, primary or permanent	$28.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	$35.00
D2330	Resin-based composite – 1 surface, anterior	$22.00
D2331	Resin-based composite – 2 surfaces, anterior	$29.00
D2332	Resin-based composite – 3 surfaces, anterior	$35.00
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	$88.00
D2390	Resin-based composite crown, anterior	$115.00
D2391	Resin-based composite – 1 surface, posterior	$47.00
D2392	Resin-based composite – 2 surfaces, posterior	$59.00
D2393	Resin-based composite – 3 surfaces, posterior	$82.00
D2394	Resin-based composite – 4 or more surfaces, posterior	$115.00
D2510	Inlay – Metallic – 1 surface	$430.00
D2520	Inlay – Metallic – 2 surfaces	$430.00
D2530	Inlay – Metallic – 3 or more surfaces	$430.00
D2542	Onlay – Metallic – 2 surfaces	$490.00
D2543	Onlay – Metallic – 3 surfaces	$490.00

D2544	Onlay – Metallic – 4 or more surfaces	$490.00
D2740	Crown – Porcelain/ceramic substrate	$515.00
D2750	Crown – Porcelain fused to high noble metal	$470.00
Code	**Procedure description**	**W1-09**
Crown and bridge – All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals 1 unit).Coverage for replacement of crowns and bridges is limited to 1 every 5 years.		
	Per tooth charge for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine.	$150.00
D2751	Crown – Porcelain fused to predominantly base metal	$415.00
D2752	Crown – Porcelain fused to noble metal	$440.00
D2780	Crown – 3/4 cast high noble metal	$480.00
D2781	Crown – 3/4 cast predominantly base metal	$425.00
D2782	Crown – 3/4 cast noble metal	$450.00
D2790	Crown – Full cast high noble metal	$480.00
D2791	Crown – Full cast predominantly base metal	$425.00
D2792	Crown – Full cast noble metal	$450.00
D2794	Crown – Titanium	$480.00
D2910	Recement inlay – Onlay or partial coverage restoration	$43.00
D2915	Recement cast or prefabricated post and core	$43.00
D2920	Recement crown	$43.00
D2929	Prefabricated porcelain/ceramic crown - Primary tooth	$155.00
D2930	Prefabricated stainless steel crown – Primary tooth	$105.00
D2931	Prefabricated stainless steel crown – Permanent tooth	$105.00
D2932	Prefabricated resin crown	$130.00
D2933	Prefabricated stainless steel crown with resin window	$155.00
D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	$155.00
D2940	Protective restoration	$15.00
D2950	Core buildup – Including any pins	$105.00
D2951	Pin retention – Per tooth – In addition to restoration	$23.00
D2952	Post and core – In addition to crown, indirectly fabricated	$165.00
D2954	Prefabricated post and core – In addition to crown	$140.00
D2960	Labial veneer (resin laminate) – Chairside	$105.00
D6210	Pontic – Cast high noble metal	$470.00
D6211	Pontic – Cast predominantly base metal	$425.00
D6212	Pontic – Cast noble metal	$450.00
D6214	Pontic – Titanium	$480.00
D6240	Pontic – Porcelain fused to high noble metal	$470.00
D6241	Pontic – Porcelain fused to predominantly base metal	$425.00
D6242	Pontic – Porcelain fused to noble metal	$450.00
D6245	Pontic – Porcelain/ceramic	$470.00
D6602	Inlay – Cast high noble metal, 2 surfaces	$460.00
D6603	Inlay – Cast high noble metal, 3 or more surfaces	$480.00

D6604	Inlay – Cast predominantly base metal, 2 surfaces	$405.00
Code	**Procedure description**	**W1-09**
D6605	Inlay – Cast predominantly base metal, 3 or more surfaces	$415.00
D6606	Inlay – Cast noble metal, 2 surfaces	$430.00
D6607	Inlay – Cast noble metal, 3 or more surfaces	$440.00
D6610	Onlay – Cast high noble metal, 2 surfaces	$460.00
D6611	Onlay – Cast high noble metal, 3 or more surfaces	$480.00
D6612	Onlay – Cast predominantly base metal, 2 surfaces	$405.00
D6613	Onlay – Cast predominantly base metal, 3 or more surfaces	$415.00
D6614	Onlay – Cast noble metal, 2 surfaces	$430.00
D6615	Onlay – Cast noble metal, 3 or more surfaces	$450.00
D6624	Inlay – Titanium	$470.00
D6634	Onlay – Titanium	$470.00
D6740	Crown – Porcelain/ceramic	$525.00
D6750	Crown – Porcelain fused to high noble metal	$480.00
D6751	Crown – Porcelain fused to predominantly base metal	$425.00
D6752	Crown – Porcelain fused to noble metal	$450.00
D6780	Crown – 3/4 cast high noble metal	$480.00
D6781	Crown – 3/4 cast predominantly base metal	$425.00
D6782	Crown – 3/4 cast noble metal	$450.00
D6790	Crown – Full cast high noble metal	$480.00
D6791	Crown – Full cast predominantly base metal	$425.00
D6792	Crown – Full cast noble metal	$450.00
D6794	Crown – Titanium	$480.00
	Complex rehabilitation – Additional charge per unit for multiple crown units/complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)*	$135.00
D6930	Recement fixed partial denture	$64.00
Endodontics (root canal treatment, excluding final restorations)		
D3110	Pulp cap – Direct (excluding final restoration)	$38.00
D3120	Pulp cap – Indirect (excluding final restoration)	$38.00
D3220	Pulpotomy – Removal of pulp, not part of a root canal	$87.00
D3221	Pulpal debridement (not to be used when root canal is done on the same day)	$87.00
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	$87.00
D3310	Anterior root canal – Permanent tooth (excluding final restoration)	$330.00
D3320	Bicuspid root canal – Permanent tooth (excluding final restoration)	$390.00
D3330	Molar root canal – Permanent tooth (excluding final restoration)	$530.00
D3331	Treatment of root canal obstruction – Nonsurgical access	$155.00
D3332	Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth	$155.00
D3333	Internal root repair of perforation defects	$155.00
D3346	Retreatment of previous root canal therapy – Anterior	$470.00
D3347	Retreatment of previous root canal therapy – Bicuspid	$530.00
D3348	Retreatment of previous root canal therapy – Molar	$675.00

D3410	Apicoectomy/periradicular surgery – Anterior	$415.00
Code	**Procedure description**	**W1-09**
D3421	Apicoectomy/periradicular surgery – Bicuspid (first root)	$455.00
D3425	Apicoectomy/periradicular surgery – Molar (first root)	$480.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$165.00
D3430	Retrograde filling per root	$115.00
Periodontics (treatment of supporting tissues [gum and bone] of the teeth) periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the patient charge schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months when covered on the patient charge schedule.		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$270.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$125.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$125.00
D4240	Gingival flap (including root planing) – 4 or more teeth per quadrant	$330.00
D4241	Gingival flap (including root planing) – 1 to 3 teeth per quadrant	$180.00
D4245	Apically positioned flap	$310.00
D4249	Clinical crown lengthening – Hard tissue	$365.00
D4260	Osseous surgery – 4 or more teeth per quadrant	$595.00
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$350.00
D4263	Bone replacement graft – First site in quadrant	$290.00
D4264	Bone replacement graft – Each additional site in quadrant	$225.00
D4266	Guided tissue regeneration – Resorbable barrier per site	$380.00
D4267	Guided tissue regeneration – Nonresorbable barrier per site (includes membrane removal)	$430.00
D4270	Pedicle soft tissue graft procedure	$425.00
D4275	Soft tissue allograft	$440.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous *(missing*) tooth position in graft	$440.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous (missing) tooth position in same graft site	$220.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant *(limit 4 quadrants per consecutive 12 months)*	$115.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth – per quadrant *(limit 4 quadrants per consecutive 12 months)*	$64.00
D4355	Full mouth debridement to allow evaluation and diagnosis *(1 per lifetime)*	$86.00
D4381	Localized delivery of antimicrobial agents per tooth	$45.00
D4910	Periodontal maintenance *(limit 4 per calendar year) (only covered after active periodontal therapy)*	$78.00
Prosthetics (removable tooth replacement – dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.		
D5110	Full upper denture	$575.00
D5120	Full lower denture	$575.00

D5130	Immediate full upper denture	$615.00
Code	**Procedure description**	**W1-09**
D5140	Immediate full lower denture	$615.00
D5211	Upper partial denture – Resin base (including clasps, rests and teeth)	$430.00
D5212	Lower partial denture – Resin base (including clasps, rests and teeth)	$430.00
D5213	Upper partial denture – Cast metal framework (including clasps, rests and teeth)	$670.00
D5214	Lower partial denture – Cast metal framework (including clasps, rests and teeth)	$670.00
D5225	Upper partial denture – Flexible base (including clasps, rests and teeth)	$460.00
D5226	Lower partial denture – Flexible base (including clasps, rests and teeth)	$460.00
D5410	Adjust complete denture – Upper	$38.00
D5411	Adjust complete denture – Lower	$38.00
D5421	Adjust partial denture – Upper	$38.00
D5422	Adjust partial denture – Lower	$38.00
Repairs to prosthetics		
D5510	Repair broken complete denture base	$73.00
D5520	Replace missing or broken teeth – Complete denture (each tooth)	$73.00
D5610	Repair resin denture base	$73.00
D5630	Repair or replace broken clasp	$92.00
D5640	Replace broken teeth – Per tooth	$73.00
D5650	Add tooth to existing partial denture	$73.00
D5660	Add clasp to existing partial denture	$92.00
Denture relining (limit 1 every 36 months)		
D5710	Rebase complete upper denture	$220.00
D5711	Rebase complete lower denture	$220.00
D5720	Rebase upper partial denture	$220.00
D5721	Rebase lower partial denture	$220.00
D5730	Reline complete upper denture – Chairside	$130.00
D5731	Reline complete lower denture – Chairside	$130.00
D5740	Reline upper partial denture – Chairside	$130.00
D5741	Reline lower partial denture – Chairside	$130.00
D5750	Reline complete upper denture – Laboratory	$195.00
D5751	Reline complete lower denture – Laboratory	$195.00
D5760	Reline upper partial denture – Laboratory	$195.00
D5761	Reline lower partial denture – Laboratory	$195.00
Interim dentures (limit 1 every 5 years)		
D5810	Interim complete denture – Upper	$330.00
D5811	Interim complete denture – Lower	$330.00
D5820	Interim partial denture – Upper	$265.00
D5821	Interim partial denture – Lower	$265.00

Implant/abutment supported prosthetics – All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years.		
Code	**Procedure description**	**W1-09**
	Per tooth charge for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine.	$150.00
D6053	Implant/abutment supported removable denture for completely edentulous arch	$875.00
D6054	Implant/abutment supported removable denture for partially edentulous arch	$970.00
D6058	Abutment supported porcelain/ceramic crown	$815.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$770.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$715.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$740.00
D6062	Abutment supported cast metal crown (high noble metal)	$770.00
D6063	Abutment supported cast metal crown (predominantly base metal)	$715.00
D6064	Abutment supported cast metal crown (noble metal)	$740.00
D6065	Implant supported porcelain/ceramic crown	$815.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$770.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$770.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	$815.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal)	$770.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)	$715.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)	$740.00
D6072	Abutment supported retainer for cast metal fixed partial denture (high noble metal)	$770.00
D6073	Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)	$715.00
D6074	Abutment supported retainer for cast metal fixed partial denture (noble metal)	$740.00
D6075	Implant supported retainer for ceramic fixed partial denture	$815.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (titanium, titanium alloy, high noble metal)	$770.00
D6077	Implant supported retainer for cast metal fixed partial denture (titanium, titanium alloy, high noble metal)	$770.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$875.00

D6079	Implant/abutment supported fixed denture for partially edentulous arch	$970.00
D6092	Recement implant/abutment supported crown	$82.00
D6093	Recement implant/abutment supported fixed partial denture	$103.00
D6094	Abutment supported crown (titanium)	$770.00
D6194	Abutment supported retainer crown for fixed partial denture (titanium)	$770.00
Code	**Procedure description**	**W1-09**
	Complex rehabilitation on implant/abutment supported prosthetic procedures – Additional charge per unit for multiple crown units/complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)*	$135.00
Oral surgery (includes routine postoperative treatment) Surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (disease) exists.		
D7111	Extraction of coronal remnants – Deciduous tooth	$53.00
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$53.00
D7210	Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$115.00
D7220	Removal of impacted tooth – Soft tissue	$125.00
D7230	Removal of impacted tooth – Partially bony	$165.00
D7240	Removal of impacted tooth – Completely bony	$230.00
D7241	Removal of impacted tooth – Completely bony, unusual complications (narrative required)	$245.00
D7250	Surgical removal of residual tooth roots – Cutting procedure	$115.00
D7251	Coronectomy – Intentional partial tooth removal	$165.00
D7260	Oroantral fistula closure	$355.00
D7261	Primary closure of a sinus perforation	$330.00
D7270	Tooth stabilization of accidentally evulsed or displaced tooth	$180.00
D7280	Surgical access of an unerupted tooth *(excluding wisdom teeth)*	$210.00
D7283	Placement of device to facilitate eruption of impacted tooth	$49.00
D7285	Biopsy of oral tissue – Hard (bone, tooth) *(tooth related – not allowed when in conjunction with another surgical procedure)*	$180.00
D7286	Biopsy of oral tissue – Soft (all others) *(tooth related – not allowed when in conjunction with another surgical procedure)*	$135.00
D7287	Exfoliative cytological sample collection	$78.00
D7288	Brush biopsy – Transepithelial sample collection	$78.00
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$115.00
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$56.00
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$155.00
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$74.00
D7450	Removal of benign odontogenic cyst or tumor – Up to 1.25 cm	$195.00
D7451	Removal of benign odontogenic cyst or tumor – Greater than 1.25	$195.00

	cm	
D7471	Removal of lateral exostosis – Maxilla or mandible	$215.00
D7472	Removal of torus palatinus	$215.00
D7473	Removal of torus mandibularis	$215.00
D7485	Surgical reduction of osseous tuberosity	$155.00
D7510	Incision and drainage of abscess – Intraoral soft tissue	$74.00
D7511	Incision and drainage of abscess – Intraoral soft tissue – Complicated	$115.00
Code	**Procedure description**	**W1-09**
D7880	Occlusal orthotic device, by report - *(limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)*	$455.00
D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure	$14.00
D7963	Frenuloplasty	$20.00
Orthodontics (tooth movement) Orthodontic treatment (maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$480.00
D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$480.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	$500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	$515.00
D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	$515.00
D8660	Pre-orthodontic treatment visit	$66.00
D8670	Periodic orthodontic treatment visit – As part of contract	
	Children – Up to 19th birthday:	
	24-month treatment fee	$2,472
	Charge per month for 24 months	$103.00
	Adults:	
	24-month treatment fee	$3,336
	Charge per month for 24 months	$139.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$345.00
D8999	Unspecified orthodontic procedure – By report *(orthodontic treatment plan and records)*	$195.00

General anesthesia/IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the patient charge schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the patient charge schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or IV sedation when used for the purpose of anxiety control or patient management.		
D9220	General anesthesia – First 30 minutes	$190.00
D9221	General anesthesia – Each additional 15 minutes	$84.00
D9241	IV conscious sedation – First 30 minutes	$190.00
D9242	IV conscious sedation – Each additional 15 minutes	$73.00
Emergency services		
D9110	Palliative (emergency) treatment of dental pain – Minor procedure	$48.00
D9440	Office visit – After regularly scheduled hours	$77.00
Miscellaneous services		
D9940	Occlusal guard – By report *(limit 1 per 24 months)*	$285.00
Code	**Procedure description**	**W1-09**
D9941	Fabrication of athletic mouth guard - *(limit 1 per 12 months)*	$110.00
D9951	Occlusal adjustment – Limited	$56.00
D9952	Occlusal adjustment – Complete	$260.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays *(all other methods of bleaching are not covered)*	$165.00

This list may contain CDT codes and/or portions of, or excerpts from the nomenclature contained within the *Current Dental Terminology*, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.

LIMITS & EXCLUSIONS – DHMO PLAN

The following expenses are not covered by DHMO coverage:

- Services not listed on the DHMO Patient Charge Schedule.
- Services provided by an out-of-network Dentist without CIGNA's prior approval, except in the case of Emergency as specified above.
- Services related to an Injury or Illness covered under Workers' Compensation, occupational disease or similar laws, plans or policies (whether statutorily mandated or not).
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program other than Medicaid.
- Services relating to injuries that are intentionally self-inflicted.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or dental surgery (i.e., performed solely to improve appearance).

- General anesthesia, sedation and nitrous oxide (but if you reside in Maryland, these expenses will be covered if medically necessary and authorized by your Physician).
- Prescription drugs (however, certain prescription drugs are covered under the Medical Plan).
- Procedures, appliances or restorations if the main purpose is to: change vertical dimension (i.e., the degree of separation of the jaw when teeth are in contact); or diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed on the DHMO Patient Charge Schedule.
- The completion of crown and bridge, dentures or root canal treatment already in progress on the date your DHMO coverage begins (this exclusion does not apply to Texas residents).
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
- Services associated with the placement or prosthodontic restoration of a dental implant.
- Services considered to be unnecessary or Experimental in nature (for Pennsylvania residents, only Experimental services will be excluded).
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a Hospital.
- Services to the extent you are compensated for them under any group medical plan, no-fault auto insurance policy or insured motorist policy (this exclusion does not apply to Arizona residents; for Kentucky and North Carolina residents, services compensated under no-fault auto or insured motorist policies are not excluded; for Maryland residents, services compensated under group medical plans are not excluded).
- Except as set forth above, pre-existing conditions are not excluded (for Texas residents, no pre-existing conditions are excluded).

VISION BENEFITS

Eligible Associates can enroll in vision coverage for themselves only or for themselves and their Eligible Dependents, without regard to any other coverage elected under the Plan. Vision coverage will be provided in accordance with the Vision Service Plan insurance certificate and policy (the terms and provisions of which are incorporated herein by this reference) to Covered Persons enrolled in such coverage. Below is a summary of benefits provided, but the insurer's documents control.

If you elect vision coverage, you can obtain vision services through an in-network, VSP provider or an out-of-network provider, but you'll save money by using an in-network provider. Benefits are only payable for eligible optical charges, eye examinations and/or optical materials prescribed by a legally qualified ophthalmologist or optometrist. The vision plan provides both eyeglasses and contact lenses every calendar year.

How Do I Use VSP? You may call Vision Service Plan (VSP) at 1-800-877-7195 or visit their website at www.vsp.com for a list of participating doctors. Upon completion of the exam, pay the doctor the Copay on the Schedule of Vision Benefits. The Vision Plan will pay the doctor the remaining amount. If you receive additional services or items not covered by the Vision Plan, you are responsible for the cost of these services or items. Claims procedures are furnished automatically, without charge, by VSP. You can submit for reimbursement online at www.vsp.com.

What Happens If I Don't Use A VSP Provider? If you use a non-VSP provider, you must pay the provider directly and submit your itemized statement to VSP, along with a nonmember claim form (available from VSP). You will be reimbursed only to the extent of the out-of-network benefits shown in the Schedule of Vision Benefits, which may not pay all of your expenses.

LIMITATIONS & EXCLUSIONS – VISION BENEFIT PLAN

The following are not covered under the Vision Benefit Plan:

- Special procedures, such as orthoptics, vision training and subnormal vision aids.
- Safety glasses or other special purpose vision aids.
- Medical or surgical treatment of the eyes. However, such treatment may be covered by the Medical Plan.
- Replacement of lost or broken lenses and frames.
- Duplicate glasses, lenses or frames.
- Services or materials not listed in the Schedule of Vision Benefits.
- Radial Keratotomy or laser surgery to correct nearsightedness or farsightedness.
- Experimental or investigational treatment/procedure.
- Service or treatment rendered by, or optical supplies prescribed by, anyone other than a legally qualified ophthalmologist or optometrist.

SCHEDULE OF VISION BENEFITS

Vision Benefits for Covered Persons will be paid in accordance with the following chart:

Benefit Description	In-Network (VSP)	Out-of-Network	Benefit Frequency
Copay Glasses • Materials (Lenses/Frames)	$15	$15	One per calendar year
Eye Examination after $10 copay	100%	Up to $45	One per calendar year
Frames • Frames 20% savings on the amount over the allowance	100% (up to $200 allowance)	Up to $70	One set of frames every calendar year
Lenses • Single Vision • Standard Bifocal • Standard Trifocal • Lenticular	 100% 100% 100% 100%	Up to: $30 $50 $65 $100	One set of lenses every year
Lenses Enhancements • Poly-carbonate	 100%	Not covered	One set of lenses every year
• Standard progressive • Premium progressive • Custom progressive	$55 $95-$105 $150-$175	$50	
Necessary Contact Lenses • Replacement of lenses following cataract surgery • Where visual acuity is not correctable to 20/70 in the better eye by use of spectacle lenses • Certain conditions of anisotropia • Keratoconus	100%	$210	One set every year In lieu of elective contact lenses
Elective Contacts • Elective Contacts (materials) • Contact exam-Fitting and Evaluation	$150 allowance for materials 15% discount on exam and fitting. Copay up to $50	Up to $105 (includes allowance for contact exam and materials)	Every calendar year
Suncare	$200 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts. $15 copay		Every calendar year

LIFE & AD&D INSURANCE

LIFE INSURANCE BENEFITS

Life insurance will be provided in accordance with the life insurance policy (the terms and provisions of which are incorporated herein by this reference) governing such benefits to Covered Associates enrolled in such coverage. Subject to the terms of the insurance policy, Covered Associates can enroll their Eligible Dependents in life insurance coverage and can increase their own coverage without regard to any other coverage elected under the Plan. Below is a summary of benefits provided, but the insurer's documents control.

All full-time Associates will receive a basic level of life insurance equal to one times your annual salary. The coverage amount will be rounded to the next higher $1,000. For the basic level and additional supplemental life coverage, "Salary" means your base pay only (no commissions included in the calculation, and no overtime or bonuses). Coverage for full-time salon leaders is based on an annual salary amount of $40,000.

You may elect and pay for additional amounts of coverage for yourself or coverage for your Spouse and/or children. During your initial enrollment, you can elect up to the maximum amount of life insurance but will be required to submit evidence of insurability for coverage that is greater than three times your annual salary. After your initial enrollment, you can increase your coverage by only one level annually during open enrollment.

What Are the Coverage Options for Me? At your initial benefit enrollment election period, you may elect the following levels of coverage:

Supplemental Life Coverage	**Salon Leaders**	**Evidence of good Health required**	**FORM**
1 times annual salary*	$40,000	NO	Not required
2 times annual salary*	$80,000	NO	Not required
3 times annual salary*	$120,000	NO	Not required
4 times annual salary*	$160,000	**YES**	Evidence of Insurability information will be sent to the home address and if approved additional coverage will be effective on the approval date.**
5 times annual salary*	$200,000	**YES**	Evidence of Insurability information will be sent to the home address and if approved additional coverage will be effective on the approval date.**

*The maximum amount of life insurance for you, including the basic level of life insurance paid for by the Company and any additional coverage you elect and pay for, is $1,000,000.

**The amount of coverage in force until the evidence of insurability is approved is 3 times annual salary up to the plan maximum of $1,000,000 for basic life plus any additional life coverage.

What Are the Coverage Options for My Spouse/Domestic Partner? $5,000 or $10,000

What Are the Coverage Options for My Child(ren)? $2,500 or $5,000 per child*

What Are the Coverage options for Family Coverage? $2,500/child* and $5,000/spouse/domestic partner or 5,000/child* and $10,000/spouse/domestic partner

*$100 maximum per child for children birth to six months of age.

Who are considered eligible children for the Life Insurance? An Associate's unmarried child(ren) who meet the following requirements:

- A child less than 19 years old;
- A child who is 19 or more years old but less than 26 years old and primarily supported by the Associate;
- A child who is 19 or more years old, primarily supported by the Associate and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of child's condition and dependence must be submitted as requested by the plan document.

Will I Have Imputed Income? If the level of basic life insurance coverage provided by the Company exceeds $50,000, you will have to pay tax on the imputed income, which is the cost of any insurance coverage amount over $50,000. Imputed income is noted on your paycheck as "GTL" and is added to your income for purposes of calculating FICA taxes.

Is the Life Insurance Premium Ever Suspended? If you become totally disabled and meet all of the following conditions, you can continue coverage without paying premiums under the waiver of premium if:

- you become disabled while insured under the life insurance plan and prior to age 60;
- your disability is continuous and is due to bodily injury or sickness;
- you are unable to work for pay or profit in any job for which you are or may become suited by reason of education, training or experience;
- you stay totally disabled for nine consecutive months; and
- you submit proof of your total disability to the insurance company within 12 months from when your disability begins.

Is There an Accelerated (Living) Benefit For Terminal Illness? If you are diagnosed as terminally ill with a life expectancy of 6 months or less, you can receive up to 80% of your total life insurance benefit for a maximum of $500,000) (Living Benefit). The Living Benefit is subtracted from benefits payable when you die. Only one Living Benefit may be paid per insured, and you must apply for the Living Benefit by completing an Accelerated (Living) Benefit Request Form and sending it to the Benefits Department. *Note*: Your eligibility for Medicaid or other government benefits or entitlements could be affected by your electing a Living Benefit.

Supplemental Life Suicide Exclusion - Supplemental Life benefits will not be paid if death is a result of suicide, while sane or insane unless state law differs, within 2 years from the effective date of coverage.

How Do You File a Death Benefit Claim? You or your beneficiary should contact the Benefits Department to complete the claim process. You or your beneficiary must provide a death certificate along with a completed claim form, and the insurance company will then pay the benefit to you or your beneficiary. See Claim and Appeal section for more details.

Can I be covered as an Associate and a Dependent? No, you may not elect coverage for your dependent if your dependent is covered as an Associate by the plan. In addition, no person can be insured as a dependent of more than one Associate under the policy.

AD&D BENEFITS

AD&D coverage is voluntary and offers full-time Associates the ability to purchase extra insurance protection. If you have AD&D coverage and die from an accident, your beneficiary will receive a death benefit in addition to that provided under your regular life insurance coverage. If you suffer a loss, as noted in the schedule below, an AD&D Benefit will be paid to you. Associates cannot enroll their Eligible Dependents in AD&D coverage.

AD&D coverage will be provided subject to the terms of the insurance policy governing AD&D coverage (the terms and provisions of which are incorporated herein by this reference). Below is a summary of benefits provided, but the insurer's documents control.

The coverage you choose must be the same as your life insurance coverage for company provided and any supplemental coverage. For example, if your life insurance coverage is basic life plus 1 times additional coverage, any AD&D coverage you elect must be 2 x annual salary.

What Coverage Amounts Are Available? AD&D Coverage	Salon Leader
1 x annual salary *	$40,000
2 x annual salary *	$80,000
3 x annual salary *	$120,000
4 x annual salary *	$160,000
5 x annual salary *	$200,000
6 x annual salary *	$240,000

What is the Maximum Benefit? $1,000,000

*The coverage amount will be rounded to the next $1,000. "Salary" means your base pay only (no commissions included in the calculation and no overtime or bonuses). Coverage for full-time salon leader is based on $40,000.

Table of AD&D Loss

Type of Loss	Benefit Amount Paid
Life	100%
Quadriplegia (total paralysis of both upper and lower limits)	100%
Two or more hands or feet	100%
Entire sight in both eyes	100%
One hand and one foot	100%
Loss of one hand or one foot and sight in one eye	100%
Speech and hearing of both ears	100%
Paraplegia (total paralysis of both upper or lower limbs)	75%
Sight of one eye	50%
Speech	50%
Hearing of both ears	50%
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50%
Loss of either hand or foot	50%
Thumb and index finger on same hand	25%
Loss of all the toes of the same foot	20%

Note: If more than one injury occurs as a result of a single accident, the plan pays only one benefit equal to the largest benefit amount payable.

How Do You Qualify for AD&D Benefits? AD&D Benefits will be paid only if you suffer accidental bodily injury which, independent of all other causes, results in any of the losses described in the table above, and:

- such loss occurs while you are insured for this benefit;
- such loss occurs within 365 days of the accident that causes the loss; and
- such loss is the result of an accident of a type not excluded by the limits and exclusions described below.

AD&D Benefits also will be paid as follows:

Coma – 1% of the total coverage amount will be paid on a monthly basis while a comatose condition caused by a covered accident exists up to 11 months.

24- Hour All Risk Accident Protection-Business and Pleasure – AD&D Benefits will be paid for covered losses incurred during an accident while you are riding as a passenger in or boarding or alighting from, or from being struck by any certified civilian aircraft operated by a pilot who holds a certificate of competency, or any transport aircraft operated by the Military Airlift Command or its foreign equivalents

Exposure and Disappearance – Subject to all other provisions, AD&D Benefits will be paid when:

- a covered loss results from unavoidable exposure to the elements; or
- if after one year, your body has not been found from the date of the wrecking, sinking or disappearance of the conveyance in which you were riding in the course of a trip which would otherwise be covered under this policy, it will be presumed that your death resulted directly and independently of all other causes from a covered accident.

Seat Belt Benefit – 10% of the total coverage amount (up to a maximum of $25,000) will be paid to your beneficiary if you die as a result of a covered accident when:

- you were driving or were a passenger in an automobile at the time the accident occurred;
- you were using your seat belt properly at the time of the accident;
- the accident occurred while you were insured under the policy; and
- seat belt usage was verified in the police accident report or in a signed statement by a doctor, paramedic, police officer, coroner or other person of competent authority, who was at the scene of the accident.
- the seat belt benefit will not be paid if you are a) under the influence of any intoxicant, excitant, hallucinogen, or any narcotic or other drug, or similar substance as verified in the police accident report (unless administered under the advice of a physician; and b) are operating the Automobile.

How Do You Make a Claim For AD&D Benefits? Contact the Benefits Department for information and any required forms necessary for filing a claim with the insurance company. To receive benefits, we must inform the insurance company in writing of your AD&D claim within 31 days after a covered loss occurs or starts (or as soon as reasonably possible). You must provide the insurance company with a "proof of loss" within 90 days after the loss occurs or starts (or as soon as reasonably possible). If you are receiving ongoing payments for a continuing loss, you must provide the insurance company "proof of loss" within 90 days after the end of each period for which a payment is made (or as soon as reasonably possible). Unless you are legally incompetent, "proof of loss" will not be accepted if provided later than one year from the date the loss occurred or started. Benefits will be paid to you after "proof of loss" is received by the insurance company. If you die, benefits will be paid to your beneficiary.

Appeal Procedure for Denied Claims. Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified.

Issues and comments that might affect the outcome of the review may also be submitted.
The Insurance Company has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.

AD&D LIMITS & EXCLUSIONS

Benefits will not be paid if you are injured or die as a result of:

1. Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. Declared or undeclared war or act of war;
6. Flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    a. except as a passenger on a regularly scheduled commercial airline;
    b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
    c. being used for: (i) crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang- gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or (ii) any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    d. designed for flight above or beyond the earth's atmosphere;
    e. an ultra-light or glider;
    f. being used for the purpose of parachuting or skydiving;
    g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
7. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
8. A Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
9. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
10. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.
11. In addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Subscriber;
    b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;
    c. living in the Covered Person's household;
    d. a parent, sibling, Spouse or child of the Covered Person

BENEFICIARY

You should name a beneficiary for your life insurance plan(s) when you are first eligible for fulltime benefits and, unless legally restricted, you can change your beneficiary at any time. To name or change your beneficiary, you will complete the Beneficiary Designation in the enrollment system or complete a Beneficiary Designation Form found at benefits.petsmart.com and submit it to the Benefits Department for processing.

The online beneficiary designation is a three-step process that starts with adding the personal information for your beneficiary. The second step is completed in the basic life section of the online enrollment system where the percent designated for all beneficiaries is indicated. The third step is to save your elections and print a confirmation statement. The beneficiary designation will apply to basic, supplemental life and the AD&D plans. You may also designate a beneficiary(s) by completing a Beneficiary Designation Form found at benefits.petsmart.com and submit it to the Benefits Department for processing. The effective date of the change is the date it is processed by the Benefits team. The beneficiary designation will apply to basic, supplemental and AD&D plans. The beneficiary for dependent life is the Associate.

Upon your death, the proceeds will be divided between the designated beneficiaries as you have indicated. If your primary beneficiary dies before you, your contingent beneficiary will receive your life insurance benefits. Subject to applicable state law, if no named beneficiary survives you or if you have not named a beneficiary, the proceeds will be paid to:

- your surviving Spouse; if none, then,
- your surviving child(ren); if none, then,
- your surviving parent(s); if none, then,
- your surviving brother(s) or sister(s); if none, then,
- your estate.

Death Benefit – Your beneficiary will receive a lump sum payment unless he/she chooses an optional form of payment offered by the insurance carrier.

Dependent Life Beneficiary – You will automatically be named as the designated beneficiary of your dependent's life insurance proceeds.

Conversion Privilege – If your employment with the Company is terminated, you can convert your company provided life insurance coverage by filing an application for conversion with the insurance carrier within 31 days after your termination. You will receive a notice directly from the carrier on the application process for the conversion options and the response time required.

Portability Privilege – If your employment with the Company is terminated, you can port your supplemental life insurance coverage by filing a portability enrollment application with the insurance carrier within 31 days after your termination. You will receive a notice directly from the carrier on the application process for the portability options and the response time required.

DISABILITY

SHORT TERM DISABILITY

All full-time Associates, other than those who work in a state that provides paid medical leave for their own serious health condition, are covered by the Short-Term Disability (STD) plan. If you become disabled due to non-occupational injury or illness, you may be eligible to receive STD Benefits. An Associate is considered disabled if, solely because of injury or sickness, he or she is unable to perform the material duties of his or her regular occupation. STD Benefits will be provided to all Covered Associates in accordance with short-term disability policy (the terms and provisions of which are incorporated herein by this reference) governing such benefits to Covered Associates enrolled in the coverage. Below is a summary of benefits provided, but the insurer's documents control.

SCHEDULE OF STD BENEFITS

Benefit	60% of weekly earnings*
Maximum Benefit	$2,000 per week
Minimum Benefit	$50 per week
Benefit Waiting Period	7 calendar days**
Maximum Benefit Period	12 weeks**

*STD Benefit is based on a six-week average of gross income including commissions, overtime pay excluding bonuses, car allowances, fringe benefits and other extra compensation. Any increase in an Associates covered earnings will not be effective during a period of continuous disability.

**The Maximum Benefit Period for NY Associates is 26 weeks as required by state law as of the date of this publication. In NY, STD benefits for full-time Associates will be paid at 60% for the first 12 weeks of disability after the 7-day waiting period. STD benefits will be paid at the state mandated level for the next 12-13 weeks depending on the length of disability and may be offset by any long-term disability compensation or NY paid leave received if applicable. Part-time Associates in NY will receive the mandated statutory state plan as required by state law. The NY state mandated plan has a 7- calendar day waiting period before benefits are paid.

** The Maximum Benefit Period for HI Associates is 26 weeks as required by state law as of the date of this publication. In HI, STD benefits for full-time Associates will be paid at 60% for the first 12 weeks of disability after the 7-day waiting period. STD benefits will be paid at the state mandated level for the next 12-13 weeks depending on the length of disability and may be offset by any long-term disability compensation received if applicable. Part-time Associates in HI will receive the mandated statutory state plan as required by state law. The HI state mandated plan has a 7- calendar day waiting period before benefits are paid.

**STD benefits will be coordinated with any paid leave program provide by the work jurisdiction which may result in reduced benefits.

How Do You Make a Claim for Benefit Payments? You must file a claim with the disability provider to receive STD Benefits. To file a claim, contact the disability provider at 1-855-709-6395 or online at mycigna.com. A disability representative will take all the necessary information to process your claim. They will contact your physician to obtain information regarding your claim for short term disability. You must be disabled from performing the material duties of your regular occupation during the entire period you receive benefits and under a physician's regular care and attendance. Reasonable accommodations (consistent with

the requirements of the Americans with Disabilities Act) will be reviewed to assist the return to work. If you work in a state with paid medical leave you must file a claim under your state disability or paid leave plan.

When Does Coverage End? Your coverage ends if the STD program or Plan is discontinued or, if earlier, you are no longer eligible.

Are There Disability Benefit Offsets? An Employee for whom Disability Benefits are payable under this Plan may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits. For a complete list of other income benefits refer to the plan document. Email the Benefits Department at benefits@petsmart.com to request a copy of the plan document.

How Are Successive Disabilities Treated? Successive periods of total disability due to the same or related causes will be considered one continuous period of disability. If you return to work on a full-time active basis (e.g., you are actively at work) for 14 consecutive days, any subsequent total disability will be covered as a new disability regardless of its cause.

Are There Any Limits or Exclusions? Only one benefit will be paid for a disability due to two or more injuries and illnesses. The insurer will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

- suicide, attempted suicide, or self-inflicted injury while sane or insane.
- war or any act of war, whether or not declared.
- active participation in a riot.
- commission of a felony.
- the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.
- any cosmetic surgery or surgical procedure that is not Medically Necessary, except reconstructive surgery related to: 1) surgery when surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; and 2) congenital disease or anomaly of a covered dependent child which has resulted in functional defect; "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. (The insurer will pay benefits if the Disability is caused by the Employee donating an organ in a non-experimental organ transplant procedure.)

In addition, the insurer will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution.

SHORT TERM DISABILITY and State offered disability or paid leave

If you work in any state that has a state-run paid disability leave program, you must file a claim under your state disability or paid leave plan. If you become disabled due to non-occupational injury, or illness, you may be eligible to receive State Disability Benefits. STD Benefits will

be provided to all Covered Associates in these states in accordance with the state's required disability or paid leave policies governing such benefits to Covered Associates eligible for the coverage. Information on placing a claim for STD benefits in these states is available on the corresponding state's website.

LONG TERM DISABILITY

All full-time salaried Associates, full-time hourly Associates assigned to Phoenix Home Office and full-time hourly store leaders are automatically covered under the Long-Term Disability (LTD) program. If you are a full-time hourly store or Distribution Center Associate, you can purchase the Voluntary LTD coverage.

If you become disabled due to an accidental injury or illness you may be eligible to receive LTD Benefits after your disability has lasted for a continuous period as listed in the schedule of LTD benefits. There is a separate plan for Executive LTD coverage.

LTD Benefits will be provided in accordance with the long-term disability insurance policy (the terms and provisions of which are incorporated herein by this reference) governing such benefits to Covered Associates enrolled in such coverage. Below is a summary of benefits provided, but the insurer's documents control.

SCHEDULE OF LTD BENEFITS

Waiting Period	the later of 13 weeks or the end of the STD benefit period.
Benefit	60% of your monthly Earnings* (rounded to the nearest dollar), subject to the Minimum and Maximum Benefit and the Maximum Benefit Period (see chart below)** (Associates in a state that provides state paid leave or disability payments may have a reduction of benefit for any period of time they are receiving state disability or paid leave payments)
Minimum Benefit	$100 per month
Maximum Benefit	$10,500 per month

*"Earnings" mean your base pay as of the day before your disability began (excluding bonuses and any other extra compensation). **Commissions if eligible are included for Salon Leaders only**, averaged over the last 6 weeks before the date of disability. **LTD Benefits are calculated based on a 30-day period and will be prorated if payable for less than a 30-day period.

After LTD benefits have been paid for 24 months, you will still be considered disabled if you are unable (due to disability) to earn more than 60% of your pre-disability Earnings (as defined above) in any occupation that you are (or may be) reasonably qualified for, based on your education, training, or experience.

LONG TERM DISABILITY CLAIMS IN NJ, NY, CA, CT, HI, RI, MA, WA AND WASH DC

Associates residing in these states that are Covered Associates in accordance with either the company provided, or Voluntary LTD Plan will be eligible to file a claim for the LTD benefits once they have completed the LTD benefit waiting period. Associates in these locations and any other jurisdiction that provides paid leave may have a reduction of benefit for any period of time they are receiving state disability payments beyond the 13-week benefit waiting period. Contact the disability provider found in the Quick Reference Chart section of this document to file a claim for LTD benefits.

Maximum Benefit Period

Age When Disability Begins	Maximum Benefit Period
Age 62 or under	Your 65th birthday or 42 monthly benefit payments, if later
Age 63	36 monthly benefit payments
Age 64	30 monthly benefit payments
Age 65	24 monthly benefit payments
Age 66	21 monthly benefit payments
Age 67	18 monthly benefit payments
Age 68	15 monthly benefit payments
Age 69 or later	12 monthly benefit payments

When Do LTD Payments Commence? You must file a claim with the insurance company within 31 days after you become disabled (or as soon as reasonably possible). If you do not submit a claim on time, your claim may be denied, or your LTD Benefits may be reduced.

You must provide "proof of loss" to the insurance company within 90 days of becoming disabled (or as soon as reasonably possible, but in no event later than one year after the 90-day period). The insurance company may require that you submit additional "proof of loss" while you are receiving LTD Benefits. If you do not provide the initial (or additional) "proof of loss" on a timely basis, your claim may be denied (or your LTD Benefits may cease).

LTD Benefits will be paid on at least a monthly basis. If you die, any LTD Benefits that are due but not paid when you die will be paid to your beneficiary.

When Do LTD Payments End? Your LTD Benefits will end on the earliest of the following dates:

- when the Maximum Benefit Period ends;
- when you are no longer disabled or are no longer receiving appropriate care from a physician for your disability;
- when you die;
- when you earn more than 60% of your Earnings (as adjusted after your first 12 months of LTD Benefits) in your regular occupation or, after you have received benefits for 24 months, in any occupation for which you are reasonably qualified given your education, training and experience; or

- when you refuse to participate in rehabilitation efforts as required by the insurance company or the Company.

Are There Any Reductions in Benefits?
An Employee for whom Disability Benefits are payable under this Plan may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits. For a complete list of other income benefits refer to the plan document. Email the Benefits Department at benefits@petsmart.com to request a copy of the plan document.

May the Insurance Company Recover Overpayments? The insurance company has the right to recover (from you or your beneficiary) any amounts paid in excess of your LTD Benefits, including the right to reduce future benefit payments to offset for any overpayments.

When Does LTD Coverage End? Your coverage ends if the LTD policy or Plan is terminated or, if earlier, the date you cease to be employed by the Company in a category eligible for LTD benefits. If you cease to be employed by the Company in a category eligible for LTD benefits because of a covered disability, your coverage will end when you cease to be disabled, you have received the Maximum LTD Benefits, or the Maximum LTD Benefit Period has expired, whichever happens first. If you go on a leave of absence (other than a disability leave), your coverage ends the day before your leave begins.

May LTD Coverage Be Reinstated? If your coverage ends because you go on an approved leave of absence, your coverage may be reinstated if you return to active service in a category of employment that is eligible for LTD benefits.

How Are Successive Disabilities Treated? Successive periods of disability due to the same or related causes will be considered one continuous period of disability. If you return to work on a full- time, active basis (e.g., you are actively at work) for six consecutive months, any subsequent disability will be covered as a new disability regardless of its cause.

LTD LIMITS & EXCLUSIONS

Are There Any Limits or Exclusions For Mental Illness, Alcoholism and Drug Abuse? LTD Benefits will not be paid for more than 24 months (during your lifetime) if your disability is caused by, or contributed to by, alcoholism, anxiety disorders, delusional (paranoid) disorders, depressive disorders, drug addiction or abuse, eating disorders, mental illness or somatoform disorders (psychosomatic illness). If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Are There Any Limits or Exclusions for Pre-existing Conditions with the basic Company Provided Plan? LTD Benefits will not be paid if your disability is caused by, contributed to by, or results from a pre-existing condition. For purposes of company provided LTD Benefits, a "pre- existing condition" is any injury or sickness for which you incurred expenses, received medical treatment, care or services (including diagnostic measures), took prescribed drugs or

medicines, or for which a reasonable person would have consulted a physician, within 3 months before becoming covered by the LTD program.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you have been in Active Service for a continuous period of 3 months during which you have received no medical treatment, care or services in connection with the pre-existing conditions or are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Are There Any Limits or Exclusions For Pre-existing Conditions: Voluntary Plan? LTD Benefits will not be paid if your disability is caused or contributed to by, or results from a pre-existing condition. For purposes of Voluntary LTD Benefits, a "pre-existing condition" is an injury or sickness for which you incurred expenses, received medical treatment, care or services (including diagnostic measures), took prescribed drugs or medicine, for which a reasonable person would have consulted a physician, within 3 months before becoming covered by the Voluntary LTD program.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you have been in Active Service for a continuous period of 3 months during which you have received no medical treatment, care or services in connection with the pre-existing conditions or are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Are There Any Other Exclusions? LTD Benefits will not be paid on either the Company provided or the Voluntary LTD plan if your disability is the result (directly or indirectly) of:

- your attempted suicide or intentionally injuring yourself;
- war or any act of war, whether or not declared;
- your serving on full-time, active duty in any armed forces;
- your engaging in terrorism or active participation in a riot; or
- your commission of a felony.

LTD Benefits will not be paid for any period of disability during which you:

- refuse to participate in rehabilitation efforts, as required by the insurer;
- are not receiving appropriate care for your disability;
- refuse to participate in a transitional work arrangement or other modified work arrangement offered to you by the Company;
- fail to cooperate with the Administrator or the insurance company in the administration of your claim for LTD Benefits, including but not limited to not providing required information or documents; or
- are incarcerated in a penal or corrections institution.

LTD ADDITIONAL REQUIREMENTS & BENEFITS

Must I Participate In Rehabilitation During A Period of Disability? If the insurer determines that a Disabled Employee is a suitable candidate for rehabilitation, the insurer may require the Employee to participate in a Rehabilitation Plan and assessment at our expense. The insurer has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. The insurer will work with the Employee, the Employer and the Employee's Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities. The Rehabilitation Plan may, at the insurer's discretion, allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program.

If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

Is There A Reasonable Accommodation Benefit? To enable you to return to work from a disability, the insurer may pay for a reasonable accommodation (such as a modification or adjustment to your work environment) to be made by the Company. The reasonable accommodation must:

- be made on your behalf and result in your ability to return to work for the Company;
- be approved by the insurer in writing before it is implemented, or any expense is incurred; and
- meet the standards for a reasonable accommodation as established by the Americans With Disabilities Act.

What is the Social Security Assistance Program? The insurer may help you in applying for Social Security Disability Income (SSDI) Benefits and may require you to file an appeal if it believes a reversal of a prior decision is possible.

The Insurance Company will reduce Disability Benefits by the amount it estimates the Employee will receive, if the Employee refuses to cooperate with or participate in the Social Security Assistance Program.

Is a Survivor Benefit Payable? If you die while receiving LTD Benefits, your surviving Spouse will receive a lump sum payment in an amount equal to three times the monthly LTD Benefits you were receiving at the time of your death (Survivor Benefit). If you are not married when you die, the Survivor Benefit will be paid to your children in equal shares or, if you do not have children, to your estate. "Spouse" means your lawful spouse."Children" means your unmarried children under age 21 who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.

PLAN ADMINISTRATION

FUNDING & ADMINISTRATION

The Company self-funds the following plans:

Plan	Third-Party Administrator
Medical	UnitedHealthcare
Medical	Surest Healthcare
Dental Plan I & II	CIGNA Dental Health
Prescription Drug Program	CVS Caremark
Behavior Health	OptumHealth Behavior Services
Health Reimbursement Account	UnitedHealthcare
Flexible Spending Account	UnitedHealthcare

Benefits in the self-funded plans are paid from the general assets of the Company. The third-party administrators specified above provide administrative services (such as claims processing) only, and don't guarantee payment of any benefits.

The following benefits are not subject to ERISA (and, in the case of the HSA, not sponsored by PetSmart), but are listed here for your convenience:

Plan	Third-Party Administrator
Health Savings Account	OptumHealth Bank
Dependent Day Care Flexible Spending Account	UnitedHealthcare

The following plans are fully insured through policies with the following insurers (i.e., benefits are paid by the insurance companies and all administrative services are provided by the insurance companies):

Plan	Insurer
Vision	Vision Services Plan
Employee Assistance Plan	OptumHealth Behavior Services
Life Insurance	New York Life
Accidental Death & Dismemberment	New York Life
Dependent Life	New York Life
Short Term Disability	New York Life
Long Term Disability	New York Life
Dental Maintenance Organization	CIGNA Dental Health

The Plans have no control over any diagnosis, treatment, care or lack thereof or other services delivered to you by a provider and disclaim liability for any loss or injury caused to you by a provider by reason of negligence, failure to provide treatment, or otherwise.

COORDINATION OF 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 determines 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 D.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 D.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 Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Expense.

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

Determining the Allowable Expense If this Plan is Secondary

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 Medicare limiting charge as the limiting.

Medicare Crossover Program
The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

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

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

Does This Plan Have the Right of Recovery?

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

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

SUBROGATION RULES

Am I Required to Reimburse the Plan If I Am Injured By a Third Party? 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 legal theories, such as the so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine," or similar 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, 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 plan year Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the plan 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 plan 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.

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

Determining Which Plan is Primary

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

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

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

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

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

MEDICARE CROSSOVER PROGRAM

In certain limited situations, Medicare will be primary to this coverage. The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier(s) have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

CLAIMS UNDER ERISA'S CLAIMS AND APPEALS PROCEDURES

There are two types of claims that may be made under the Plan.

- An **eligibility claim** is a claim to participate in a benefit offered under the Plan or to change an election to participate during the year. Examples of eligibility claims include claims regarding whether you are enrolled in the correct benefit option, or claims related to whether you properly enrolled a dependent. Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.
- A **benefit claim** is a claim for a particular benefit under the Plan. For example, a benefit claim can relate to whether a specific treatment or prescription is covered by the medical or prescription drug plan. A benefit claim also includes a rescission (i.e., retroactive termination) of coverage. A benefit claim typically includes your initial request for benefits. For benefit claims, please see the claims and appeals section for the applicable benefit below.

Eligibility Claims and Appeals – All ERISA Benefits

For initial eligibility claims for all benefits subject to ERISA, the Claims Administrator is the Benefits Department of PetSmart.To file an eligibility claim, you must request a Claim Initiation Form from the PetSmart Benefits Team. You must return the form to benefits@petsmart.com or to:

PetSmart LLC
Benefits Department- Appeals
19601 N. 27th Avenue
Phoenix, AZ 85027.

Initial Eligibility Claim

Generally, you will be notified of the decision within 15 days after the Benefits Manager receives your Claim Initiation Form; the response time frame shall not exceed the deadlines that apply to a benefit claim (i.e., a benefit determination) for the applicable benefit, as outlined within this SPD. For example, if your initial eligibility claim is for a post-service medical claim, then a response will be provided to you no later than 30 days.

However, if additional information is needed to process your eligibility claim, you will be notified within that initial period. The Plan may request a one-time extension that will generally not to exceed 15 days, or the time frame that applies to a claim for benefits as otherwise provided in this SPD.

The Benefits Manager will notify you of the deadline to submit additional information, if applicable.

If your claim is **approved**, the Benefits Manager will notify you in writing.

If your claim is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.

- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

Also, depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese or Navajo.

Eligibility Appeals

Before you can bring any legal action to recover Plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this section and your appeal must be finally decided by the Appeals Administrator. For eligibility claims for all Benefit Programs that are subject to ERISA, the Appeals Administrator is the Benefits Director. All decisions by the Appeals Administrator are final and binding on all parties.

If your claim is denied and you want to appeal it, you must file your appeal within 180 days or, for life insurance and AD&D benefits, within 60 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to the Appeals Administrator for the Plan at:

PetSmart LLC
Attn: Benefits Director
19601 N. 27th Avenue
Phoenix, AZ 85027

You should include the following with your written appeal:

- A copy of your claim denial notice (also referred to as an adverse benefit determination).
- The reason(s) for the appeal.
- Relevant documentation.

You will be notified of the decision generally within 30 days after receipt of your Claim Initiation Form; the response time frame shall not exceed the deadlines that apply to a benefit claim (i.e., a benefit determination) for the applicable benefit, as outlined within this SPD. For example, if your eligibility appeal is for a post-service medical claim, then a response will be provided to you no later than 60 days.

If your appeal is **approved**, the Appeals Administrator will notify you in writing.

If your appeal is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.

- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request.
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA.

Also, depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

Unless your eligibility claim pertained to a rescission, the decision on your appeal is final. As a result, the Appeals Administrator will not review your matter again, unless new facts are presented. You have a right to bring a civil action under Section 502(a) of ERISA following your appeal.

CLAIMS PROCEDURE

How Do I Submit Claims? Generally, if you think you should get coverage and/or benefits under the Plans, you or your duly authorized representative (such as a family member, doctor, or attorney) can file a claim. You must follow (and exhaust) this claims procedure and the appeals procedure (discussed in this SPD in more detail) before you can bring any legal action. Legal action must be commenced by the earlier of one year from (i) the date of the final decision by the Claims Reviewer or (ii) the date your last written communication is sent to the Claims Reviewer to the extent you do not receive a timely written response from such reviewer.

For claims information under the Surest Benefits plan, please reference the Summary Plan Description Supplement – for Surest.

You do not have to submit a claim for treatment or services rendered by a participating DHMO Dentist, but you are responsible for ensuring that the Dentist submits the claim within one year of treatment. A claim form (available from CIGNA) is required for reimbursement of any Covered Services rendered by a non-participating DHMO Dentist in the event of Emergency.

You do not have to submit a claim for treatment or services rendered by a participating Dentist in Dental Plan I or Dental Plan II, but you are responsible for ensuring that the Dentist submits the claim within one year of treatment. A claim form is required for reimbursement of any covered treatment or services rendered by a non-participating Dentist can be found at benefits.petsmart.com or www.cigna.com.

For Vision Plan services, if you use a VSP provider, your provider should bill VSP directly. If you use a non-VSP provider, you must submit a request to VSP for reimbursement of covered expenses within one year of treatment. Forms are available from VSP.

You must submit a claim form to receive reimbursement from your FSA(s) (located at benefits.petsmart.com or myuhc.com). See “Filing Claims for FSA Reimbursement” for details.

Claims for Life Insurance, Accidental Death & Dismemberment, Short Term Disability and Long-Term Disability benefits must be filed with the insurance company insuring those benefits (see "Life & AD&D" for more information).

All claims must be filed within one year of the date treatment or services are first sought, except as otherwise provided for FSA claims (see "Filing Claims for FSA Reimbursement").

The Plan, at its own expense, may require that the person whose illness, injury or disease is the basis of a claim be examined by a doctor chosen by the Plan, to the extent not otherwise prohibited by law. In case of death, the Plan may require an autopsy, unless prohibited by law.

Who Decides Claims? The Claims Processor, in its sole and complete discretion, will decide if your claim should be granted. The time period for providing a determination on a claim depends on whether your claim is an Urgent Care, Pre-Service, Post-Service, Disability Claim or other type of claim.

What Is an Urgent Care Claim? If you make a claim for medical, dental, or vision care or treatment and the time periods that would normally apply to your claim could result in your life, health, or ability to regain maximum function being seriously jeopardized or your being in severe pain that cannot be managed without the care or treatment that is the subject of the claim, then your claim will be an Urgent Care Claim.

What is a Pre-Service Claim? A Pre-Service Claim is a claim for medical, dental, or vision benefits for which you are required to obtain preauthorization, and which is not an Urgent Care Claim.

What is a Post-Service Claim? A Post-Service Claim is a claim for medical, dental, or vision benefits that is not a Pre-Service or an Urgent Care Claim. Claims for reimbursement from your FSA(s) also are Post-Service Claims.

What is a Disability Claim? A Disability Claim is a claim for a benefit that is based on a determination of whether or not benefits are payable in accordance with the terms and provisions of the applicable policy. (e.g., Short-Term or Long-Term disability benefits).

What Are Other Claims? Other claims are claims that are not Urgent Care, Pre-Service, Post-Service, or Disability Claims.

APPEAL AND CLAIM PROCEDURES -UNITEDHEALTHCARE

What this section includes:
- How Network and non-Network claims work for UnitedHealthcare and Optum.
- What to do if your claim is denied, in whole or in part.

Network Benefits

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

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

Non-Network Benefits

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

If Your Provider Does Not File Your Claim

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

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

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

due you.

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

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

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 [9][10]: Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

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.

Claim Denials and Appeals

If Your Claim is Denied

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

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 or other written information to support your request.

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

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

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

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.

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. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

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.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- An unfavorable or adverse determination involving non-network emergency services, non-network air ambulances, or services provided by a non-network practitioner at a network facility.
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

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

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

Standard External Review

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

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

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

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO's request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

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

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the

review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

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

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

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

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

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

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

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**
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.

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 PetSmart 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 PetSmart or the Claims Administrator, you must do so within one year 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 PetSmart or the Claims Administrator.

You cannot bring any legal action against PetSmart 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 PetSmart or the Claims Administrator you must do so within one year of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against PetSmart or the Claims Administrator.

APPEAL AND CLAIM PROCEDURES – CVS CAREMARK

CVS Caremark's standard claims and appeals process complies with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), the Affordable Care Act (ACA) and their implementing regulations. Members will be accorded all rights granted to them under ERISA, ACA and any related laws and regulations. The claims and appeals process implemented for any Plan Sponsor will also comply with applicable law.

Definitions
While definitions also appear in the Glossary of Defined Terms, the following terms are used in this section of your SPD to describe the claims and appeals review services provided by CVS Caremark under the PetSmart Prescription Drug Program:

Adverse Benefit Determination (Does Not Include Adverse Coverage Determinations as defined below) – The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Adverse Coverage Determination – An Adverse Coverage Determination is based solely on the terms of the Plan, including the Plan Design Document, the preferred drug lists, formulary or other plan benefits selected by the Plan Sponsor, and does not involve a determination that the requested drug is experimental or investigational or not medically necessary.

Claim – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims. Please note that a pharmacy transaction does not qualify as a claim in accordance with a Plan's procedures for filing benefit claims.

Medically Necessary (Medical Necessity) – Medications, health care services or products are

considered Medically Necessary if:

- Use of the medication, service or product meets clinically appropriate criteria in accordance with U.S. Food and Drug Administration (FDA)-approved labeling or nationally recognized compendia (such as American Hospital Formulary Service (AHFS) or Micromedex) or evidence-based practice guidelines;
- Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services and the place where services are performed; and
- Use of medication, service or product is not solely for the convenience of the member, member's family or provider.

Post-Service Claim – A claim that is not a Pre-Service Claim, as defined below; essentially, a Claim for a Plan benefit for which the medical care has already been provided.

Pre-Authorization – CVS Caremark's pre-service review of a member's initial request for a particular medication. CVS Caremark will apply a set of pre-defined medical criteria (provided or adopted by the Plan Sponsor in the PDD) to determine whether there is need for the requested medication.

Pre-Service Claim – A Claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care. Pre-Service Claims include member requests for pre-authorization.

Urgent Care Claim – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS Caremark will defer to the member's attending health care provider as to whether or not the member's Claim constitutes an Urgent Care Claim.

The CVS Caremark Claims and Appeals Process

The claims and appeal process is administered as detailed below and because this plan is self-insured, references to state requirements are removed because they do not apply due to ERISA pre-emption.

Pre-Authorization Claim Review Services

CVS Caremark will implement the prescription drug utilization management programs by evaluating member requests for certain medicines and/or other prescription benefits against pre-defined medical criteria adopted by the Plan specifically related to use of those medicines or prescription benefits before the prescription is filled or the medical care is provided.

If CVS Caremark determines that the member's request for pre-authorization cannot be

approved, that determination will constitute an Adverse Benefit Determination.

Coverage Determination Review Services

A member's request for a particular drug or benefit will be compared against the preferred drug lists, formularies or other defined plan benefits to determine if the requested drug is a covered benefit.

If CVS Caremark determines that the member's request for a drug or benefit cannot be approved based on the terms of the Plan, including the preferred drug lists or formularies, that determination will constitute an Adverse Coverage Determination.

Post-Service Claims Review Services
A member's request for payment of a post-service claim for a particular drug or benefit will be compared against the preferred drug lists, formularies, or other defined plan benefits to determine if the requested item qualifies as a covered benefit.

If CVS Caremark determines that the member's request for the drug or benefit cannot be approved based on the terms of the Plan, including the preferred drug lists or formularies, that determination will constitute an Adverse Coverage Determination. The decision will be communicated to the member via a Paper Claims Reconciliation Statement.

Timing of Review

Pre-Authorization Review – CVS Caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim as soon as possible, but not later than 72 hours.

Coverage Determination Review – CVS Caremark will make a decision on a Coverage Determination within 15 days after it receives such a request. If the member is requesting the Coverage Determination of an Urgent Care Claim, a decision on such request will be made as soon as possible, but not later than 72 hours.

Post-Service Review – CVS Caremark will make a decision on a Post-Service Claim within 30 days after it receives such a request.

Appeals of Adverse Benefit Determinations or Adverse Coverage Determinations:

If an Adverse Benefit Determination or Adverse Coverage Determination is rendered on the member's Claim, the member may file an appeal of that determination. The member's appeal of the Adverse Benefit Determination or Adverse Coverage Determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the Adverse Benefit Determination or Adverse Coverage Determination.

If the Adverse Benefit Determination or Adverse Coverage Determination is rendered with

respect to an Urgent Care Claim, the member and/or the member's authorized representative may submit an appeal by calling, faxing or mailing the request to CVS Caremark.

The member's appeal should include the following information:

- A clear statement that the communication is intended to appeal an Adverse Benefit Determination or Adverse Coverage Determination;
- Name of the person for whom the appeal is being filed. The member or prescriber may file an appeal. The member may also have a relative, friend, advocate, or anyone else (including an attorney) act on their behalf as their authorized representative;
- CVS Caremark identification number;
- Date of birth;
- A statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Comments, documents, records, relevant clinical information or other information relating to the Claim

To request an appeal, call CVS Caremark toll-free at 1-800-966-5772. Upon receipt of your request for appeal, CVS Caremark will send you a Prescription Claim Appeals Form. You and/or your physician should complete the form and mail or fax it to CVS Caremark mailing address and fax number are noted below. You may submit the appeal either on the Prescription Claim Appeal form or in other written form to;

MAIL
Caremark, Inc.
Appeals Department MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

FAX
1-866-443-1172
ATTN: Appeals Department

Review of Adverse Benefit Determinations of Pre-Service Claims

CVS Caremark will provide the first level review of standard appeals of Pre-Service Claims. Such appeals will be reviewed against pre-determined criteria relevant to the drug or benefit being requested. If the member's appeal does not n meet these criteria, a review will be conducted by an appropriate qualified reviewer. A denial notice will be sent to the member with instructions how to request a second level Medical Necessity review.

If the member's first level standard appeal is denied, the member may appeal CVS Caremark's decision and request a second level Medically Necessary review. The second level review for whether the requested drug or benefit is Medically Necessary will be conducted by an appropriately qualified reviewer or sub-delegated medical necessity review organization.

When a member's appeal is related to an Urgent Care Claim, CVS Caremark will perform both the first level review and the second level Medical Necessity review, combined within 72 hours.

If the first level request is approved, no further review is required, and a notice of approval will be sent to the member. If the first level review cannot be approved, a second level Medical Necessity review will be initiated automatically. The member will receive notice of the determination at the conclusion of the Medical Necessity review. The two levels are combined in order to meet the 72-hour turnaround time requirement.

Review of Adverse Coverage Determinations

CVS Caremark provides a single-level appeal for Adverse Coverage Determinations. Upon receipt of an appeal of an Adverse Coverage Determination, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists, formularies or other defined plan benefits.

Appeal Review Procedure

During its review of an appeal of an Adverse Benefit Determination or Adverse Coverage Determination, CVS Caremark shall:

- Provide for a full and fair review, allowing the member to review the Claim file and to present evidence and testimony. This includes providing the member (free of charge) with new or additional evidence or rationale relied upon-in advance of a final internal Adverse Benefit Determination, and giving the member a reasonable opportunity to respond;
- Take into account all comments, documents, records and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination of the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members;
- Provide a review that is designed to ensure the independence and impartiality of the person making the decision;
- Provide a review that does not give consideration to the initial Adverse Benefit Determination or Adverse Coverage Determination and is conducted by someone other than the individual who made the initial Adverse Benefit Determination or Adverse Coverage Determination (or a subordinate of such individual); and
- Provide for an expedited review process for Urgent Care Claims.

For a claim requiring a Medical Necessity Review, CVS Caremark, in addition to the above, shall also:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Ensure that the health care professional was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual); and
- Upon request, identify the health care professional, if any, whose advice was obtained in connection with the Adverse Benefit Determination.

Timing of Review

Pre-Service Claim Appeal of Adverse Benefit Determination – CVS Caremark will make a decision on the first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the member's appeal.

If the Member requests a second-level appeal following an Adverse Benefit Determination on first-level appeal, CVS Caremark will make a decision within 15 days after the second-level appeal is received.

If the member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made as soon as possible, but not later than 72 hours after the request for appeal is received (for both the first- and second-level appeals, combined).

Pre-Service Claim Appeal of Adverse Coverage Determination – CVS Caremark provides a single-level appeal for Adverse Coverage Determinations. CVS Caremark will make a decision on the appeal of an Adverse Coverage Determination rendered on a Pre-Service Claim within 30 days after it receives the member's appeal.

If the member is appealing an Adverse Coverage Determination of an Urgent Care Claim, a decision on such appeal will be made as soon as possible, but not later than 72 hours after the request for appeal is received.

Post-Service Claim Appeal – CVS Caremark provides a single-level appeal for Post-Service Claim Appeals. CVS Caremark will make a decision on an appeal of a Post-Service Claim within 60 days after it receives such an appeal.

Notice of Adverse Benefit Determination, Adverse Coverage Determination, Appeal of Adverse Benefit Determination or Appeal of Adverse Coverage Determination:

Following the review of a member's Claim, CVS Caremark will notify the member of any Adverse Benefit Determination, Adverse Coverage Determination, Appeal of Adverse Benefit Determination or Appeal of Adverse Coverage Determination, in writing, in a culturally and linguistically appropriate manner. Decisions on Urgent Care Appeals will also be communicated by telephone. When required by state laws or regulations, decisions on other Adverse Benefit Determinations and Adverse Coverage Determinations will be communicated by telephone as well. This notice will include:

- The specific reason or reasons for the determination in easily-understood language;
- Reference to pertinent Plan provision on which the determination was based;
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination, either a copy of the specific rule, guideline, protocol or

other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request;

- If the Adverse Benefit Determination or Appeal of Adverse Benefit Determination is based on a Medical Necessity, either the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request;
- A statement of the member's right to bring action under ERISA Section 502(a), if applicable;
- A description of the available internal appeals process and external review process, including information on how to file an appeal; and
  Information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review.

Authority as Claims Fiduciary

CVS Caremark shall serve as the claim's fiduciary with respect to prescription drug benefit Claims arising under the Plan and review of appeals of Adverse Benefit Determinations and Adverse Coverage Determinations. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties.

External Review

If your appeal under the internal review process is rejected for coverage based on medical necessity grounds and you do not agree with that decision, you or your doctor (on your behalf) may submit a request for an external review for medical necessity. In addition to a medical benefit type claim, a rescission (a retroactive termination of coverage) is eligible for an external review; other eligibility type claims are not. You have four (4) months from receipt of a final adverse determination.

CVS Caremark will provide an external appeal application with the final adverse determination issued through our internal appeal process or our written waiver of an internal appeal.

Medical necessity reviews are conducted by an external review organization not affiliated with CVS Caremark. This independent organization will conduct an independent specialist review for medical necessity of a prior authorization denial after CVS Caremark's second internal appeal review. All available clinical information must be submitted when a request for an external review for medical necessity is made.

This process follows these steps:

- The independent review organization will select an independent specialist to conduct the review.

- The independent specialist will review the available medical records and any additional information obtained from the provider and will write an independent rationale in support of the final decision.
- In some urgent cases, the second level review and independent review are conducted concurrently, and a final determination will be sent to the member or his/her representative.

The letter containing the rationale will be forwarded to CVS Caremark for communication to the member or the member's representative. You should receive written notification of the outcome of the external review within 45 days (72 hours for an oral response to an urgent care claim) of the date CVS Caremark receives your request for an External Review. If you would like more details regarding the External Review process, please contact CVS Caremark. If the external review organization overturns the original rejection and coverage is granted, coverage will be authorized by CVS Caremark.

APPEAL AND CLAIM PROCEDURES – CIGNA DENTAL

Pre-Service Claim (Benefit Determination)

A Pre-Service Claim is a claim for a service or treatment that has not yet been provided. If the request for benefits is filed improperly, you will be notified within 5 days and you will have 30 days to provide the completed request. If the request is incomplete, the member will be notified within 15 days. You will be notified of the benefit determination within 15 days after receiving the completed pre-service claim. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. If a claim for Benefits is denied in part or in whole, you can contact Cigna Dental by phone at 1-800-244-6224 or in writing to the address that appears on your explanation of benefits to file an appeal.

Pre-Service Appeals (Benefit Determination on Review)

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call 1-800-244-6224 or write Cigna at the address that appears on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed, and the decision made by someone not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after we receive an appeal for a preservice coverage determination.

Post-Service Claim (Benefit Determination)

A Post-Service Claim is a claim for a service or treatment that has already been provided.
When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to

make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Post Service Appeals (Benefit Determination on Review)

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call 1-800-244-6224 or write us at the address that appears on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed, and the decision made by someone not involved in the initial decision. We will respond in writing with a decision within 60 calendar days after we receive an appeal for a post service coverage determination.

Urgent Care Claim (Benefit Determination)

An urgent care claim is a claim for dental care or treatment that, if the longer time frames for non-urgent care were applied, the delay: (1) could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

Urgent care claims can be filed by calling Cigna at 1-800-244-6224 and indicating that your claim is an Urgent Care Claim. If the request for benefits is filed improperly, you will be notified within 24 hours. If the request is incomplete, you will be notified within 24 hours. You must then provide the completed request within 48 hours after receiving notice of additional information required.

Urgent claims will be reviewed, and a determination should be made within 72 hours of Cigna’s receipt of the appeal request.

You may be notified by phone of the decision and then, you will receive a written notice within 3 days of an oral denial.

Urgent Appeal Requests Benefit Determination on Review

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to

write, you may ask Cigna to register your appeal by telephone. Call 1-800-244-6224 or write us at the address that appears on your ID card, explanation of benefits, or claim form.

If you or your doctor believes an appeal request is urgent, write "urgent" on the written appeal request. Urgent appeals will be reviewed, and a determination should be made within 72 hours of Cigna's receipt of the appeal request.

Information Provided if Claim/Appeal is Denied

If a claim (benefit determination) is denied, in whole or in part, the denial notice must contain:

- The specific reason(s) for the denial;
- The Plan provisions on which the denial was based.
- Any additional material or information you may need to submit to complete the claim.
- Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge upon request).
- If based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgement for the determination (or a statement that such explanation will be provided free of charge upon request).
- The Plan's appeal procedure.

If an appeal (benefit determination) is denied, in whole or in part, the denial notice will contain everything that the claim denial notice contained plus:

- A statement regarding the documents to which the claimant is entitled.
- Information or a statement regarding other voluntary dispute resolution options and a statement that the claimant has a right to bring a civil action under Section 502(a) of ERISA.

This process generally is the same for the Cigna DHMO plan. Please contact Cigna for details at 1-800-244-6224

APPEAL AND CLAIM PROCEDURES – LIFE AND DISABILITY

The Plan Administrator designates and names New York Life as the named fiduciary for deciding claims and appeals for benefits under the Plan. New York Life shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan (the Plan Administrator will retain the ability to determine whether claimant is eligible to enroll in disability benefits), and to make any related findings of fact. All decisions made by New York Life shall be final binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018; contact New York Life for a copy of the claims and appeals procedures that applied prior to April 1, 2018).

A disability "claim" is any claim which requires a determination of disability by New York Life regardless of the type of policy under which it arises (for example short-term, waiver of

premium or long-term disability benefits). Retroactive terminations or discontinuances of disability coverage that is not due to nonpayment of premiums or contributions (i.e., rescissions) also give rise to a claim and/or appeal under ERISA.

A disability claim is "filed" as of the date New York Life first receives, in writing (including electronically) or by telephone (through the intake department), notice that a claimant is seeking disability benefits under the Policy/Plan. Claim can be submitted at 1-855-709-6395 or at mycigna.com. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

New York Life has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy/Plan. New York Life may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30-day periods. If this should happen, New York Life must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for New York Life's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date New York Life receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, New York Life may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, New York Life will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, New York Life will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, New York Life will pay the appropriate benefit. If the claim decision is adverse (which includes a rescission of coverage), in whole or in part, New York Life will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy/Plan provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to New York Life of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on

behalf of New York Life in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to New York Life made by the Social Security Administration;

6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria New York Life relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy/Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA. Depending on what county you live in, you may be able to receive such information in Spanish, Chinese, Tagalog, and Navajo.

Appeal of Denied Disability Claims Whenever a claim decision is fully or partially adverse (including a rescission of coverage), unless ERISA provides otherwise, the claimant must appeal once to New York Life. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to New York Life, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by New York Life, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by New York Life within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. New York Life has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, New York Life may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, New York Life must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for New York Life 's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date New York Life receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, New York Life will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by New York Life for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, New York Life may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, New York Life will notify the claimant, in writing, stating what information is needed and why it is needed. Before New York Life issues an adverse benefit decision on appeal, if New York Life considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if New York Life intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, New York Life will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, New York Life will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy/Plan provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant’s right to obtain the information about those procedures;
5. A statement of claimant’s right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant’s right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to New York Life of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of New York Life in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to New York Life made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria New York Life relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;

8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy/Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA. Depending on what county you live in, you may be able to receive such information in Spanish, Chinese, Tagalog, and Navajo.

APPEAL AND CLAIM PROCEDURES – LIFE INSURANCE

The Insurance Company has 90 days from the date it receives a claim for any Life Insurance benefit, to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. If this should happen, the Insurance Company must provide notice in writing that its review period has been extended for an additional 90 days.

If this extension is made because additional information must be furnished, these extension periods will begin when the additional information is received. The requested information must be furnished within 90 days.

During the review period, the Insurance Company may require:

(i) a medical examination of the Insured, at its own expense; or
(ii) additional information regarding the claim.

If a medical examination is required for, the Insurance Company will notify the Insured of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit.

If the claim is denied, in whole or in part, the Insurance Company will provide written notice within the review period. The Insurance Company's written notice will include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for the claim to be reconsidered, and the reason this information is necessary.
4. A statement regarding the right to appeal the decision, and an explanation of the appeal procedure, including a statement of the right to bring a civil action under Section 502(a) of ERISA if the appeal is denied.

Appeal Procedure for Denied Claims for Life Insurance

Whenever a claim is denied, there is the right to appeal the decision. A written request for

appeal must be made to the Insurance Company within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.

Special Rule During COVID-19 Emergency

Certain deadlines under the Plan's existing claim and appeal rules will be modified to comply with Department of Labor and Internal Revenue Service guidance on the COVID-19 pandemic.

Specifically, if an event that gives rise to certain claim or appeal deadlines occurs prior to July 10, 2023, the applicable claim or appeal deadline will not begin to run until July 10, 2023.
If the event that gives rise to certain claim or appeal deadlines occurs on or after July 10, 2023, the normal claim or appeal deadline will apply.

1. the date within which you may file a benefit claim under the Plan's claims and appeals procedures described above;
2. the date within which you may file an appeal of an adverse benefit determination under the Plan's claims and appeals procedures described above;
3. the date within which you may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination;
4. and the date within which you may file information to perfect a request for external rule upon a finding that the request was not complete.

QUICK REFERENCE CHART

Information		
Plan Name and Number	PetSmart LLC Smart Choices Plan (501) PetSmart LLC Flexible Benefits Plan (601)	
Plan Sponsor's name, address, and phone number:	PetSmart LLC 19601 North 27th Avenue Phoenix, AZ 85027 1-623-580-6100	
Plan sponsor's federal IRS Employer Identification Number:	94-3024325	
Plan Type:	Welfare Benefit Plans providing medical, dental, vision, life, accidental death and dismemberment and disability benefits.	
Plan Year:	January 1 through December 31	
Plan Administrator's name, business address, zip code and business telephone number:	PetSmart LLC 19601 North 27th Avenue Phoenix, AZ 85027 1-623-580-6100	
The name, address and zip code of the person designated as agent for the service of legal process is:	PetSmart LLC SVP, Human Resources 19601 North 27th Avenue Phoenix, AZ 85027 1-623-580-6100	
The Plan is funded with:	The general assets of the Company and contributions by Associates and various insurance policies where noted below	
PPO, HDHP & Out of Network Medical Medical Claims Processor	Group # 701439 UnitedHealthcare	1-866-501-3061
Behavioral Health Services	United Behavioral Health	1-866-501-3061
Surest HealthPlan Medical Claims Processor	Group #78800214 Surest Benefits Inc.	1-833-997-1084
Employee Assistance Program	OptumHealth Behavioral Services	1-800-788-5614
Prescription Drug Plan	CVS Caremark	1-855-821-0355
Dental Plan I & II & DHMO Eligibility, benefits, pre-certification and dental review	CIGNA Companies	1-800-244-6224

QUICK REFERENCE CHART
cont'd

Vision	Insured Group #12140632 Vision Service Plan (VSP)	1-800-877-7195
Short Term Disability	Insured Policy# LK-980200 New York Life	1-855-709-6395
Long Term Disability	Insured Policy # LK980201 New York Life	1-855-709-6395
Life Insurance	Insured Policy # FLX980272 New York Life	1-215-761-1000
Accidental Death & Dismemberment	Insured Policy # OK980292 New York Life	1-215-761-1000
FSA & HRA Claims Processor	UnitedHealthcare	1-866-501-3061
Heath Savings Account	Optum Bank	1-866-234-8913

GLOSSARY OF DEFINED TERMS

The following words and phrases utilized in the Summary Plan Description with the initial letter capitalized have the meanings set forth in the Glossary, unless a clearly different meaning is required by the context in which the word or phrase is used:

"Accident" means an unforeseen and unavoidable event resulting in an Injury which is not due to the fault of the Covered Person.

"Administrator" means the Company, which is responsible for the day-to-day functions and management of the Plan. The Company may choose, in its sole discretion, to delegate to any person or entity responsibility for any aspect of the administration of the Plan.

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

- surgical services;
- Emergency health services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.
- An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

"Ambulatory Surgical Facility" means a public or private facility, licensed and operated according to applicable law, which does not provide services for a patient to stay overnight and which admits and discharges patients from the facility in the same day. The facility must have an organized medical staff of Physicians, maintain permanent facilities equipped and operated primarily for the purpose of performing ambulatory surgical procedures and supply registered professional nursing services whenever a patient is in the facility. The facility may be free-standing or hospital- based.

"**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)" means the amount you must pay for Covered Health Services in a calendar year before the Medical Plan and Dental Plan, as applicable, will begin paying Benefits in that calendar year. The Deductibles are shown in the applicable schedule of benefits.

"Associate" means a person employed as a common law employee by an adopting Employer.

"Annual Maximum Benefit" means the maximum amount the Medical Plan and Dental Plan, as applicable, will pay for certain Benefits during the calendar year. See the Schedule of Medical Benefits and the Schedule of Dental Benefits for any Annual Maximum Benefit amounts.

"**Approved 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.

"Assisted Reproductive Technology (ART)" – the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples include, but are not limited to procedures such as:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT)

"Autism Spectrum Disorders" a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

"Bariatric Resource Services (BRS)" – A program administered by the Claims Administrator or its affiliates made available to you by PetSmart LLC. The BRS program provides:

- Specialized 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

"Benefits" means Plan payments for Covered Health Services, subject to the terms and conditions of the Plan.

"Birthing Center" means a public or private facility, other than private offices or clinics of Physicians, which meets the free-standing birthing center requirements of the State Department of Health in the state where the Covered Person receives the services. The birthing center must:

- Provide a facility established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a child born at the center;
- Provide supervision by at least one specialist in obstetrics and gynecology;
- Provide a Physician or certified nurse midwife at all births and during the immediate postpartum period;

- Provide extended staff privileges to Physicians who practice obstetrics and gynecology in an area Hospital;
- Contain at least two beds or two birthing rooms;
- Provide full-time nursing services directed by an R.N. or certified nurse midwife;
- Include arrangements for diagnostic x-ray and lab services;
- Have the capacity to administer local anesthetic or to perform minor Surgery;
- Accept only patients with low-risk pregnancies;
- Have a written agreement with a Hospital for Emergency transfers; and
- Maintain medical records on each patient and child.

"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 appozimate body fat.

"Care Coordination℠" means programs provided by UnitedHealthcare 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.

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

"Chiropractor" - means an individual who is properly licensed and has a degree of Doctor in Chiropractic (D.C.).

"Claims Administrator" means the Administrator or any individual(s) and/or entity(ies) designated by the Administrator to review and process, in accordance with "Claims Procedures" and "Appeals Procedures," the initial determination of claims with respect to one or more benefits offered under the Plan.

"Claims Reviewer" means the Administrator or any individual(s) and/or entity(ies) designated by the Administrator to review, in accordance with "Claims Procedures" and "Appeals Procedures," claims that are denied by the Claims Processor with respect to one or more benefits offered under the Plan. The Claims Reviewer must be a named fiduciary and cannot be the individual (or a subordinate thereof) who made the initial determination with respect to the claim being reviewed by the Claims Reviewer.

"Coinsurance" the charge stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in the applicable schedule of benefits.

"Company" means PetSmart LLC

"Congenital Anomaly" means a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

"Congenital Heart Disease (CHD)" is any structural heart problem or abnormality that

has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

"Consolidated Omnibus Budget Reconciliation Act of 1985" or COBRA" is 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.

"Copayment" or **"Copay"** means the charge, stated as a set dollar amount, that you are required to pay for certain covered services and supplies under the Medical (including the Prescription Drug Program), Dental and Vision Plans. 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.

"Corrective Appliances" mean items which are prosthetic (*i.e.*, used to replace all or part of a natural body organ or function thereof) or orthotic (*i.e.*, used to support a weakened body part or to correct a body part) and necessary for the restoration of function or replacement of a body part.

"Cosmetic Procedures" are procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Processor. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

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

"Covered Associate" means an Associate who is enrolled in one or more coverages offered under the Plan. An individual shall be considered a Covered Associate only with respect to those coverages for which he/she is enrolled.

"Covered Dependent" means an Eligible Dependent who is enrolled by a Covered Associate in one of more coverages offered under the Plan by a Covered Associate. An individual shall be considered a Covered Dependent only with respect to those coverages for which he/she is enrolled.

"**Covered Health Services**" are those health services, including services, supplies or Pharmaceutical Products, which the Company determines to be:

- Medically Necessary
- Described as a Covered Health Service in this SPD including in the applicable schedule of benefits;
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility and Participation;
- Not otherwise excluded in this SPD under Limits and Exclusions.

"Covered Person" means a Covered Associate, Covered Dependent, or a Qualified Beneficiary who is enrolled in one or more coverages offered under the Plan. An individual shall be considered a Covered Person only with respect to those coverages for which he/she is enrolled.

"Custodial Care" refers to services that do not require special skills or training and that:

- non-health related services, such as provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating);
- health-related services that are provided for the primary purpose of meeting the personal needs of the patient of maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

"Dentist" means an individual acting within the scope of his/her license, holding the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.D.M.), who is legally entitled to practice dentistry under the laws of the state or jurisdiction where the services are rendered. Services and treatment performed by a Dentist include those performed by a dental hygienist or other trained person performing services under the direction of the Dentist.

"Designated Network Benefits" – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that is identified as Designated Network providers. Refer to *Schedule of Benefits Appendix A or B*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

"Designated Provider" - a provider and/or facility that:

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

The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

"Designated Virtual Network Provider" means a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on Claims Administrator's behalf, to deliver Covered Health Services through live video technology or

audio only.

"Disability Claim" has the same meaning as set forth in "Appeals Procedures."

"Domestic Partner" See "Who Qualifies as a "Domestic Partner" for Purposes of the Plan?

"Domestic Partnership" a relationship between an Associate and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside disposable;
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.

"Domiciliary Care" refers to 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)" is medical equipment that is all of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes with respect to treatment of a Sickness, Injury or their symptoms;
- 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;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

"Elective Hospital Admission" means any non-emergency Hospital admission that may be scheduled at the Covered Person's convenience without jeopardizing the Covered Person's life or causing serious impairment of bodily function.

"Elective Surgical Procedure" means any non-emergency surgical procedure that may be scheduled at the Covered Person's convenience without jeopardizing the Covered Person's life or causing serious impairment of bodily function.

"Eligible Child" See "Who Qualifies as "Eligible Children" for Purposes of the Plan?" for the definition of "Eligible Child."

"Eligible Dependent" See "Who Are My Eligible Dependents?" for the definition of "Eligible Dependent."

"Eligible Expenses" for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, How the Plan Works.

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

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

"Emergency" means 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" means, 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.

"Employer" means the Company and the entities listed on Schedule A attached to the official plan, which may be amended by the Company from time to time. If you want to know if your employer is on Schedule A, please call the Benefits Department.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended. ERISA is the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

"Experimental and Investigational Services" are medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing clinical trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Clinical Trials for which Benefits are available as described under Clinical Trials

section. Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section
- If you are not a participant in a qualifying Clinical Trial as described under the Clinical Trials section.and 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 it's 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)" is a statement provided by UnitedHealthcare or another insurer or Third-Party Administrator to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other adjustments taken;
- the net amount paid by the Plan; and
- the reason(s) why the Plan did not pay for a service.

"Fertility Solutions (FS)" refers to a program administered by UnitedHealthcare or its affiliates made available to you by the company. The FS program provides**:**

- Specialized clinical consulting services to Associates and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

"Flex Plan" means the PetSmart Flexible Benefits Plan.

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

"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.

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

"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 Savings Account" is a tax-advantaged account that you can use to pay for any qualified health expenses incurred by yourself or your eligible dependents, while covered under a high deductible medical plan. HSA contributions accumulate over time with interest or investment earnings, are portable after employment, and can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis (and subject to 20% penalty).

"Health Statement(s)" is a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

"HDHP" means the high-deductible health plan medical option.

"High Deductible Health Plan" is a medical plan that has a higher deductible and a lower premium than a traditional medical plan.

"Home Health Care" means part-time, intermitted Skilled Nursing Care, services, and supplies provided by a licensed Home Health Care Agency, which is not considered Custodial Care as defined in this section.

"Home Health Care Agency" means a program or organization authorized by law to provide health care services in the home which:

- Is primarily engaged in providing Skilled Nursing Care and other therapeutic services under the supervision of Physicians or registered nurses;
- Is operated according to policies that are established by a group of professional personnel associated with the agency (including one or more Physicians and one or more registered nurses);
- Maintains clinical records on all patients; and
- Is licensed by the jurisdiction where it is located, if licensure is required, and is run according to the laws of that jurisdiction which pertain to agencies providing Home Health Care.

"Hospice" means a facility or organization licensed and operated according to applicable law, which administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less.

"Hospital" means a public or private facility, licensed and operated according to

applicable law, which provides care and treatment by Physicians and Nurses on a 24-hour basis for an Illness or Injury through the medical, surgical, and diagnostic facilities on its premises. "Hospital" includes a mental, nervous, or Substance-Related and Addictive Disorders treatment facility that is licensed and operated according to applicable law. The term "Hospital" does not include a facility or any part thereof which is a residential treatment facility or a place for rest, the aged, or convalescent care, such as rest homes, nursing homes, convalescent homes, homes for the aged, or facilities primarily affording custodial, educational, or rehabilitative care.

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

"HRA" means health reimbursement account.

"HRA Benefit Dollars" means the amount the Company allocates for you annually depending on your coverage category. See the table in the *Medical Benefits Section*, under *Health Reimbursement Account* for coverage categories.

"HSA" means a health savings account.

"Iatrogenic Infertility" an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes

"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.

"Illness" means any bodily sickness or disease or congenital abnormalities of a newborn child who is covered under the Plan, as diagnosed by a Physician and as compared to a person's previous condition. For purposes of determining benefits payable, "Illness" includes pregnancy of a Covered Associate or a Covered Dependent who is the Spouse of a Covered Associate.

"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.

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

"Inpatient" means treatment in an approved and licensed facility during the period when charges are made for room and board.

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

"Intensive Behavioral Therapy (IBT)" is 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 Treatment" 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.

"Intermediate Care" means Mental Health or Substance-Related and Addictive Disorder treatment that encompasses the following:

- care at a Residential Treatment Facility;
- care at a Partial Hospitalization/Day Treatment program; or
- care through an Intensive Outpatient Treatment Program.

"Intermittent Care" means skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.
- Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

"Limited-Purpose FSA" is a flexible spending account that reimburses only for services or treatments for dental care (excluding premiums) and services or treatments for vision care (excluding premiums).

"Manipulative Treatment" means 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" is 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"** refers to healthcare services that are all of the following as determined by the Claims Administrator's or its designees, 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, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms;

- not mainly for your convenience or that of your doctor or other health care provider;
- not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

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

The Claim 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 Claim Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling 1-866-501-3061, and to Physicians and other health care professionals on www.UHCprovider.com.

"Medicare" means the programs (including Parts A, B, C and D) established by Title XVIII of the United States Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

"Mental Health Services" Services for the diagnosis and treatment of those mental or psychiatric categories that are listed in the current edition of the *International Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of 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 American Psychiatric Associations* does not mean that treatment for the condition is a Covered Health Service.

"Mental Health/Substance-Related and Addictive Disorder Services Administrator" is the organization or individual designated by PetSmart who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

"Mental Illness" represents those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Disease section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of 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 American Psychiatric Associations* 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 UnitedHealthcare or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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" is a description of how Benefits are paid for Covered Health Services provided by Network providers.

"Non-Medical 24-Hour Withdrawal Management" An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

"Non-Network Benefits" is a description of how Benefits are paid for Covered Health Services provided by non-Network providers.

"Network Provider" is a health care Provider who has:

- entered into an agreement with the Administrator or an affiliate; and
- agreed to accept specified reimbursement rates for Covered Health Services.

"Nondurable Supplies" mean supplies that cannot stand repeated use and/or are considered disposable and limited to a one-person or one-time use, such as incontinence pads, soap, or diapers.

"Nurse" means a person acting within the scope of his/her license and holding a degree/licensure of Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), a Licensed Practical Nurse (L.P.N.), or a Certified Nurse Practitioner (C.N.P.). "Nurse" includes a certified nurse midwife who is performing obstetrical procedures within the scope of his/her license.

"Obesity Surgery" Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

You have enrolled in the Bariatric Resource Services (BRS) program.

- You are enrolled in the Bariatric Resourse Servcices (BRS) program.

- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.

You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.

"Orthotics" are devices that straighten or change the shape of a body part, including but not limited to cranial banding and some types of braces.

"Outpatient" means treatment either outside of a Hospital setting or at a Hospital when room and board charges are not incurred.

"Out-of-Pocket Maximum" is the maximum amount you pay out-of-pocket every calendar year including the amount you pay toward the Annual Deductible (if applicable) as shown in the Schedule of Medical Benefits and the summary of the Prescription Drug Program. Expenses used to satisfy the Network Out-of-Pocket Maximum under the Medical Plan may also be used to satisfy the Non-Network Out-of-Pocket Maximum and expenses used to satisfy the Non-Network Out-of- Pocket may also be applied to satisfy the Network Out-of-Pocket under the Medical Plan.

Once you have reached the Out-of-Pocket Maximums, the Plan pays Benefits at 100% of Eligible Expenses for claims incurred during the remainder of that calendar year. The following table identifies what does and does not apply toward your network and non-network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out- of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Member Responsibility phase of Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No
Charges for non-medical emergencies	No	No

"Partial Hospitalization/Day Treatment" a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

"Personal Health Support" are 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" is the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

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

"Physician" means a person acting within the scope of his/her license who is legally entitled to practice medicine under the laws of the state or jurisdiction in which the services are provided and who holds the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatry (D.P.M.). Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Plan.

The term "Physician" does not include the Covered Person or his/her Covered Dependents or any person who is the Spouse, Same-Sex Domestic Partner, parent, child, brother, or sister of such Covered Person or his/her Covered Dependents.

"Placed for Adoption" means the assumption and retention by an individual of a legal obligation for total or partial support of the child in anticipation of adoption.

"Plan Administrator" means PetSmart LLC

"Plan" means either the Smart Choices Plan or the Flex Plan.

"Plans" means, collectively, the SmartChoices Plan and the Flex Plan.

"Plan Year" means the fiscal year of the Plan commencing each January 1 and ending the following December 31.

"Post-Service Claim" has the same meaning as set forth in "Appeals Procedure." If a Post- Service Claim is also an Urgent Care Claim, it must be processed as an Urgent Care Claim and not as a Post-Service Claim.

"PPO" means preferred provider organization.

"Pregnancy" includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

"Preimplantation Genetic Testing (PGT)"- A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

"Pre-Service Claim" has the same meaning as set forth in "Appeals Procedure." If a Pre-Service Claim is also an Urgent Care Claim, it must be processed as an Urgent Care Claim and not as a Pre-Service Claim.

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

"Primary Care Physician" a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance-Related and Addictive Disorders Services, any licensed clinician is considered on the same basis as a Primary Care Physician for the provision of all services other than psychological testing.

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

- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

"Provider" is a health care professional or facility operating as required by law.

"Qualified Beneficiary" See "Which Qualifying Events Will Cause an Associate to be a Qualified Beneficiary?", "Which Qualifying Events Will Cause an Associate's Spouse to be a Qualified Beneficiary?", and "Which Qualifying Events Will Cause an Associate's Eligible Children to be a Qualified Beneficiary?" for the definition of "Qualified Beneficiary."

"Qualifying Event" See "Which Qualifying Events Will Cause an Associate to be a Qualified Beneficiary?", "Which Qualifying Events Will Cause an Associate's Spouse to be a Qualified Beneficiary?", and "Which Qualifying Events Will Cause an Associate's Eligible Children to be a Qualified Beneficiary?" for the definition of "Qualifying Event."

"Reconstructive Procedure" is 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.

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 and as otherwise required to comply with the Women's Health and Cancer Rights Act of 1998. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

"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 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 either:

1) An *All Payer Model Agreement* if adopted, or
2) 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.

"Rehabilitation" means therapy services (physical, speech, or occupational therapy) providing significant measurable improvement of an individual who is restricted and unable to perform normal body function as a result of Illness, Injury, or Surgery, requiring the skills of a professionally licensed therapist working under the direction of a qualified M.D. or D.O. (when required by state law). Active rehabilitation refers to an individual who readily participates in

therapy services toward specific functional goals. Maintenance rehabilitation refers to therapy rendered after a patient has met functional goals and no continued improvement is anticipated, but additional therapy of a less intense nature and decreased frequency is reasonable to maintain, support, and/or preserve the patient's functional level.

"Relevant Information": Information is "relevant" if it was relied upon in deciding the claim, was submitted, considered or generated in the course of deciding the claim (even if not relied upon in deciding the claim), or demonstrates compliance with administrative procedures or safeguards that were required in deciding the claim. For a Post-Service Claim, a Pre-Service Claim, an Urgent Care Claim, or a Disability Claim, information also will be considered "relevant" if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis (even if not relied upon in deciding the claim).

"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 treatment plan related to a chronic and/or acute health illness or condition. The treatment plan 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" is treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- it is established and operated in accordance with applicable state law for Residential Treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator;
- Offers organized treatment services that feature a planned and structured regime of care in a 24 setting and provides as least the basic services:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

"**Routine Patient Care**" means Covered Health Services that would otherwise be covered under the Medical Plan for a Participant not enrolled in a clinical trial. However, Routine Patient Care does not include:

- the investigational item, device or service itself;
- items and services not included in the direct clinical management of the Participant, but instead provided in connection with data collection and analysis;

- service inconsistent with widely accepted and established standards of care for the particular diagnosis; and
- services related to an Approved Clinical Trial received outside of the United States.

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

"Shared Savings Program" a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by UnitedHealthcare, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

"Sickness" means physical illness, disease or Pregnancy. The term Sickness as used in this Summary Plan Description does not include Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

"Skilled Nursing Care" means skilled care, teaching, and rehabilitation services, performed or supervised by licensed technical or professional medical personnel that:

- Are ordered and provided under the direction of a Physician;
- Are intermittent and part-time (i.e., nursing service duration not to exceed 16 hours per day, typically on less than a daily basis); and
- Require the skills of licensed technical or professional medical personnel (e.g., R.N. or L.P.N) in that the service is so inherently complex that it can be safely and efficiently performed only by or under the supervision of this licensed technical/professional medical individual.
- They are not Custodial Care, as defined in this section. Such services include, but are not limited to, initiation of intravenous therapy and initial management of medical gases (*e.g.*, oxygen).

"Skilled Nursing Facility" means a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

"**SmartChoices Plan"** means the PetSmart SmartChoices Benefit Plan.

"Specialist" a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Mental Health Services and Substance-Related and Addictive Disorder Services, any licensed clinician is considered on the same basis as a Specialist. For Mental Health Services and Mental Health Services and Substance-Related and Addictive Disorder Services, a licensed clinician who provides psychological testing is considered on the same basis as a Specialist.

"Specialty Care Unit" means a section, ward, or wing within a Hospital (*e.g.*, an intensive care unit or cardiac care unit) that offers specialized care for a patient's needs and typically provides constant observation, special supplies or equipment, and/or care by registered nurses or highly trained professionals.

"Specialist Management Solutions (SMS)" is a program available at no cost to Members where advocates help Members schedule consults with a provider, connect Members with other benefit programs, and serve as the single point of contact for Members throughout their health care journey. Specialists in the SMS alliance use ambulatory surgery centers (ASC), which means employees may receive surgical care and other procedures in an outpatient setting which may result in cost savings. Specialities include: Cardiovascular, Ear Nose and Throat "ENT", Gastrointestinal, GeneralSurgery, MSK/Spine, Ophthalmology, Orthopedic, Pain Management, Podiatry, Urology, Women's Health.

"Spinal Manipulation" means the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

"Spouse" See "Who Qualifies as a "Spouse" for Purposes of the Plan?" for the definition of "Spouse."

"Substance-Related and Addictive Disorder 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 the American Psychiatric Association*. The fact that a disorder is listed in the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

"Surgery" means any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

"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. A e surrogate provides the egg and therefore the surrogate is biologically (genetically) related to the child.

"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.

"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 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.

"Unproven Services" are health services, including medications and devices regardless of the U.S. Food and Drug Administration (FDA) approval, that, , are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from:

- well-conducted randomized controlled trials; or
- well-conducted cohort studies in the prevailing published peer-reviewed medical literature.

Well-conducted randomized controlled trial. Two or more treatments are compared to each other, and the patient ise not allowed to choose which treatments they receive.

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.

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

If you have a life-threatening Sickness or condition that is likely to cause death within one year of the request for treatment, The Claims Administrator may, at it's discretion, consider an

otherwise Unproven Service is a Covered Health Service for that Sickness or condition. Prior to such consideration, The Claims Administrator must first establish that there is sufficient evidence to conclude that, eventhough unproven, the service has significant potential as an effective treatment for that Sickness or condition.,

UnitedHealthcare and PetSmart may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life- threatening. For this to take place, all of the following conditions must be met:

- If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved. It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and PetSmart do not believe that sufficient clinical evidence has been published in peer- reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and PetSmart to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.
- The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's and PetSmart'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

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

"Urgent Care Claim" has the same meaning as set forth in "Appeals Procedure." The determination as to whether a claim is an Urgent Care Claim must be made by an individual acting on the Plan's behalf and applying the judgment of a prudent layperson who possesses average knowledge of health and medicine; provided, however that any claim that is determined by a Physician with knowledge of the Claimant's medical condition to be an Urgent Care Claim shall be processed as an Urgent Care Claim.

"Visit" means a personal interview between Covered Person and a Physician, Dentist, Chiropractor, or other person providing services under the direction and supervision of any of the foregoing.

"Well Child Care" means charges made by a Physician for care of a healthy newborn or dependent child under age 18, and not as a result of Illness, Accident, or Injury or in connection with a specific diagnosis of Illness or Injury.

FORMS AND NOTICES

The following notices are attached to this summary.

1. HIPAA Notice of Privacy Practices
2. Medicare Part D Notice
3. Initial Notice of COBRA Rights
4. Women's Health and Cancer Rights Act of 1998
5. Statement of Rights under Newborn's and Mother's Health Protection Act

If you are viewing this online, the notices are also located in the Quick Links section at benefits.petsmart.com.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective September 23, 2013

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Overview

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the PetSmart LLC SmartChoices Benefit Plan, the PetSmart LLC Flexible Benefits Plan (collectively, "Plan") are required to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI") and to inform you about:

- the Plan's uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and/or with the Secretary of the Office of Civil Rights of the U. S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) is information (including genetic information) in any form (oral, written, or electronic) that is created or received by or on behalf of the Plan that relates to your past, present, or future physical or mental health condition, or the provision of health care services to you, or payment for those health care services and that identifies you or from which there is a reasonable basis to believe the information could be used to identify you.

Health information your employer receives during the course of performing non-health plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI. Similarly, health information you submit to your employer to show that you are eligible for disability leave is not PHI.

Section 1. Notice Of PHI Uses And Disclosures

Under HIPAA, a Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Some uses and disclosures fall within the categories described below. Note that every permissible use or disclosure in a category is listed; however, all the ways in which a Plan is permitted to use or disclose PHI will fall within one of the categories:

Required Disclosures*:* Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Disclosure of your PHI may be required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations. A Plan may also disclose your PHI when required to do so under federal, state or local law.

Disclosures to Plan Sponsor*:* The Plan also may disclose PHI to certain employees of the Plan Sponsor (PetSmart, LLC.) to enable the Plan Sponsor to carry our certain administrative functions on behalf of the Plan. PetSmart's employees will only use or disclose such information as necessary to perform administration functions on behalf of the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. A Plan may disclose any enrollment and disenrollment information it holds to PetSmart. For example, a Plan may tell PetSmart if an individual has dropped from coverage due to fraud or similar improprieties. A Plan may also share summary health information with PetSmart for certain limited purposes. However, the Plans will not disclose your protected health information for any employment purpose or for any other employee benefit plan purpose without your specific authorization.

Disclosures to Business Associates: A Plan may contract with individuals or entities known as Business Associates to perform various functions on behalf of the Plan or to provide certain types of services. In order to perform these

functions or to provide these services, the Business Associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing to implement appropriate safeguards regarding such PHI. For example, a Plan may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation.

Treatment: A Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment: A Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes but is not limited billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health Care Operations: A Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan. Health Care Operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your PHI to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

Public Health Activities: A Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health or Safety: A Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Health Oversight: A Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings: If you are involved in a lawsuit or similar proceeding, a Plan may disclose your PHI in response to a court or administrative order. A Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor or disclosure by the court or tribunal.

Law Enforcement: A Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person. . If you are an inmate of a correctional institution or are in the custody of law-enforcement officials, we may disclose your PHI to the

correctional institution or a law-enforcement official, if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Coroners, Medical Examiners and Funeral Directors*:* A Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Research: A Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Organ and Tissue Donations: If you are an organ donor, a Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation: A Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence: A Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans: If you are a member of the armed forces, a Plan may disclose your PHI as required by military command authorities**.** A Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Disclosures to Family Members and Personal Representatives: A Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent:

- the information is directly relevant to such individual's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

A Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents.

However, the Plan is not required to disclose information to a personal representative if it has a reasonable belief that (i) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or (ii) treating such person as your personal representative could endanger you; and (iii) in the exercise of professional judgment, it is not in your best interest to treat such individual as your personal representative.

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested restrictions or confidential communications, and if we have agreed to the request, we will send mail as provided by the request.

Uses And Disclosures That Require Your Written Authorization: Other uses or disclosures of your PHI not described above or permitted by applicable law will only be made with your written authorization. Any authorization you provide to a Plan regarding the use and/or disclosure of your PHI may be revoked at any time by providing written notice to the Privacy Officer. Revocation of your authorization will be effective only for future uses and disclosures. It will not have any effect on PHI that may have been used or disclosed in reliance of your authorization and prior to receiving your written revocation.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about

you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

In addition, a Plan cannot (i) engage in the sale of your PHI; (ii) use or disclose your PHI for marketing purposes or (iii) otherwise receive direct or indirect remuneration for the use or disclose of your PHI without your written authorization.

Section 2. Rights of Individuals

Right to Request Confidential Communications: You have the right to request that a Plan communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that a Plan contact you at home, rather than work.
The Plan will accommodate reasonable requests if disclosure of all or part of your protected health information could endanger you.

In order to request a type of confidential communication, you must submit your request in writing to the following Privacy Officer: Director of Benefits, at 19601 N. 27th Avenue, Phoenix, AZ 85027, 1-800-738-1385.

Right To Request Restrictions On PHI Uses And Disclosures: You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your case.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following Privacy Officer: Director of Benefits, at 19601 N. 27th Avenue, Phoenix, AZ 85027, 1-800-738-1385.

If the Plan does agree to the request, it will adhere to the restriction until you agree to or request termination of the restriction or limitation or the Plan notifies you that it no longer agrees to the restriction or limitation. However, if you are in need of emergency medical treatment and the restricted information is needed to provide the emergency treatment, a Plan may disclose the restricted information to a provider so that you can obtain the necessary treatment.

Right To Inspect And Copy PHI: Subject to certain exceptions, you have a right to inspect and obtain a copy of your PHI contained in a "designated record set," that may be used to make decisions about your health care benefits for as long as the Plan maintains the PHI.

Designated Record Set includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days: however, a single 30-day extension is allowed if the Plan is unable to comply with the deadline. The information will be provided in the form and format you request, if it is readily producible in such form or format, or if not, in such other form or format agreed upon by you and the Plan.
Otherwise, the requested information will be provided to you in a readable hard copy form.

The Plan may charge you a reasonable fee for the costs of copying (supplies and/or labor), mailing and summarizing the information (if you have requested or consented to a summary) associated with your request; however, if the information is provided to you electronically, the fee will not exceed the actual labor costs.

If your PHI is in a designated record set maintained by a Business Associate, you may be referred directly to the

Business Associate.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following Privacy Officer: Director of Benefits, at 19601 N. 27th Avenue, Phoenix, AZ 85027, 1-800-738-1385.
In certain limited circumstances, the Plan may deny your request. In some cases, you have a right to have the denial reviewed by a licensed health care professional. If applicable, the procedures to exercise any such right will be described in the denial.

Right To Amend PHI: You have the right to request the Plan to amend your PHI or a record about you in a designated record set that you believe is incomplete or incorrect for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. The Plan may deny your request if the information: (i) is not part of the medical information kept by or for the Plan; (ii) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (iii) is not part of the PHI available to you for access under HIPAA; or (iv) the Plan determines that the information is complete and correct. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the following Privacy Officer: Director of Benefits.

The Right To Receive An Accounting Of PHI Disclosures: At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (three years in the case of disclosures from any electronic health records) prior to the date of your request. An accounting is not required to include PHI disclosures made: (1) to carry out treatment, payment or health care operations (unless the disclosure is made from an electronic health record) ; (2) to you or pursuant to your authorization; (3) to family, friends or other persons involved in your care; (4) for national security or intelligence purposes; (5) incidental to otherwise permissible disclosures; (6) as part of a limited data set; and (6) prior to the compliance date (April 14, 2003).

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. However, the Plan will notify you of the cost and provide you with an opportunity to withdraw or modify your request before any costs are incurred.

The Right to Be Notified of a Breach: You have the right to be notified in the event the Plan discovers a breach of involving your unsecured PHI.

The Right To Receive A Paper Copy Of This Notice Upon Request: To obtain a paper copy of this Notice, contact the following Privacy Officer: Director of Benefits. You are entitled to a paper copy of the Notice even if you agreed to receive this Notice electronically.

A Note About Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those

vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

Any revised version of this Notice will be distributed (by mail, electronically, or by other permitted method) within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard: When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:
- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to you;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bides or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. However, the Plan may not use any genetic information for underwriting purposes.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following Privacy Officer: Director of Benefits, at 19601 N. 27th Avenue, Phoenix, AZ 85027, 1-800-738-1385. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following Privacy Officer: Director of Benefits, at 19601 N. 27th Avenue, Phoenix, AZ 85027, 1-800-738-1385 or by email benefits@petsmart.com.

IMPORTANT NOTICE FROM PETSMART ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

This is a federally required notice for all individuals who are eligible for Medicare Part D. If you are not currently eligible for Medicare, you may disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PetSmart and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage including which drugs are covered at what cost, within the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage first became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- PetSmart has determined that the prescription drug coverage offered under the PetSmart SmartChoices Benefits Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage (i.e., coverage that is at least as good as Medicare prescription drug coverage). Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join Medicare.

When Can You Join a Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you join a Medicare drug plan, you can either keep your existing PetSmart coverage or drop such coverage. Note, however, that prescription drug coverage under the PetSmart SmartChoices Benefits Plan is available only as part of your medical coverage – that is, if you elect medical coverage, you automatically receive prescription drug coverage, and if you don't elect medical coverage, you cannot separately elect prescription drug coverage.

If you decide to continue your prescription drug coverage under the PetSmart SmartChoices Benefits Plan and simultaneously join a Medicare drug plan, your coverage under the Medicare drug plan will be coordinated with your prescription drug coverage under the PetSmart SmartChoices Benefits Plan. Note, however, that you will likely have to pay the cost of both coverages.

Before doing anything, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Please contact us for more information about what happens to your existing coverage if you join a Medicare drug plan.

When Will You Have to Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PetSmart and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may have to pay a higher premium (i.e., a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the PetSmart Benefits Team at 1-866-263-8411 or email us at benefits@petsmart.com. NOTE: You will receive this notice annually and also before the next period during which you can join a Medicare drug plan, and if this coverage through PetSmart changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show that whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 1, 2022

Name of Entity/Sender: PetSmart, Inc.

Contact – Position/Office: Director of Benefits and Offerings

Address: 19601 N. 27th Ave., Phoenix, AZ 85027

INITIAL NOTICE OF COBRA RIGHTS

This notice is being made available to you because you are eligible under the PetSmart LLC SmartChoices Benefit Plan.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law; the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family who are covered under the Plan when you would otherwise lose your coverage under the PetSmart LLC SmartChoices Benefit Plan. For more information about your rights and obligations under the Plan and under federal law, you should read the COBRA section of this Summary Plan Description (SPD) or contact the PetSmart Benefits Department.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about many of these options at **www.healthcare.gov.**

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, your domestic partner and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both.
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Continuation Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.
The employer must notify the Plan Administrator of the following qualifying events;

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse of a dependent child's losing eligibility for coverage as a dependent child), you must notify the PetSmart Benefits Department within 60 days after the qualifying event occurs. You must send this notification and supporting documentation in writing, to the PetSmart Benefits Department.

How is COBRA Continuation Coverage Provided?
Once the PetSmart Benefits Department receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Extension of Continuation Coverage:
There are two ways in which the 18-month period of COBRA continuation coverage can be extended;

Disability: If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination
- The date of the covered employee's termination of employment or reduction of hours and;
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered associate's termination of employment or reduction of hours.

Second Qualifying Event: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18

additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or gets divorced or legally separated, employee's becoming entitled to Medicare benefits (under Part A, Part B, or both) or if the dependent child stops being eligible under the Plan as a dependent child, This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under The Plan had the first qualifying event not occurred

The COBRA coverage periods described above are the maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's summary plan description.

Questions
If you have any questions concerning your COBRA continuation coverage you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.

The COBRA Administrator who is responsible for administering COBRA continuation coverage for the PetSmart LLC SmartChoices Benefit Plan is:

WageWorks Inc., a HealthEquity Company
PO Box 226101 Dallas TX 75222-6101 (877)722-2667
mybenefits.wageworks.com

SPECIAL RIGHTS FOLLOWING MASTECTOMY

The Women's Health and Cancer Rights Act of 1998 (WCRA) requires that a group health plan provides Benefits under the Plan to participants who have undergone mastectomies covered by the Plan.

The Plan must offer mastectomy benefits for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery/reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomies, including lymph edemas.

The Medical Plan complies with the above requirements. The extent to which any of the above services are appropriate following a mastectomy is a matter to be determined by consultation between you and your Physician. The Medical Plan does not deny eligibility, or continued eligibility to enroll or to renew coverage, under the terms of the Plan solely for the purpose of avoiding the requirements of the WCRA; nor does the Medical Plan penalize or otherwise reduce or limit reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with the WCRA. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

MOTHER'S AND NEWBORN'S RIGHTS

Group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law does not prohibit the mother's or the newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). Any length of stay in excess of these periods may be subject to continued stay review.

Schedule of Medical Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section *Additional Coverage Details*.

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 the *Glossary* section.

Appendix A: Schedule of Medical Benefits PPO Plans & Out of Network Plan

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
Health Reimbursement Account (HRA)	• Company allocated benefit dollars to be used for covered health care expenses including medical copays, coinsurance and annual deductibles, along with prescription drug expenses (retail and mail order). • Unused benefit dollars at the end of the Plan Year roll over to the next year. • If your employment terminates for any reason, your HRA benefit dollars will be forfeited and the benefit dollars in your HRA will revert back to the Company. • HRA benefit dollars will be used first (with the exception of FSA dollars if you elect the health care Flexible Spending Account) to pay for eligible expenses, up to the HRA amount. Once the HRA dollars are used, you are responsible for any remaining expenses up to the deductible and out-of-pocket limits. • If you elect to participate in the HealthCare Flexible Spending Account (FSA), FSA dollars will be used before HRA dollars because the FSA dollars have a limited rollover at the end of the Plan year. • If you participate in the HDHP with an HSA, your HRA benefit dollars will be "frozen" meaning that you cannot use HRA benefit dollars for the Plan Year during which you are enrolled in the HSA.	$0		$250 individual/ $500 family		$0

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
Annual Deductible (individual/ family) Must be paid by you before benefits are paid for covered services that have coinsurance	• A Covered Person must pay the applicable annual deductible before the Medical Plan will pay its share of the applicable coinsurance amount. • The annual deductible does not apply to the Prescription Drug Program. The Prescription Drug • Program will pay benefits without regard to satisfaction of any deductible. Any expenses incurred by a Covered Person under the Prescription Drug Program do not apply to satisfying the annual deductible under the Medical Plan. • Will not be applied for Office Visits, for most Covered Services paid at 100%, Covered Services that require a Copayment, or as otherwise specifically waived in this Schedule of Medical Benefits. • The annual deductible does not apply to any Preventive Care provided in-network to a Covered Person. • The individual deductible applies separately to each Covered Person. • The family deductible applies collectively to all Covered Persons in the same family. • If the family deductible is met, the individual deductible will not be applied to any Covered Person in the family for the remainder of the Plan Year. • The full amount of the applicable annual deductible must again be satisfied with respect to any Covered Services rendered in the next Plan Year regardless of whether they are rendered in connection with or as a result of the Accident occurring in the prior Plan Year. • If you switch status during the Plan Year from a Covered Associate to a Covered Dependent (or vice versa)	$1,250 individual/ $2,500 family	$2,500 individual/ $5,000 family Applies to all services	$1,750 individual/ $3,500 family	$3,500 individual/ $7,000 family Applies to all services	$1,250 individual/ $2,500 family Applies to all services

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
Annual Deductible cont'd Must be paid by you before benefits are paid for covered services that have coinsurance	without a break in coverage under the Medical Plan, any amounts accumulated toward the annual deductible during the Plan Year prior to the switch in status shall apply toward the annual deductible after the switch in status. • Expenses that do not apply toward the annual deductible include (i) charges for services that are not Covered Services under the Medical Plan, (ii) Copayments, and (iii) noncompliance penalties (including the additional deductible amount of $300 for failure to obtain pre-notification and the cost of Covered Services that are not paid by the Medical Plan due to the reduced coinsurance amount for failure to obtain pre-notification). Coupons or offers used from pharmaceutical manufactures or affiliate.					
Annual Out-of-Pocket Maximum	• After any annual deductible is satisfied, the Medical Plan will pay its share of the applicable coinsurance percentage, for Covered Services as specified in this Schedule of Medical Benefits, until you have reached your annual out-of-pocket maximum. • Once the annual out-of-pocket maximum is reached, the Medical Plan will pay for 100% of Covered Services for the remainder of the Plan Year. • Includes your annual deductible. • Expenses that do not apply toward the Medical Plan's annual out-of-pocket maximum include (i) charges for services that are not Covered Services under the Medical Plan, and (ii) noncompliance penalties (including the additional deductible amount of $300 for failure to obtain prior authorization and the cost of Covered Services that are not paid by the Medical Plan due to the	$3,500 individual/ $7,000 family	$7.000 individual/ $14,000 family	$4,250 individual / $8,000 family	$8,500 individual/ $17,000 family	$3,500 individual/ $7,000 family

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
	reduced coinsurance amount for failure to obtain prior authorization). Coupons or offers used from pharmaceutical manufactures or affiliate. • The medical annual out-of-pocket maximum does not apply to the Prescription Drug Program. The Prescription Drug Program has a separate annual out-of-pocket maximum.					
Annual Maximum Benefit	• Certain Covered Services are subject to limits on the number of services that will be covered during a Plan Year. • These limits are set forth in this Schedule of Medical Benefits. • All medical benefits provided to a Covered Person during a Plan Year count toward these limits without regard to whether there has been an interruption in the continuity of the Covered Person's coverage.	See chart for limits	See chart for limits	See chart for limits	See chart for limits	See chart for limits
Lifetime Maximum	• Lifetime refers to the period of time a Covered Person participates in the Medical Plan. • All benefits provided to a Covered Person during his/her lifetime apply toward this limit without regard to whether there has been an interruption in the continuity of the Covered Person's coverage. With the exception of Infertility Services see that section.	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Physician Services Care Provided by a Primary Care Physician - Office Visits	• Family Practice, General Practice, Internal Medicine, Pediatrician, Gynecologist. • If no office visit is charged, a copay/coinsurance does not apply. For example, allergy shots or medical management.	$25 copay	60%*	$25 copay	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
Physician Services - Specialist Office	• Any Covered Specialist not listed as a Primary Care Physician. • Behavioral Health visits 1-3 when accessed through the Employee Assistance Program are covered at $0 copay. • If no office visit is charged, a copay does not apply. For example, allergy shots or medical management.	$50 copay	60%*	$50 copay	60%*	80%*
Virtual Care Services Diagnosis and treatment of low acuity medical conditions, through the use of interactive audio and video tele-communication and transmissions, and audio-visual communication technology	• Treatment in real-time between the patient and a distant Physician or health care 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 going to www.myuhc.com or by calling the telephone number on your ID card. • Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.	$25 copay	Non-Network Benefits are not available.	$25 copay	Non-Network Benefits are not available.	Designated Network and Network 80%*
Preventive Care • Wellness Exams • Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • Preventive care services and items with an	• Well Child Care 0-18 years of age (does not include visits for colds, flu or other injury or illness). • Autism screening (children at 18 and 24 months). • Hearing screenings for newborns. • Vision screening for children between ages 3-5 years. • Well Adult Care (does not include visits for colds, flu or other injury or illness). • Screening of adults for obesity, depression, alcohol misuse, high blood pressure, Type-2 Diabetes (adults with high blood pressure), HIV (adults at higher risk).	100%; no copay	Not Covered	100%; no copay	Not Covered	100% no copay or coinsurance

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
A or B rating recommended by the United States Preventive Services Task Force Preventive Care and Screenings in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, adolescents and women • Breast pumps	• Well-woman visits for women under age 65, including for preconception and prenatal care. • Osteoporosis screening for women over age 60 and depending on risk factors. • FDA-approved contraceptive methods and sterilization procedures and education and counseling. • Screening for gestational diabetes (women 24-28 weeks pregnant and women at high risk). • Prenatal and postnatal lactation support and counseling in conjunction with a birth. • Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. • Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. • Benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician • Mammogram frequency: • Age 35 to 40 – 1 baseline • Age 40 & Over - annually • One exam and mammogram per calendar year covered at 100%; additional exams or diagnostics covered as any other illness. • Screening colonoscopy starting at age 50. • Breast Cancer Genetic Test (BRCA) Counseling • Healthy diet counseling • Cholesterol abnormalities screening • Cervical cancer screening every 3 years for women ages 21 to 65					

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
	• Tobacco use counseling and interventions through the Quit For Life Program.					
COVID-19 Vaccine and Preventive Care	Coronavirus preventive services: any item, service, or immunization intended to prevent or mitigate COVID-19 disease, that is: • an evidence-based item or service that has in effect a rating of ''A'' or ''B'' in the current recommendations of the United States Preventive Services Task Force; or • an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC.	100%; no copay	100%; no copay	100%; no copay	100%; no copay	100%; no copay
Laboratory Technical and Professional Fees (ordered by Physician or Chiropractor), facility charges and supplies and equipment • Genetic testing	• Wellness Diagnosis	100%	Not covered	100%	Not covered	100%
	• COVID-19 Diagnosis (applies during COVID-19 public health emergency prior to May10, 2023. • The public health emergency coverage for COVID-19 diagnosis ended May 11, 2023.	100% 80%*	100% 60%*	100% 80%*	100% 60%*	100% 80%*
	• Illness Diagnosis	80%*	60%*	80%*	60%*	80%*
Radiology (X-Ray)/Nuclear Medicine (ordered by Physician or Chiropractor) • Technical and professional fees • Ultrasound, other than maternity • Radiation therapy	• Wellness Diagnosis	100%	Not covered	100%	Not covered	100%
	• Illness Diagnosis	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
• Presumptive and Definitive Drug Tests						
Urgent Care Center	• The Medical Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in the Glossary of Defined Terms section. When Urgent Care services are provided in a Physician's office, the Medical Plan pays Benefits as described under Physician's Office Services earlier in this section.	$50 copay	60%*	$50 copay	60%*	80%*
Emergency Services Hospital emergency room for appropriate medical care, including medical screening examinations, emergency room charges, physicians, lab work and pharmacy provided while in the Emergency Room.	• True Medical Emergencies. True emergencies are paid at the network deductible and network coinsurance level. • Non-Medical Emergencies • If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay and 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. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under Eligible Expenses in How the Plan Works. .	80%* plus $200 copay/visit 50%* plus $200 copay/visit	80%* plus $200 copay/visit 50%* plus $200 copay/visit	80%* plus $200 copay/visit 50%* plus $200 copay/visit	80%* plus $200 copay/visit 50%* plus $200 copay/visit	80%* plus $200 copay/visit 50%* plus $200 copay/visit
Ambulance Services Emergency Ambulance Ground transportation (e.g., ambulance) to nearest appropriate facility as	• True Medical Emergencies • Non-Medical Emergencies • Ambulance service by air is covered in an emergency if ground transportation is impossible or would put your life or health in serious jeopardy.	80%* 80%*	80%* 50%*	80%* 80%*	80%* 50%*	80%* 80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
Medically Necessary for treatment of medicalEmergency, acute Illness or inter- health care facility transfer. Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section *How the Plan Works*.	• Transportation provided by a licensed professional ambulance, other than Air Ambulance, between facilities when the transport is from a non-network hospital to a network hospital; to a hospital that provides a higher level of care that was not available at the original hospital; to a more cost-effective acute care facility; or from an acute facility to a sub-acute setting.					
Acupuncture	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. • Any combination of Network Benefits and Non-Network Benefits is limited to 30 treatments per.	$50 copay/visit	60%*	$50 copay/visit	60%*	80%*
Allergy Care	• PCP or Specialist office visit co- pay for PPO1 and PPO2 and Out of Network will apply based on provider status and deductible	See limitations and explanation	See limitations and explanation	See limitations and explanation	See limitations and explanation	See limitations and explanation

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
	applies to allergy testing and diagnosis evaluation. • If no office visit is charged, a copay does not apply. For example, allergy shots.					
Private Duty Nursing - Outpatient Skilled care services provided by an RN or LPN in your home	• Must be ordered by a Physician. • Custodial Care and/or assistance with activities of daily living excluded. • Lifetime maximum $10,000.	80%*****	60%*	80%*****	60%*	80%*
Infertility Services and Fertility Solutions • Infertility Services must be received at a Designated Network • Limited to a lifetime maximum medical benefit of $25,000 and $10,000 Prescription drug coverage. • See eligibility requirements in the Covered Health Benefits section of this SPD	• Ovulation induction and controlled ovarian stimulation. • Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI). • Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI). • Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm. • Preimplantation Genetic testing (PGT) and related services. • Cryopreservation - embryo's (storage is limited to 12 months). Exclusions: The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embry (fertilized eggs): • Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under Infertility Services including the cost for fertilization (in vitro	Outpatient Facility 80% Inpatient Facility 80%* Designated Facility only	Not covered	Outpatient Facility 80% Inpatient Facility 80%* Designated Facility only	Not covered	Outpatient Facility 80% Inpatient Facility 80%* Designated Facility only

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
	fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer. • Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under Infertility Services including thawing and insemination. • Fertility Preservation for Iatrogenic Infertility.					
Maternity • Facility and Physician fees payable under Hospital, licensed Birthing Center, and physician benefit design, as indicated in this section • Termination of pregnancy • Newborn circumcision	• Coverage for newborn infants, following their birth, if properly added to medical plan within 45 days of birth. • Refer to newborn eligibility guidelines to ensure continued coverage for your newborn. • Coverage for termination of pregnancy only in accordance with Federal or State laws. • Lab work as required during pregnancy paid at 100%. • Initial ultrasound during pregnancy is covered. As required with complicated pregnancies, additional ultrasounds may be covered. • Licensed midwife is covered only in a covered birthing center; home births are not covered.	Physician Office Visits: $25 Copay for the 1st Visit only; other pre-natal visits paid at 100% Physician Delivery and Hospital Charges: 80%*	60%*	Physician Office Visits: $25 Copay for the 1st Visit only; other pre-natal visits paid at 100% Physician Delivery and Hospital Charges: 80%*	60%*	80%*
Family Planning • Surgical sterilization (e.g., vasectomy or tubal ligation) • FDA approved contraceptive birth control devices including but not limited to injectables (Depo-	• Network physician or health care professional: • Intrauterine devices (IUD) including insertion and removal • Diaphragms (covered under the pharmacy benefit if purchased by prescription at a network pharmacy) • Services to place/remove/inject covered FDA-approved contraception methods • Sterilization procedures for women, such as tubal ligations	Physician Office Visit $25 or $50 Copay Outpatient Facility 80% Inpatient Facility 80%*	60%*	Physician Office Visit $25 or $50 Copay Outpatient Facility 80% Inpatient Facility 80%*	60%*	Physician Office Visit 80% Outpatient Facility 80% Inpatient Facility 80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
Provera), IUD, and diaphragm • Fertility expenses diagnostic services						
Hospital Services (inpatient) • Room & Board in semi-private room (i.e., 2 or more beds), general nursing services • Specialty Care Units (e.g., ICU, CCU) • Lab/x-ray/diagnostic services • Related - ancillary services (e.g., covered medications given to you in the hospital, supplies) • Newborn care • Detoxification • Residential and partial hospitalization	• Hospital Admissions and related services subject to prior authorization to Personal Health Support • For elective admissions, you must obtain prior authorization from Personal Health Support five business days before admission. Failure to do so will result in an additional $300 reduction deductible AND a coinsurance reduction to 50%. • For emergency admissions, you must notify Personal Health Support within 48 hours of admission. Failure to do will result in an additional $300 reduction AND a coinsurance reduction to 50% for any in-patient Hospital Services. • Coverage for infants if properly added to the Medical Plan within 45 days following birth. • Members must notify the Mental Health/Substance-Related and Addictive Disorder Services Administrator in advance of any treatment to receive these benefits. Failure to do will result in an additional $300 reduction AND a coinsurance reduction to 50%.	80%*	60%*	80%*	60%*	80%*
Physician Services (in-Hospital)- • Surgeon fees • Assistant surgeon -	• Professional fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation facility,	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
(when approved) • Anesthesia fees for MD, DO, CRNA • Pathologist Fees • Radiologist fees • Subject to notification to Personal Health Support	Alternate facility, outpatient surgery facility, or birthing center. • 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 *How the Plan works*					
Outpatient Surgery • Hospital or free standing Ambulatory Surgical Facility • Surgery done in physician's office • Surgeon charges	• Subject to prior authorization from Personal Health Support for diagnostic catherization, electrophysiology implant and sleep apnea surgeries. • The deductible is waived for charges related to an outpatient surgery at an in-network facility, including the anesthesiologist, the surgeon, and the facility. • Effective 01/01/2023, the Plan requires members to engage with Specialist Management Solutions (SMS) prior to receiving elective outpatient surgery. Failure to go through SMS will result in a $300 penalty. The penalty will NOT apply to the INN and OON Deductible. The penalty will apply to the INN and OON OOP Max.	Physician Office Visit $50 Copay 80%	60%*	Physician Office Visit $50 Copay 80%	60%*	80% 80%
Outpatient & Specialized Health Care Facilities • Skilled Nursing Facility or Inpatient Rehabilitation Facility • Licensed Hospice Care	• Subject to prior authorization from Personal Health Support. • Skilled Nursing Facility/Inpatient Rehabilitation Facility. Confinement limited to 60 days per calendar year. This is a combined limit so no more than 60 days regardless if using in-network or out-of-network providers. • Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
	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. • Maintenance rehab services/coma stimulation excluded. • Hospice care provided either inpatient or outpatient, is limited to 6 months per covered person per lifetime. This is a combined limit so no more than 6 months regardless if using in-network or out-of-network providers.					
Therapy/ Rehabilitation Services (Physical, Occupational, Speech) • Short term active progressive Rehabilitation therapy services under direction of an MD or DO and requiring performance by licensed therapists • Physical, occupational, or speech therapy from a qualified practitioner.	• Outpatient rehab services subject to maximum 60 Visits per calendar year. This includes physical, occupational and speech therapy. • The 60-visit limit does not apply to these services when related to a Behavioral Health (including Autism Spectrum Disorder) and/or Substance Abuse Disorder. • Cardiac and pulmonary outpatient therapies are covered without an annual limit. • Covered only if received under the direct supervision of the attending MD or DO.	80%*	60%*	80%*	60%*	80%*
Home Health Care/Home Infusion Services Part-time, intermittent Skilled Nursing Care	• Subject to Prior Authorozation for out of network services. • Maximum of 100 Visits per year. (one visit equals four hours of Skilled Home Health Care services.) • See exclusion for custodial, personal care, and childcare.	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
	• Home physical therapy services payable per therapy benefits. • Infusion medications payable as medical benefit.					
Infusion Therapy - Outpatient	• Infusion therapy received at an outpatient facility or physician's office. • Some examples of treatment include: antibiotics, hydration, pain management and cancer chemotherapy.	80%*	60%*	80%*	60%*	80%*
Chemotherapy/ Cancer Diagnosis	• Includes covered services received in physician's office, inpatient hospital or outpatient setting.	80%*	60%*	80%*	60%*	80%*
Dialysis-Therapeutic Treatments Outpatient	• Dialysis therapy including both hemodialysis and peritoneal dialysis received at an outpatient facility or physician's office.	80%*	Not covered	80%*	Not covered	80%*
Cellular and Gene Therapy Services must be received at a Designated Provider	• 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. • Prior Authorization required	Physician Office Visit $25 or $50 Copay Outpatient Facility 80% Inpatient Facility 80%*	Not covered	Physician Office Visit $25 or $50 Copay Outpatient Facility 80% Inpatient Facility 80%*	Not covered	80%*
Spinal Manipulation Includes ancillary and related services	• Visits for spinal manipulation and other chiropractic treatments (in-network and out-of-network) are limited to 30 visits per calendar year. This is a combined limit so no more than 30 visits regardless if using in- network or out-of-network providers. All visits related to such treatment count towards the maximum, not just visits with manipulations or modalities.	$50 copay/visit	60%*	$50 copay/visit	60%*	80%*
Durable Medical Equipment (DME) • Rental or purchase at	• Subject to pre-notification to Personal Health Support for purchase or rental of $1,000 or more. • Must be ordered by Physician for outpatient use and subject to pre-	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
option of Administrator • Payment extended toward- most cost-effective model only • Repair, replacement, adjustment, and servicing payable only as necessary as defined by Covered Health Services in the *Glossary of Defined Terms* section.	notification to Personal Health Support. • Examples: equipment to administer oxygen; wheelchairs; hospital beds; burn garments; braces that straighten or change the shape of a body part; braces that stabilize an injured body part; delivery pumps for tube feedings; insulin pumps and supplies. • Hearing aids per hearing impaired ear available every 3yrs. • Rental of breast- feeding equipment is covered at no cost share and does not require prior authorization. Member must contact a network physician or DME supplier to receive at no charge. • Failure to do will result in an additional $300 reduction AND a coinsurance reduction to 50%.					
Non-durable Supplies Coverage extended to: • Sterile surgical supplies immediately post-Surgery supplies required to operate DME or prosthetic appliances	• Limited to supplies that meet definition. • Supplies and services that are provided in provider's office are subject to the applicable office visit copay when a physician's office visit is charged. • Supplies required for use by skilled home health personnel only for the duration of their services. • Colostomy/ostomy supplies • Antiembolism and vascular support garments	80%*	60%*	80%*	60%*	80%*
Corrective Appliances (Prosthetic Devices, Orthotics not Dental) • Rental or purchase at option of Administrator • Payment extended	• Must be ordered by Physician. • Orthopedic or corrective shoes-- limited to once in a period of 12 months for adults and once in a period of 6 months for children under age 19 when replacement required due to growth. • Artificial limbs and eyes replacing those natural limbs and eyes initially lost due to Illness or Injury while covered under the Medical Plan.	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
toward standard model only, as applicable • Repair, replacement, adjustment, and servicing payable only as - approved by UHC. • Original fitting, adjustment, and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired.	• Occupational therapy supplies. • Shoe orthotics (standard or custom), arch supports, lifts, wedges and insoles are not covered, whether or not prescribed by a physician. • Replacement of corrective appliances will only be covered if the replacement is necessary due to a change in the physical condition of the Covered Person • Subject to pre-notification to Personal Health Support for purchase or rental of $1,000 or more. • Failure to do will result in an additional $300 reduction AND a coinsurance reduction to 50%.					
Blood Transfusions	• Must be ordered by Physician. • Blood transfusions and blood products and equipment for its administration. • Expenses related to autologous blood donation (patient's own blood) when provided for an eligible enrollee pertinent to a necessary/eligible service, Illness or Injury.	80%*	60%*	80%*	60%*	80%*
Breast Reduction Claim must meet care coordination guidelines and receive approval by Optum.	• Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedure	Physician Office Visit $25 or $50 Copay Outpatient Facility 80%	60%*	Physician Office Visit $25 or $50 Copay Outpatient Facility 80%	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
		Inpatient Facility 80%*		Inpatient Facility 80%*		
Reconstructive Services Reconstructive Procedures are services performed when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part **Reconstructive Services(cont'd)**	• Reconstructive Services are subject to pre-notification to Personal Health Support. • 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 Medical 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. Contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services. • There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose which is considered a Cosmetic Procedure. The Medical Plan does not provide Benefits for Cosmetic Procedures, as defined in the Glossary of Defined Terms section.	80%*	60%*	80%*	60%*	80%*
Human Organ and Tissue Transplantation Payable only for	• Pre-certification with Personal Health Support is required in order for services to be payable under the Medical Plan.	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
eligible services directly related to the transplant to include: • Facility and professional services • FDA approved drugs • Organ/tissue procurement/ acquisition fees Donor expenses when donor not covered by other insurance • Necessary equipment and supplies • Rehabilitative services • Travel benefits • Reimbursement for lodging	• Includes CAR-T cell therapy for malignancies when ordered by a Physician • Benefits available include bone marrow, heart, heart/lung, cornea, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, and small bowel. • Nonhuman organ/tissue transplants and drugs or medicine in clinical trials are excluded. • Travel benefits – see Travel and lodging benefits for details.					
Second Opinion Program – through UHC Second & third opinions **2nd.MD – third-party offering**	• At the Covered Person's request a second or third opinion can be requested. • 2nd.MD allows Covered Person's the ability to connect with board-certified, expert doctors for an expert second opinion via phone or video	100% after $50 Copay	60%*	100% after $50 Copay	60%*	80%*
Prescriptions/ Drugs	• Details for pharmacy and mail order plan benefits are in the Prescription Drug Program section of this SPD.					
Dental Services	• Dental services for an accident are subject to pre-notification to Personal Health Support. • Accidental Injury to sound, natural teeth. Limits apply; contact UHC for details. • The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident.	80%*	60%*	80%*	60%*	80%*

*After Annual Deductible is Satisfied

		PPO 1		PPO 2		Out of Network
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of- Network**	**Out-of-Network Plan**
	• Dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident. • Dental services if approved when determined that hospitalization is appropriate to safeguard the health of the patient.					
Behavioral Health Benefits	• These benefits are provided through OptumHealth Behavioral Services in accordance with the Schedule. • Some services (whether Inpatient or Outpatient) require notification to OptumHealth to be covered at the highest benefit level. This includes; • Mental Health (MH) or Substabce Use Disorder (SUD) Inpatient Treatment • MH or SUD Partial/Day Hospitalization • MH or SUD Residential Treatment • Outpatient Electro-Convulsive Treatment • Applied Behavioral Analysis (ABA) for the treatment of Autism • Transcranial Magnetic Stimulation (TMS) • Psychological Testing • Failure to obtain prior authorization will result in an additional $300 reduction AND a coinsurance reduction to 50%. • In a life-threatening situation, go directly to the Hospital and report any Hospital admission to OptumHealth by the next scheduled workday.	$50 copay	60%*	$50 copay	60%*	80%*
Health Management Virtual Behavioral Therapy and Coaching Programs	• Services must be received from a Designated Provider. Additional information regarding Health Management Virtual Behavioral Therapy and Coaching programs can be found in Section, *Additional Coverage and Prior Authorization Details*.	Designated Network Ableto Therapy360 at 100%	No coverage	Designated Network Ableto Therapy360at 100%	No coverage	Designated Network Ableto Therapy360at 100%

*After Annual Deductible is Satisfied

Appendix B: Schedule of Medical Benefits HDHP

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of-Network**
Annual Deductible (individual/ family) Must be paid by you before benefits are paid for covered services that have coinsurance	• A Covered Person must pay the applicable annual deductible before the Medical Plan will pay its share of the applicable coinsurance amount. • The annual deductible does not apply to any Preventive Care provided in-network to a Covered Person. • The individual deductible is only applicable for Associate Only coverage. • The family deductible applies collectively to all Covered Persons in the same family and must be met before coinsurance begins. • If the family deductible is met, the individual deductible will not be applied to any Covered Person in the family for the remainder of the Plan Year. • The full amount of the applicable annual deductible must again be satisfied with respect to any Covered Services rendered in the next Plan Year regardless of whether they are rendered in connection with or as a result of the Accident occurring in the prior Plan Year. • If you switch status during the Plan Year from a Covered Associate to a Covered Dependent (or vice versa) without a break in coverage under the Medical Plan, any amounts accumulated toward the annual deductible during the Plan Year prior to the switch in status shall apply toward the annual deductible after the switch in status. Expenses that do not apply toward the annual deductible include (i) charges for services that are not Covered Services under the Medical Plan, and (ii) noncompliance penalties (including the additional deductible amount of $300 for failure to obtain pre-notification and the cost of Covered Services that are not paid by the Medical Plan due to the reduced coinsurance amount for failure to obtain pre-notification). • Coupons or offers used from pharmaceutical manufactures or affiliate do not apply to the deductible. • The Annual Deductible does apply to the Prescription Drug Program. See the Prescription Drug section of the SPD for more details.	$2,150 individual/ $4,250 family Applies to all services	$4,300 individual/ $8,500 family Applies to all services

*After Annual Deductible is Satisfied

Appendix B Schedule of Medical Benefits HDHP Plan

Benefit Description	Limitations & Explanations HDHP Plan	In-Network	Out-of-Network
Annual Out-of-Pocket Maximum (individual/ family) Must be paid by you before benefits are paid for covered services that have coinsurance	• After any annual deductible is satisfied, the Medical Plan will pay its share of the applicable coinsurance percentage, for Covered Services as specified in this Schedule of Medical Benefits, until you have reached your annual out-of-pocket maximum. • Once the annual out-of-pocket maximum is reached, the Medical Plan will pay for 100% of Covered Services for the remainder of the Plan Year. • Includes your annual deductible. • Individual Out of Pocket Maximum only applies for Associate Only coverage. • The family deductible applies collectively to all Covered Persons in the same family and must be met before coinsurance begins. • Expenses that do not apply toward the Medical Plan's annual out-of-pocket maximum include (i) charges for services that are not Covered Services under the Medical Plan, and (ii) noncompliance penalties (including the additional deductible amount of $300 for failure to obtain prior authorization and the cost of Covered Services that are not paid by the Medical Plan due to the reduced coinsurance amount for failure to obtain prior authorization). • Coupons or offers used from pharmaceutical manufactures or affiliate do not apply to the maximum out of pocket.	$5,000 individual/ $10,000 family The 2023 ACA Individual OOP Maximum is $9,100 which means no individual in a family can have an OOP maximum greater than $9,100. As a result, a new Individual Maximum of $9,100 will be embedded within the $10,000 Family OOP Maximum for the HDHP plan effective 1/1/2023.	$10,000 individual/ $20,000 family
Annual Maximum Benefit	• Certain Covered Services are subject to limits on the number of services that will be covered during a Plan Year. • These limits are set forth in this Schedule of Medical Benefits. • All medical benefits provided to a Covered Person during a Plan Year count toward these limits without regard to whether there has been an interruption in the continuity of the Covered Person's coverage.	See chart for limits	See chart for limits
Lifetime Maximum	• Lifetime refers to the period of time a Covered Person participates in the Medical Plan. • All benefits provided to a Covered Person during his/her lifetime apply toward this limit without regard to whether there has been an interruption in the continuity of the Covered Person's coverage.	Unlimited	Unlimited
Physician Services Care Provided by a Primary Care Physician	• Family Practice, General Practice, Internal Medicine, Pediatrician, Gynecologist. • If no office visit is charged, a copay does not apply. For example, allergy shots or medical management.	80%*	60%*

*After Annual Deductible is Satisfied

Appendix B Schedule of Medical Benefits HDHP Plan

Benefit Description	Limitations & Explanations HDHP Plan	In-Network	Out-of-Network
Preventive Care • Wellness Exams • Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • Preventive care services and items with an A or B rating recommended by the United States Preventive Services Task Force • Preventive Care and Screenings in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, adolescents and women • Breast pumps	• Well Child Care 0-18 years of age (does not include visits for colds, flu or other injury or illness). • Autism screening (children at 18 and 24 months). • Hearing screenings for newborns. • Vision screening for children between ages 3-5 years. • Well Adult Care (does not include visits for colds, flu or other injury or illness). • Screening of adults for obesity, depression, alcohol misuse, high blood pressure, Type-2 Diabetes (adults with high blood pressure), HIV (adults at higher risk). • Well-woman visits for women under age 65, including for preconception and prenatal care. • Osteoporosis screening for women over age 60 and depending on risk factors. • FDA-approved contraceptive methods and sterilization procedures and education and counseling. • Screening for gestational diabetes (women 24-28 weeks pregnant and women at high risk). • Prenatal and postnatal lactation support and counseling in conjunction with a birth. • Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. • Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. • Benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician • Mammogram frequency: • Age 35 to 40 – 1 baseline • Age 40 & Over - annually • One exam and mammogram per calendar year covered at 100%; additional exams or diagnostics covered as any other illness. • Screening colonoscopy starting at age 50 • Breast Cancer Genetic Test (BRCA) Counseling • Healthy diet counseling • Cholesterol abnormalities screening • Cervical cancer screening every 3 years for women ages 21 to 65. • Tobacco use counseling and interventions through the Quit For Life Program.	100%	Not covered

*After Annual Deductible is Satisfied

Appendix B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of-Network**
Virtual Care Servcies Diagnosis and treatment of low acuity medical conditions, through the use of interactive audio and video tele- communication and transmissions, and audio-visual communication technology	• Treatment in real-time between the patient and a distant Physician or health care 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 going to www.myuhc.com or by calling the telephone number on your ID card. • Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary	80%	Non-Network Benefits are not available.
COVID-19 Vaccine and Preventive Care	Coronavirus preventive services: any item, service, or immunization intended to prevent or mitigate COVID-19 disease, that is: • an evidence-based item or service that has in effect a rating of ‘‘A’’ or ‘‘B’’ in the current recommendations of the United States Preventive Services Task Force; or • an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC.	100%; no copay	100%; no copay
Radiology (X- Ray)/Nuclear Medicine (ordered by Physician or Chiropractor) • Technical and professional fees • Ultrasound, other than maternity • Radiation therapy Presumptive and Definitive Drug Tests	• Wellness Diagnosis • Illness Diagnosis	100% 80%*	Not covered 60%*
Laboratory Technical and Professional Fees (ordered by Physician or Chiropractor	• Wellness Diagnosis • Illness Diagnosis	100% 80%*	Not covered 60%*

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of-Network**
Emergency Services Hospital emergency room for appropriate medical care, including medical screening examinations, emergency room charges, physicians, lab work and pharmacy provided while in the Emergency Room.	• True Medical Emergencies. • True emergencies are paid at the network deductible and network coinsurance level. • Non-Medical Emergencies If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead.	80% 60%*	80% 60%*
Urgent Care Center	• The Medical Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in the Glossary of Defined Terms section. • When Urgent Care services are provided in a Physician's office, the Medical Plan pays Benefits as described under Physician's Office Services earlier in this section.	80%*	60%*
Maternity • Facility and Physician fees payable under Hospital, licensed Birthing Center, and physician benefit design, as indicated in this section • Termination of pregnancy • Newborn circumcision	• Coverage for newborn infants, following their birth, if properly added to medical plan within 45 days of birth. • Refer to newborn eligibility guidelines to ensure continued coverage for your newborn. • Coverage for termination of pregnancy only in accordance with Federal or State laws. • Initial ultrasound during pregnancy is covered. As required with complicated pregnancies, additional ultrasounds may be covered. • Licensed midwife is covered only in a covered birthing center; home births are not covered.	80%*	60%*
Family Planning • Surgical sterilization (e.g., vasectomy or tubal ligation) • FDA-approved contraceptive birth control • devices including but not limited to injectables • (Depo-Provera), IUD, and diaphragm • Fertility expenses diagnostic services	• The following contraceptive procedures are covered at 100% and are not subject to the deductible when performed by a network physician or health care professional: • Intrauterine devices (IUD)including insertion and removal • Diaphragms (covered under the pharmacy benefit if purchased by prescription at a network pharmacy) • Services to place/remove/inject covered FDA-approved contraception methods • Sterilization procedures for women, such as tubal ligations	Visit 80%* Outpatient Facility 80% Inpatient Facility 80%*	60%*

*After Annual Deductible is Satisfied

Infertility Services and Fertility Solutions • Infertility Services must be received at a Designated Network • Limited to a lifetime maximum medical benefit of $25,000 and $10,000 Prescription drug coverage.	• Ovulation induction and controlled ovarian stimulation. • Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI). • Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI). • Preimplantation Genetic Testing (PGT) and Related Services • Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm. • Cryopreservation - embryo's (storage is limited to 12 months). • The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embry (fertilized eggs) exclusions: • Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under *Infertility Services* including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer. • Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under *Infertility Services* including thawing and insemination. • Fertility Preservation for Iatrogenic Infertility.	Physician Office Visit 80%* Outpatient Facility 80%* Inpatient Facility 80%*	Not Covered
Private Duty Nursing - Outpatient Skilled care services provided by an RN or LPN in your home	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. • Any combination of Network Benefits and Non-Network Benefits is limited to 30 treatments per.	80%	60%
Spinal Manipulation Includes ancillary and related services	• Visits for spinal manipulation and other chiropractic treatments (in-network and out-of-network) are limited to 30 visits per calendar year. This is a combined limit so no more than network or out-of-network providers. All visits related to such treatment count towards the maximum, not just visits with manipulations or modalities.	80%*	60%*

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
AmbulanceTransportation Services Ground transportation (e.g., ambulance) to nearest appropriate facility as Medically Necessary for treatment of medical Emergency, acute Illness or inter- health care facility transfer. **Non-Emergency Ambulance**; • Ground or Air Ambulance, as the Claims Administrator determines appropriate. **Emergency Ambulance** Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section *How the Plan Works*.	Graound or Air Ambulance After you meet the annual Deductible • True Medical Emergencies • Non-Medical Emergencies • Ambulance service by air is covered in an emergency if ground transportation is impossible or would put your life or health in serious jeopardy. • • Transportation provided by a licensed professional ambulance, other than Air Ambulance, between facilities when the transport is from a non-network hospital to a network hospital; to a hospital that provides a higher level of care that was not available at the original hospital; to a more cost-effective acute care facility; or from an acute facility to a sub-acute setting.	80%* 80%*	80%* 60%*
Acupuncture	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. • Any combination of Network Benefits and Non-Network Benefits is limited to 30 treatments per.	80%*	60%*
Allergy Care	• PCP or Specialist office visit co- insurance and deductible applies to allergy testing and diagnosis evaluation. If no office visit is charged, a co-insurance does not apply. For example, allergy shots.	80%*	60%*

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
Hospital Services (inpatient) • Room & Board in semi-private room (i.e., 2 or more beds), general nursing services • Specialty Care Units (e.g., ICU, CCU) • Lab/x- ray/diagnostic services • Related - ancillary services (e.g., covered medications given to you in the hospital, supplies) • Newborn care • Detoxification • Residential and partial hospitalization	• Hospital Admissions and related services subject to prior authorization to Personal Health Support. • For elective admissions, you must obtain prior authorization from Personal Health Support five business days before admission. Failure to do so will result in an additional $300 reduction AND a coinsurance reduction to 50%. • For emergency admissions, you must notify Personal Health Support within 48 hours of admission. Failure to do will result in an additional $300 reduction AND a coinsurance reduction to 50% for any in-patient Hospital Services. • Coverage for infants if properly added to the Medical Plan within 45 days following birth. • Members must notify the Mental Health/Substance-Related and Addictive Disorder Services Administrator in advance of any treatment to receive these benefits. Failure to do will result in an additional $300 reduction AND a coinsurance reduction to 50%.	80%*	60%*
Physician Services (in-Hospital)- • Surgeon fees • Assistant surgeon - (when approved) • Anesthesia fees for MD, DO, CRNA • Pathologist Fees • Radiologist fees • Subject to notification to Personal Health Support	• Professional fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation facility, Alternate facility, outpatient surgery facility, or birthing center. • 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 How the Plan works.	80%*	60%*

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
Outpatient **Surgery** • Hospital or free standing Ambulatory Surgical Facility • Surgery done in physician's office Surgeon charges Effective 01/01/2023, PetSmart is requiring members to engage with Specialist Management Solutions (SMS) prior to receiving elective outpatient surgery. Failure to go through SMS will result in a $300 penalty. The penalty will NOT apply to the INN and OON Deductible. The penalty will apply to the INN and OON OOP Max.	• Subject to prior authorization from Personal Health Support for diagnostic catherization, electrophysiology implant and sleep apnea surgeries.	80%*	60%*
Obesity Surgery For Designated Network Benefits, obesity surgery must be received by a Designated Provider. Limited to one time	Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true: • You have enrolled in the Bariatric Resource Services (BRS) program. • You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present. • You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4. • You have a 3-month physician or other health care provider supervised diet documented within the last 2 years. • You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation. • You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.	Dending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section	N/A

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

Outpatient & Specialized Health Care Facilities • Skilled Nursing Facility or Inpatient Rehabilitation Facility • Licensed Hospice Care	• Subject to prior authorization from Personal Health Support. • Skilled Nursing Facility/Inpatient Rehabilitation Facility. Confinement limited to 60 days per calendar year. This is a combined limit so no more than 60 days regardless if using in-network or out-of-network providers. • 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. • Maintenance rehab services/coma stimulation excluded. • Hospice care provided either inpatient or outpatient, is limited to 6 months per covered person per lifetime. This is a combined limit so no more than 6 months regardless if using in-network or out-of-network providers.	80%*	60%*

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
Therapy/ Rehabilitation Services (Physical, Occupational, Speech) • Short term active progressive Rehabilitation therapy services under direction of an MD or DO and requiring performance by licensed therapists • Physical, occupational, or speech therapy from a qualified practitioner speech therapy from a qualified practitioner	• Outpatient rehab services subject to maximum 60 Visits per calendar year. This includes physical, occupational and speech therapy. • The 60-visit limit does not apply to these services when related to a Behavioral Health (including Autism Spectrum Disorder) and/or Substance Abuse Disorder. • Cardiac and pulmonary out- patient therapies are covered without an annual limit. • Covered only if received under the direct supervision of the attending MD or DO.	80%*	60%*
Home Health Care/Home Infusion Services Part-time, intermittent Skilled Nursing Care	• Subject to Prior Authorization. • Maximum of 100 Visits per year. (one visit equals four hours of Skilled Home Health Care services.) • See exclusion for custodial, personal care, and childcare. • Home physical therapy services payable per therapy benefits. • Infusion medications payable as medical benefit.	80%*	60%*
Infusion Therapy- Outpatient	• Infusion therapy received at an outpatient facility or physician's office. • Some examples of treatment include: antibiotics, hydration, pain management and cancer chemotherapy.	80%*	60%*
Chemotherapy/ Cancer Diagnosis	• Includes covered services received in physician's office, inpatient hospital or outpatient setting	80%*	60%*
Dialysis- Therapeutic treatments Outpatient	• Dialysis therapy including both hemodialysis and peritoneal dialysis received at an outpatient facility or physician's office	80%*	Not covered

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
Durable Medical Equipment (DME) • Rental or purchase at option of Administrator • Payment extended toward- most cost-effective model only. • Repair, replacement, adjustment, and servicing payable only as necessary as defined by Covered Health Services in the *Glossary of Defined Terms* section.	• Failure to do will result in an additional $300 reduction AND a coinsurance reduction to 50%. • Subject to pre-notification to Personal Health Support for purchase or rental of $1,000 or more. • Must be ordered by Physician for outpatient use and subject to pre-notification to Personal Health Support. • Examples: equipment to administer oxygen; wheelchairs; hospital beds; burn garments; braces that straighten or change the shape of a body part; braces that stabilize an injured body part; delivery pumps for tube feedings; insulin pumps and supplies. • Hearing aids per hearing impaired ear available every three years. • Rental of breast- feeding equipment is covered at no cost share and does not require prior authorization. • Member must contact a network physician or DME supplier to receive at no charge.	80%*	60%*
Non-durable Supplies Coverage extended to: • sterile surgical supplies immediately post-Surgery supplies required to operate DME or prosthetic appliances	• Limited to supplies that meet definition. • Supplies required for use by skilled home health personnel only for the duration of their services. • Colostomy/ostomy supplies • Antiembolism and vascular support garments	80%*	60%*
Corrective Appliances (Prosthetic Devices, Orthotics Other than Dental) • Rental or purchase at option of Administrator • Payment extended toward standard model only, as applicable • Repair, replacement, adjustment, and servicing payable only as approved by United Healthcare. Original fitting, adjustment, and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired	Must be ordered by Physician. • Orthopedic or corrective shoes-- limited to once in a period of 12 months for adults and once in a period of 6 months for children under age 19 when replacement required due to growth. • Artificial limbs and eyes replacing those natural limbs and eyes initially lost due to Illness or Injury while covered under the Medical Plan. • Occupational therapy supplies. • Shoe orthotics (standard or custom), arch supports, lifts, wedges and insoles are not covered, whether or not prescribed by a physician. • Replacement of corrective appliances will only be covered if the replacement is necessary due to a change in the physical condition of the Covered Person.	80%*	60%*

*After Annual Deductible is Satisfied

Appendex B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
Prescriptions/ Drugs	• Details for pharmacy and mail order plan benefits are in the Prescription Drug Program section of this SPD.		
Blood Transfusions	Must be ordered by Physician. • Blood transfusions and blood products and equipment for its administration. • Expenses related to autologous blood donation (patient's own blood) when provided for an eligible enrollee pertinent to a necessary/eligible service, Illness or Injury.	80%*	60%*
Breast Reduction Claim must meet care coordination guidelines and receive approval by Optum.	• Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital • Anomaly without improving or restoring physiologic function are considered Cosmetic Procedure.	80%*	60%*
Reconstructive Services - Reconstructive Procedures are services performed when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part.	• Reconstructive Services are subject to pre-notification to Personal Health Support. • 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 Medical 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. Contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services. • There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. • A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose which is considered a Cosmetic Procedure. The Medical Plan does not provide Benefits for Cosmetic Procedures, as define in the Glossary of Defined Terms	80%*	60%*

*After Annual Deductible is Satisfied

Appendix B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
Human Organ and Tissue Transplantation Payable only for eligible services directly related to the transplant to include: Payable only for eligible services directly related to the transplant to include: • Facility and professional services • FDA approved drugs • Organ/tissue procurement/acquisition fees • Donor expenses when donor not covered by other insurance • Necessary equipment and supplies • Rehabilitative services • Travel benefits Reimbursement for lodging	• Pre-certification with Personal • Health Support is required in order for services to be payable under the Medical Plan. Includes CAR-T cell therapy for malignancies when ordered by a Physician. Benefits available include bone marrow, heart, heart/lung, cornea, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, and small bowel. • Nonhuman organ/tissue transplants and drugs or medicine in clinical trials are excluded. • Travel- see Travel and lodging benefits for details.	80%*	60%*
Second Opinion Program – through UHC Second & third opinions • **2nd.MD – third-party offering**	• At the Covered Person's request, a second or third opinion can be requested. • 2nd.MD allows Covered Person's the ability to connect with board-certified, expert doctors for an expert second opinion via phone or video	80%* 100%	60%*
Dental Services	• Dental services for an accident are subject to pre-notification to Personal Health Support. • Accidental Injury to sound, natural teeth. Limits apply; contact UHC for details. • The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. • Dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident. • Dental services if approved when determined that hospitalization is appropriate to safeguard the health of the patient.	80%*	60%*

*After Annual Deductible is Satisfied

Appendix B Schedule of Medical Benefits HDHP Plan

HDHP w/ HSA			
Benefit Description	**Limitations & Explanations**	**In-Network**	**Out-of- Network**
Behavioral Health Benefits	• These benefits are provided through OptumHealth Behavioral Services in accordance with the Schedule • Some services (whether Inpatient or Outpatient) require notification to OptumHealth to be covered at the highest benefit level. This includes; • Mental Health (MH) or Substabce Use Disorder (SUD) Inpatient Treatment • MH or SUD Partial/Day Hospitalization • MH or SUD Residential Treatment • Outpatient Electro-Convulsive Treatment • Applied Behavioral Analysis (ABA) for the treatment of Autism • Transcranial Magnetic Stimulation (TMS) • Psychological Testing • Failure to obtain prior authorization will result in an additional $300 reduction AND a coinsurance reduction to 50%. • In a life-threatening situation, go directly to the Hospital and report any Hospital admission to OptumHealth by the next scheduled workday.	80%*	60%*
Health Management Virtual Behavioral Therapy and Coaching Programs	Services must be received from a Designated Provider. Additional information regarding Health Management Virtual Behavioral Therapy and Coaching programs can be found in Section, *Additional Coverage and Prior Authorization Details*.	Designated Network Ableto Therapy 360 at 100% After you meet the annual deductible; Benefits for the Initial Consultation will be paid at 100%.	No coverage

*After Annual Deductible is Satisfied

Appendix B Schedule of Medical Benefits HDHP Plan

Health Savings Account (HSA)	• A tax-advantaged account established to pay for qualified health expenses to include dental and vision for those who are covered under the UHC Choice Plus High-Deductible Health Plan (HDHP). • Money you contribute for health care expenses that can be used today or saved for the future • You will open an HSA account with Optum Bank and payroll deductions will be deposited into that account. • Once your deposit account reaches a designated value, known as the investment threshold, you may, if you choose, set up a separate investment account to invest a portion of your savings in mutual funds.	You decide how much to contribute, up to $3850 for individual and $7750 for family
Health Savings Account (HSA) – PetSmart contribution	• Company allocated benefit dollars to be used for covered health care expenses including medical coinsurance and annual deductibles, along with prescription drug expenses (retail and mail order).	Individual: $500/$9.61 per week* Family: $1000/$19.23 per week* *Prorated annual contribution based on plan start date

*After Annual Deductible is Satisfied