Nokia Medical Expense Plan For Management Employees

Summary Plan Description

January 2021

H000251948

Introduction

The Nokia Medical Expense Plan for Management Employees (the "Medical Plan" or the "Plan") is designed to provide protection against the cost of medical care and prescription drugs for you and your Eligible Dependents. This booklet--called a summary plan description ("SPD")--is intended to summarize the material terms of the Plan in effect as of January 1, 2021. In particular, this SPD summarizes the material terms of the Plan's Point of Service ("POS") options, the Plan's prescription drug program (for individuals covered by a POS option) and the Plan's Employee Assistance Program ("EAP"). (This SPD does not describe the terms of any of the Plan's Traditional Indemnity option or the Plan's Health Maintenance Organization ("HMO") options (and the prescription drug programs for those options), which are set forth in other summaries.) It is for informational purposes only. The actual terms of the Plan are reflected in the official Plan document, a copy of which can be obtained by writing to the Plan Administrator (see Section V., "Important Contacts" for the address of the Plan Administrator). Every care has been taken to ensure that this summary is accurate. In the event of a conflict between this document and the terms of the official Plan document, the official Plan document will control.

Nokia of America Corporation (the "Company") expects to continue the Plan but reserves the right to amend, modify, or terminate the Plan, in whole or in part, at any time by the resolution of the Company's Board of Directors or its properly authorized delegate(s), with or without advance notice to participants, for any reason, subject to applicable law. The Company reserves the right to change the amount of required participant contributions for coverage under the Plan at any time, with or without advance notice to participants.

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

This updated SPD replaces all prior SPDs, and all prior summaries of material modification, regarding the Plan.

Section A. The Plan At-A-Glance

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

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

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

Plan Features	Summary
Participation and Enrollment	Newly hired Eligible Employees are automatically enrolled in the Plan as of their first day of employment and are assigned to the Enhanced Option. Employees who were not previously Eligible Employees but who become such (for example, they transfer employment from a Nokia Group company that is not a Participating Company to a Participating Company) are automatically assigned to the Enhanced Option under the Plan as of their first day of eligibility. Newly hired and newly eligible employees then have 31 days within which to change their Coverage Option (see "Coverage Options", below) and/or to add Eligible Dependents (see "Eligible Dependents", below). If they do not do so within this 31-day period, they may change their Coverage Option and add or drop Eligible Dependents during the Plan's Annual Open Enrollment Period (or earlier if they have a Qualified Status Change). Employees who are already enrolled in the Plan may change their Coverage Option and add or drop Eligible Dependents during the Plan's Annual Open Enrollment Period (or earlier if they have a Qualified Status Change).
Eligible Dependents	If you are eligible to participate in the Plan, you may also enroll your Eligible Dependents, defined as follows: • Your Spouse/Domestic or Civil Union Partner • Your Children (including your Spouse's children, i.e., your stepchildren), up until the end of the month in which they turn age 26) • The Children of your Domestic or Civil Union Partner, provided they live with you, up until the end of the month in which they turn age 26 • Your Adult Disabled Children. Note: Each of the above terms has a specific definition. See Section B, "Terms You Should Know", for more detail regarding who is an Eligible Dependent under the Plan.

Plan Features	Summary
Coverage Options	The Plan offers the following coverage options: • Standard Option (a plan with a standard level of benefit coverage) • Enhanced Option (a plan providing a higher level of benefit coverage than the Standard option). These coverage options are described in more detail in Section E., "How the POS Options Work".
Coverage Categories	The following are the Coverage Categories for the Plan: • You only • You + your Spouse/Domestic or Civil Union Partner • You + your Children (including your Adult Disabled Children and, if applicable, the Children of your Domestic or Civil Union Partner) • You + your Family (i.e., your Spouse/Domestic or Civil Union Partner and your Children, including your Adult Disabled Children, and, if applicable, the Children of your Domestic or Civil Union Partner)
Cost of the Plan	You are required to contribute to the cost of coverage under the Plan for yourself and your enrolled Eligible Dependents. The cost of Plan coverage depends on the Coverage Option and Coverage Category (see above) you choose. Information on the cost of coverage is available from the Nokia Benefits Resource Center and through the Your Benefits Resources (YBR)™ website (see below) when you enroll in the Plan. In most instances, the cost of coverage is deducted from your paycheck on a pre-tax basis. (See Section D., "The Cost of Plan Coverage".)
Other Plan Costs	Depending on the Medical Plan option in which you enroll and whether you utilize an in-network or out-of-network provider, you might also need to pay: • A Copayment Amount • A Coinsurance Amount, and • An Annual Deductible These costs are described further in the Appendix 1, "Services Covered and Cost Sharing under the POS Options".

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

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

Section B. Terms You Should Know

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

Active Management Plan Design: The terms of the Plan applicable to Eligible Employees, other than those who, when actively employed by a Participating Company, were represented for purposes of collective bargaining by a labor union, and their Eligible Dependents.

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

- The Child was covered under the Plan as an eligible dependent immediately prior to attaining age 26, and

- The Child, prior to attaining age 26 and thereafter was and remains--
  - Physically, mentally, or developmentally disabled, and
  - Incapable of self-support, and
  - Fully dependent on you for support; and

- The Child is certified by the claims administrator for the Nokia Medical Expense Plan for Management Employees as incapacitated due to disability (certification process must be started within 31 days of the end of the month in which the Child turns age 26).

Effective March 22, 2021, for newly hired Eligible Employees, a Child of such Eligible Employee who has been continuously covered under another employer's group health plan since immediately before turning age 26 is treated as satisfying the requirement set forth in the first bullet above.

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

Allowable Amount: The portion of a Provider's charge that is eligible for reimbursement either in full or in part. Any amount by which the Provider's charge exceeds the Allowable Amount is not reimbursable under the Plan.

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

- Surgical services
- Emergency Health Services

- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible): The aggregate amount of covered charges each calendar year that the Participant must pay before the Plan begins to pay Out-of-Network benefits each calendar year.

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

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

Autism Spectrum Disorder: A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits: Plan payments for covered services, subject to the terms and conditions of the Plan.

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

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

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

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

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

Cancer Resource Services (CRS): A program administered by the Claims Administrator or its affiliates made available to you by the Plan. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

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

CHD: See Congenital Heart Disease (CHD).

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

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

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

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

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

Civil Union Partner: See Domestic or Civil Union Partner.

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

Clinical Trial: A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

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

Coinsurance: The cost-sharing method through which the Plan pays a percentage of Eligible Expenses (for example, 75 percent) and you pay a percentage (for example, 25 percent). Your Coinsurance is your share of the cost.

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

Congenital Anomaly: A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD): Any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Copayment (or Copay): A flat dollar amount (such as $30) that you are required to pay for a certain medical service (such as an office visit or supply).

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

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

Covered Health Services: Those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms
- Medically Necessary
- Described as a Covered Health Service in this SPD
- Provided to a Covered Person who meets the Plan's eligibility requirements, and
- Not otherwise excluded in this SPD.

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

Contract Rate: The specified amount a POS Provider contractually agrees to accept as a Health Plan Carrier’s payment in full for a Covered service under the Traditional Indemnity option. This rate is often lower than the Provider’s usual charge for the service.

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

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

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

CVS Caremark: The company that administers the Prescription Drug Program for participants in the POS and Traditional Indemnity options under the Plan.

Deductible: See Annual Deductible.

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

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

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

Designated Provider: A provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions, or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

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: A provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Services via interactive audio with video technology or audio only.

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

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

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

(i) They reside in the same household
(ii) They are each age 18 or older
(iii) They have the mental capacity sufficient to enter into a valid contract
(iv) They are not related to each other by blood
(v) They are not married to each other or to another person and are not the domestic partner or civil union partner of another individual
(vi) They consider themselves to have a close and committed personal relationship and have no other such relationship with any person
(vii) They are responsible for each other's welfare and financial obligations, and
(viii) They provide such other information as may be necessary for the Plan to determine whether the individual (or the Children of such individual) are Eligible Dependents under the Plan.

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

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

Domestic Partner: See Domestic or Civil Union Partner.

Domiciliary Care: Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME): Medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms
- Is not disposable
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms
- Can withstand repeated use
- Is not implantable within the body, and
- Is appropriate for use, and is primarily used, within the home.

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

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

Eligible Employees who have a Domestic or Civil Union Partner, Eligible Dependent also includes a Child of a Domestic or Civil Union Partner.

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

Eligible Expenses: 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 elsewhere in this SPD.

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

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS)
- As 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 accept.

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

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

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

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

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Employee Benefits Committee (EBC): The committee appointed by the Company to undertake certain administrative responsibilities with respect to the Plan. The EBC serves as the final review committee for all questions relating to eligibility to participate in the Plan and all other questions related to administration of the Plan, to the extent not delegated to the Claims Administrator or to the Nokia Benefits Review Team. Decisions by the EBC are conclusive and binding on all parties and not subject to further internal review.

Excluded Employee: Each of the following:

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

ERISA: The Employee Retirement Income Security Act of 1974, as amended from time to time, and all applicable regulations.

Experimental or Investigational Service(s): Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section G, "Additional Coverage Details Regarding the POS Options".
- If you are not a participant in a qualifying Clinical Trial as described under Section G, "Additional Coverage Details Regarding the POS Options", and have a Sickness or condition that is likely to cause death within one year of the request

for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB): A statement provided by the Claims 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 reductions taken
- The net amount paid by the Plan
- The reason(s) why the service or supply was not covered by the Plan.

Extended Care Facility: See Skilled Nursing Facility.

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

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

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

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

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

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- Diagnostic criteria for children:

  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

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

Genetic Counseling: Counseling by a qualified clinician that includes:

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

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

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

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

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

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

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

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

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

In-Network Benefits: See Network Benefits.

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

Injury: Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

International Assignee: Any of the following:

- An Employee who is classified as an Expatriate (Outbound Assignee) meaning the employee's home country is the United States, and the Expatriate is on a long-term international assignment for the Company outside of the United States, or
- An Employee who is classified as an Inpatriate (Inbound Assignee) meaning the employee's home country is outside of the United States, and the Inpatriate is on a long-term or short-term international assignment for the Company in the United States, or

- An Employee who is classified as on an International Professional Contract (IPC) meaning the employee does not have a designated home country and is on an international assignment for the Company in the United States.

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

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

Intensive Behavioral Therapy (IBT): Outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age-appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment: A structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care: Skilled nursing care that is provided or needed either:

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

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

Kidney Resource Services (KRS): A program administered by the Claims Administrator or its affiliates made available to you by Nokia. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with End-Stage Renal Disease (“ESRD”) or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

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

Manipulative Treatment: The therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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

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

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

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

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

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

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

Medicare: Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services: Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of 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 the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator: The organization or individual designated by the Plan who provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services.

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

Network: When used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits: The level of Benefits that are paid for Covered Health Services provided by Network providers.

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

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

- The date as determined by the Claims Administrator or the Claims Administrator's designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented; or
- December 31st of the following calendar year.

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

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

Outbreak Period: The period during which certain deadlines under the Plan are delayed. Specifically, the Outbreak Period means the period beginning on the date certain actions are required or permitted under the Plan as described in this SPD (the “Outbreak-Subject Action”) and ending on the earlier to occur of (a) the 60th day immediately following the end of the declaration of national emergency due to the Coronavirus (COVID-19) pandemic, and (b) the one-year anniversary of the Outbreak-Subject Action. Outbreak-Subject Actions are identified by a “Note” that specifically references the extended deadline due to the Outbreak Period.

Out-of-Network: When used to describe a provider of health care services, this means a provider that does not have a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

Out-of-Network Benefits: The level of Benefits paid for Covered Health Services provided by non-Network providers. See Appendix 1, "Services Covered and Cost Sharing under the POS Options", for details.

Out-of-Pocket Maximum: The maximum amount you pay every calendar year with respect to certain benefits.

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

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

Participating Company: Each of the following:

- Nokia of America Corporation
- Nokia Investment Management Corporation.

Personal Health Support: Programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse: The primary nurse that the Claims Administrator may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s): With respect to the POS Options, *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Service by a Physician.

Physician: Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a

Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan: The Medical Plan.

Plan Administrator: The Company or its designee.

Plan Sponsor: The Company.

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

Pregnancy: All of the following:

- Prenatal care
- Postnatal care
- Childbirth
- Any complications associated with the above.

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

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

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

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: A Provider of healthcare services or supplies. A Provider may be a person, such as a Physician, physical therapist, or Chiropractor; an organization, such as a Home Health Care Agency; or a facility, such as a Hospital.

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

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

Reconstructive Procedure: A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment: Treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured setting:
  - Room and board
  - Evaluation and diagnosis
  - Counseling
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

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

Sickness: Physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

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

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.

- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility: A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician: 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.

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

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

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

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

Transitional Living: Mental health services and substance-related and addictive disorder services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing 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 members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services: Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted

randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

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

Urgent Care: Care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center: 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.

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

Section C. Eligibility and Enrollment

Who Is Eligible?

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

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

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

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

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

Enrolling in the Plan

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

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

Declining Coverage

You may decline coverage under the Plan. However, if you do, you will have to wait until the next Annual Open Enrollment Period if you want to enroll in the Plan--unless you have a

Qualified Status Change. See "Changing Your Coverage During the Plan Year" later in this section.

Plan Options and Coverage Categories

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

The following coverage options are available under the Plan:

- Standard Option (a plan with a standard level of benefit coverage)
- Enhanced Option (providing a higher level of coverage than the Standard option).

To see the difference between the level of coverage offered under the Standard Option and the Enhanced Option, see Appendix 1, "Services Covered and Cost Sharing under the POS Options".

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

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

Newly Hired Employees

If you are a full-time or a part-time Eligible Employee regularly scheduled to work 20 or more hours a week, you are assigned individual ("You only") coverage under the Medical Plan as of your first day of work. You may add Eligible Dependents to your coverage provided you do so within 31 days of the date you are notified of your eligibility to enroll. If you are scheduled to work less than 20 hours a week, you must actively enroll.

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

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

If You Don't Enroll (New Hires)

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

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

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

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

Annual Open Enrollment Period

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

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

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

Changing Your Coverage During the Plan Year

You may change your coverage under the Plan during the Plan Year **only** if you have a "qualified status change". In order to be able to make a change during the year, qualified status changes must be reported through YBR or to the Nokia Benefits Resource Center within 31 days of the event. **Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, this 60-day period will not start until the end of the Outbreak Period.**

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

Please note: Your election change under the Medical Plan during the year must be due to and consistent with the type of qualified status change that has occurred. For example, if you

legally adopt a child, you may enroll the newly adopted child in the Medical Plan. You may not, however, cancel coverage for your Spouse.

Qualified Status Change	Description
Change in Marital Status	Your marriage, divorce, legal separation, the annulment of your marriage, or the death of your Spouse.
Change in Domestic or Civil Union Partner Status	The entering into of, or termination of, a Domestic or Civil Union Partner relationship.
Change in the Number of Eligible Dependents	The birth, death, legal adoption, or placement for legal adoption of one of your Eligible Dependents.
Change in Employment Status, Work Schedule, or Worksite That Causes A Change in Eligibility	You or Eligible Dependent: • Becomes employed or loses employment • Experiences a change in worksite, or • Reduces or increases hours of employment, including a switch between part-time and full-time employment or the start of, or a return from, a leave of absence. Note: Without a change in eligibility, the above changes will not permit a mid-year change.
Your Dependent Meets or No Longer Meets the Eligibility Requirements	An event that causes a dependent to meet or to no longer satisfy the Plan's eligibility requirements, for example, a Child reaches the maximum age for coverage.
Change in Place of Residence	A change in permanent residence for you or an Eligible Dependent that causes a loss of eligibility for coverage.
Significant Cost or Coverage Changes	A significant change in the cost or coverage under the Plan (for example, if costs significantly increase mid-year, you may be eligible to drop coverage) or a significant change in cost or coverage under another employer's group health plan in which one of your Eligible Dependents participates. (For example, if costs significantly increase under your Spouse's plan mid-year, your Spouse may be able to disenroll from the other employer's plan and enroll in the Medical Plan.)
Court-Ordered Coverage	A change in your responsibility to provide healthcare coverage for a dependent Child as stipulated in a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (for example, a Qualified Medical Child Support Order). Documentation must be submitted.

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

Special Enrollment Rights

The Plan provides "special enrollment rights" for both Eligible Employees and their Eligible Dependents in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and also the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). Special enrollment rights refers to the ability to enroll for coverage under the Plan outside the Plan's normal enrollment periods (e.g., when first becoming eligible for coverage or during an Annual Open Enrollment Period) in certain limited circumstances, provided timely notice is provided to the Plan, as described below.

Under HIPAA, if you declined coverage under the Plan (either when you first became eligible for coverage or during a subsequent Annual Open Enrollment Period) because you had other health insurance or other group health plan coverage (for example, coverage available under a Spouse's plan), you may be able to enroll yourself and your Eligible Dependents in this Plan if you (or any of your Eligible Dependent(s)) lose eligibility for that other coverage or if, in the case of an employer-sponsored group health plan, the other employer stops contributing toward your or your dependents' other coverage. However, you must request enrollment in the Plan within 31 days plan after your or your Eligible Dependent's(s') other coverage ends (or within 31 days after the other employer stops contributing toward that other coverage). **Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, the 31-day period will not start until the end of the Outbreak Period.**

Also under HIPAA, if you "gain" a new dependent during the Plan Year as a result of marriage, entering into a Domestic or Civil Union Partnership, or the birth, adoption, or placement for adoption of a child, you may be able to enroll yourself and your Eligible Dependents (both "new" Eligible Dependents and existing but unenrolled Eligible Dependents) in the Plan. However, you must request enrollment within 31 days after the event, i.e., the marriage, entering into such Domestic or Civil Union Partnership, birth, adoption, or placement for adoption. **Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, this 31-day period will not start until the end of the Outbreak Period.**

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

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

In addition to the foregoing special enrollment rights under HIPAA, the Plan provides for special enrollment rights under CHIPRA. If you or your Eligible Dependent is eligible for but

not enrolled in coverage under the Plan, you are eligible to enroll in the Plan outside of the Plan's Annual Enrollment Period if you meet either of the following conditions and you request enrollment with the Plan no later than the deadline described below:

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

In order to enroll in the Plan for any of those circumstances, you must request enrollment within 60 days of the event. **Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, this 60-day period will not start until the end of the Outbreak Period.**

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

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

Section D. The Cost of Plan Coverage

Employee Contributions

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

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

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

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

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

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

Cost of COBRA Coverage

"COBRA" coverage is continuation coverage that is available under the Plan in certain circumstances. See Section Q., "COBRA Continuation Coverage" for more information. There is a difference between the contributions required for active employee coverage and coverage as COBRA continuant. Please contact the Nokia Benefits Resource Center or visit the YBR website or refer to your COBRA Enrollment Notice for details on the current cost of your coverage. See Section V., "Important Contacts" for more information on how to contact the Nokia Benefits Resource Center. **Note: Under the American Rescue Plan Act of 2021,**

certain individuals, defined as "assistance eligible individuals", are eligible to receive COBRA continuation coverage at no monthly contribution cost during the period April 1, 2021 through September 30, 2021 (or the expiration of their COBRA continuation period, if sooner). For more information about this limited-time zero-contribution coverage opportunity, contact the Nokia Benefits Resource Center. (The Nokia Benefits Resource Center will also send a separate communication to those who are eligible for this opportunity.)

Section E. How the POS Options Work

Understanding Your Options Under the Medical Plan

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

- The Standard Option; and
- The Enhanced Option.

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

The details pertaining to your Medical Plan options, including Coinsurance, Deductibles, and Annual Maximum can be found in Appendix 1, "Services Covered and Cost Sharing under the POS Options".

What this section includes:
- Accessing Benefits
- Eligible Expenses
- Annual Deductible
- Copayment
- Coinsurance
- Out-of-Pocket Maximum.

Accessing Benefits

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

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

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

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Out-of-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Out-of-Network Benefits may also be referred to as Non-Network Benefits.

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

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

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

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

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

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator, and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Network Providers

The Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, the Claims Administrator will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a

provider's status or request a provider directory, you can call the Claims Administrator at the number on your ID card or log onto **www.myuhc.com**.

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

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

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

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

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

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

Designated Providers

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

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

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network

provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

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

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

Eligible Expenses

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

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

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

Advocacy Services

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

costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The Annual Deductible applies only to Out-of-Network Benefits for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

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

Out-of-Pocket Maximum

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

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums. The following table identifies what does and does not apply toward your In-Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the In-Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	Not Applicable	No

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

Prior Authorization

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

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

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Out-of-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

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

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

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

Section F. What's Covered Under the POS Options

The Services covered under the Plan's POS Options are set forth in the Appendix 1, "Services Covered and Cost Sharing under the POS Options".

Section G. Additional Coverage Details Regarding the POS Options

What this section includes:

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

This section supplements the information presented in Appendix 1, "Services Covered and Cost-Sharing under the POS Options".

While the table in Appendix 1 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. The Covered Health Services in this section appear in the same order as they do in Appendix 1 for easy reference. Services that are not covered are described in Section H, "Exclusions and Limitations--What the POS Options Do Not Cover".

Acupuncture Services

Acupuncture services for pain therapy when the service is performed by a provider in the provider's office, when the provider is either practicing within the scope of the provider's license (if state license is available) or who is certified by a national accrediting body:

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

Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of:

- Nausea of chemotherapy
- Post-operative nausea, and
- Nausea of early Pregnancy.

Any combination of Network Benefits and Out-of-Network Benefits for needle therapy is limited to 30 treatments per calendar year.

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.

Ambulance Services - Non-Emergency

Transportation by professional ambulance (not including air ambulance) between medical facilities.

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

If you fail to obtain prior authorization from the Claims administrator, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

Cellular and Gene Therapy

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

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

Clinical Trials

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

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you do not obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

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

Benefits are available for the following CHD services:

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

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services
- Physician Fees for Surgical and Medical Services
- Scopic Procedures - Outpatient Diagnostic and Therapeutic
- Therapeutic Treatments - Outpatient
- Hospital - Inpatient Stay
- Surgery - Outpatient

To receive Benefits under the CHD program, you must contact CHD Resource Services at 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 Provider performing the services (even if you self-refer to a provider in that Network).

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises.

If you do not obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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, "D.D.S." or a Doctor of Medical Dentistry; "D.M.D."; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

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); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Benefits are available only for treatment of a sound, natural tooth.

The Physician or dentist must certify that the injured tooth was:

- a virgin or unrestored tooth; or
- a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- 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; 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.

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 an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Diabetes Services

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

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 meters, including continuous glucose monitors
- Insulin syringes with needles
- Blood glucose and urine test strips
- Ketone test strips and tablets
- Lancets and lancet devices.

Diabetes supplies are covered under the Plan’s Prescription Drug Program (see Part III of this SPD).

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable; and
- not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost. 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 assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;
- shower chairs for quadriplegics;
- Jobst stockings, compression stockings;
- oxygen concentrator units and the rental of equipment to administer oxygen;
- delivery pumps for tube feedings;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section;
- shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics when prescribed by a Physician;
- custom molded cranial orthotics (helmets), when prescribed by Physician;
- braces that stabilize an injured body part are considered Durable Medical Equipment and are a Covered Health Service, 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 or conditions; and

Benefits also include dedicated speech-generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices and 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 for repair/replacement are limited to once every three years.

UnitedHealthcare provides Benefits for a single unit of Durable Medical Equipment (example: one insulin pump) and provides repair for that unit. 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 Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization from the Claims Administrator, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

Emergency Health Services - Outpatient

The Plan pays for services that are required to stabilize or initiate treatment in an Emergency. Emergency health services must be received on an outpatient basis at a Hospital or Alternate Facility.

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Out-of-Network Benefits will apply.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within two business days 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. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas
- Extensively hydrolyzed protein formulas
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment
- Chronic physical disability
- Intellectual disability, or
- Loss of life.

Gender Dysphoria

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
- Cross-sex hormone therapy administered by a medical provider
- 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:

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:

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

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.

- Must 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

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.

Prior Authorization Requirement for Surgical Treatment
For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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

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

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

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 for a Covered Person 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* in this section.

Out-of-Network Benefits are limited to:

- Unlimited visits per calendar year for physical therapy.
- Unlimited visits per calendar year for occupational therapy.
- 100 visits per calendar year for speech therapy for developmental delays. 30 visits per calendar year for speech therapy for all other diagnoses.

These visit limits apply to Out-of-Network Benefits.

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; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of In-Network Benefits and Out-of-Network Benefits for hearing aids is limited to $2,500 per calendar year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when Skilled Care is required.

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

Out-of-Network Benefits are limited to 100 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods and Private Duty Nursing, or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

Hospice Care

The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Any combination of Network Benefits and Out-of-Network Benefits is limited to 210 days per Covered Person during the entire period you are covered under the Plan.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Prior Authorization Requirement
For Out-of-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.

- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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

Injections received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy. Growth hormone therapy is covered by the plan with prior authorization.

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.

There is a special prenatal program to help during Pregnancy. It is completely voluntary, and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; and
- 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.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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

Mental Health Services

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

Benefits include the following levels of care:

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

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

Services include the following:

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

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Out-of-Network Benefits for:

- A scheduled admission for Mental Health Services (including admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Out-of-Network Benefits you must obtain prior authorization from the Claim Administrator before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, 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 reduced by 20% of Eligible Expenses up to a maximum of $400.

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.

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

Services include the following:

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

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 Out-of-Network Benefits for:

- A scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; 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 reduced by 20% of Eligible Expenses up to a maximum of $400.

Nutritional Counseling

The Plan will pay for Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include:

- diabetes mellitus;
- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

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

Obesity Surgery

The Plan covers surgical treatment of morbid obesity provided by or under the direction of a Physician provided either of the criteria is met:

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

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section B, "Terms You Should Know", and are not Experimental or Investigational or Unproven Services.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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

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

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;

- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees and facility-based Physician's fees related to outpatient surgery are described under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of Copayments, or call Customer Service at the telephone number on your ID card, or the website **www.myuhc.com** to determine the specific Copayment amount associated with each Network provider.

Prior Authorization Requirement
For Out-of-Network Benefits for sleep apnea surgeries you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

Outpatient Diagnostic Services

The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab and radiology/X-ray.
- Mammography testing.
- Presumptive Drug Tests and Definitive Drug Tests.

Limited to 18 Presumptive Drug Tests per calendar year.

Limited to 18 Definitive Drug Tests per calendar year.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related Physician Fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.
This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.

Prior Authorization Requirement
For Out-of-Network Benefits for Genetic Testing and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine

The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related Physician Fees.

Outpatient Therapeutic Treatments

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related Physician Fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Prior Authorization Requirement
For Out-of-Network Benefits for the following outpatient therapeutic services, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy, and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

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

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

Preventive Care Services

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.

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

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

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

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

Private Duty Nursing

The Plan pays for Covered Health Services for Private Duty Nursing care given on an outpatient basis when provided by a licensed nurse (R.N., L.P.N., or L.V.N.).

Out-of-Network Benefits are limited to 100 visits per calendar year.

Prosthetic Devices

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

- artificial limbs;
- artificial eyes; and
- breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

Benefits are also provided for wigs except for temporary hair loss due to disease or treatment of disease. Any combination of Network Benefits and Out-of-Network Benefits is limited to $300 per calendar year in which the condition manifested itself.

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.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. UnitedHealthcare provides Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceeds $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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

Reconstructive Procedures

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

Procedures are services considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent “bump” would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance, and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services mandated 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 Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Breast Reduction Surgery is a Covered Health Service with documentation of the following functional impairments:

- Shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts.
- Documentation from medical records of medical services related to complaints of the shoulder, neck or back pain attributable to macromastia.
- Determined not to be cosmetic by Personal Health Support.

Note: Breast Reduction Surgery is not a Covered Health Service when performed to improve appearance or for the purpose of improving athletic performance. Breast Reduction Surgery is covered when a Reconstruction has been performed on the other breast (as part of the Federal mandate).

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If authorization is not obtained from the Claims Administrator as required, or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

In addition, for Out-of-Network Benefits you must provide notification to the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for:

- Physical therapy
- Occupational therapy
- Speech therapy
- Post-cochlear implant aural therapy
- Orthoptic (vision) therapy
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident
- Pulmonary rehabilitation, and
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. 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, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Benefits are limited to:

- Unlimited visits per calendar year for physical therapy
- Unlimited visits per calendar year for occupational therapy
- Unlimited visits per calendar year for speech therapy. 100 visits per calendar year for Out-of-Network speech therapy for developmental delay, 30 visits for Out-of-Network speech therapy for other diagnosis
- Unlimited visits per calendar year for pulmonary rehabilitation therapy
- Unlimited visits per calendar year for cardiac rehabilitation therapy
- Unlimited visits per calendar year for cognitive rehabilitation therapy
- Unlimited visits per calendar year for orthoptic (vision) therapy
- Unlimited visits per calendar year for post-cochlear implant aural therapy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Services and supplies received during the Inpatient Stay, and
- Room and board in a Semi-private Room (a room with two or more beds).

Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are considered Intermittent Care (such as physical therapy three times a week).

Benefits are NOT available for custodial, maintenance or Domiciliary Care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, maintenance or Domiciliary Care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Out-of-Network Benefits are limited to 60 days per calendar year.

Prior Authorization Requirement
For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If authorization is not obtained as required, or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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

Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy

Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other Physician for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Out-of-Network Benefits for Spinal Treatment are limited to 30 visits per calendar year.

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).

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.

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 Out-of-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator prior to the admission.

- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, 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 reduced by 20% of Eligible Expenses up to a maximum of $400.

Temporomandibular Joint (TMJ) Services

The Plan pays for Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration* (FDA)-approved TMJ implants only when all other treatment has failed.

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

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 for 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 provided by a Designated Provider.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses up to a maximum of $400.

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

Urgent Care Center Services

The Plan pays for Covered Health Services received at an Urgent Care Center. When Urgent Care services are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.

Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

Virtual Visits

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

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

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

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

Section H. Exclusions and Limitations--What the POS Options Do Not Cover

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

When Benefits are limited within any of the Covered Health Services categories described in Section G, "Additional Coverage Details Regarding the POS Options", those limits are stated in the corresponding category in Appendix 1, "Services Covered and Cost-Sharing under the POS Options". Limits may also apply to some Covered Health Services that fall under more than one category. When this occurs, those limits are also stated in Appendix 1. 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 UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure
2. Aromatherapy
3. Hypnotism
4. Massage therapy
5. Rolfing
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Spinal Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section G, "Additional Coverage Details Regarding the POS Options".
7. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.

Comfort or Convenience

1. Television
2. Telephone

3. Beauty/barber service

4. Guest service

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

   - Air conditioners
   - Air purifiers and filter
   - Batteries and battery chargers
   - Dehumidifiers
   - Humidifiers.

6. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section G, "Additional Coverage Details Regarding the POS Options".

7. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

Dental

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section G, "Additional Coverage Details Regarding the POS Options".

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

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

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section G, "Additional Coverage Details Regarding the POS Options".

3. Dental implants

4. Dental braces (orthodontics)

5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia

6. Treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a Congenital Anomaly.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug Program portion of the Plan, see Part III.

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

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

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

4. Over-the-counter drugs and treatments.

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

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

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

Experimental or Investigational or Unproven Services

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

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section G, "Additional Coverage Details Regarding the POS Options".

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include the following:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.

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

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty
- Blepharoplasty
- Breast enlargement, including augmentation mammoplasty and breast implants
- Body contouring, such as lipoplasty
- Brow lift
- Calf implants
- Cheek, chin, and nose implants
- Injection of fillers or neurotoxins

- Face lift, forehead lift, or neck tightening
- Facial bone remodeling for facial feminizations
- Hair removal
- Hair transplantation
- Lip augmentation
- Lip reduction
- Liposuction
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty
- Skin resurfacing
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple)
- Voice modification surgery
- Voice lessons and voice therapy.

Hearing Aids

Bone anchored hearing aids except when either of the following applies:

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

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 under the Plan.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

Medical Supplies and Appliances

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

2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   - Ace bandages
   - Gauze and dressings
   - Syringes
   - Diabetic test strips.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of Durable Medical Equipment or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in Section G, "Additional Coverage Details Regarding the POS Options"*.* This exception does not apply to supplies for the administration of medical food products.
   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section G, "Additional Coverage Details for the POS Options"
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section G, "Additional Coverage Details Regarding the POS Options"
   - Urinary catheters for which Benefits are provided as described under *Urinary Catheters* in Section G, "Additional Coverage Details Regarding the POS Options"*.*

3. Orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section G, "Additional Coverage Details Regarding the POS Options"

   Examples of excluded orthotic appliances and devices include but are not limited to, any orthotic braces available over-the-counter.

4. Tubings and masks, except when used with Durable Medical Equipment as described in Section G, "Additional Coverage Details Regarding the POS Options" under the heading *Durable Medical Equipment*.

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

In addition to all other exclusions listed in this Section H, "Exclusions and Limitations--What the POS Options Do Not Cover", the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section G, "Additional Coverage Details Regarding the POS Options".

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, conduct and disruptive impulse control 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. Megavitamin and nutrition-based therapy.

2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in Section G, “Additional Coverage Details Regarding the POS Options”.

Physical Appearance

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

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.

   - Pharmacological regimens, nutritional procedures or treatments.

   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

   - Sclerotherapy treatment of veins.

- Hair removal or replacement by any means.
- Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Skin abrasion procedures performed as a treatment for acne.
- Treatments for hair loss.
- Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section G, "Additional Coverage Details Regarding the POS Options".

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

Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     - Assisted reproductive technology
     - Artificial insemination
     - Intrauterine insemination
     - Obtaining and transferring embryo(s)
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care
     - Screenings and/or diagnostic testing
     - Delivery and post-natal care.

   The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees
     - Surrogate insurance premiums
     - Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Donor eggs - The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval
   - Donor sperm - The cost of procurement and storage of donor sperm

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue

5. The reversal of voluntary sterilization and voluntary sterilization

6. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to,

coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

Transplants

1. Health services for organ, multiple organ and tissue transplants, except as described in *Transplantation Services* in Section G, "Additional Coverage Details Regarding the POS Options", unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

3. Health services for transplants involving permanent mechanical or animal organs.

4. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section G, "Additional Coverage Details Regarding the POS Options", unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses.

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at UnitedHealthcare's discretion.

Vision

1. Purchase cost of eyeglasses or contact lenses and fitting charge for eyeglasses or contact lenses except for the first pair of glasses and frames or contact lenses post-cataract surgery.

2. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser and other refractive eye surgery.

3. Routine vision examinations, including refractive examinations.

All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section B, "Terms You Should Know". Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

   - Medically Necessary

   - Described as a Covered Health Service in this SPD under Section G, "Additional Coverage Details Regarding the POS Options" and/or in Appendix 1, "Services Covered and Cost-Sharing under the POS Options"

   - Not otherwise excluded in the SPD under Section H, "Exclusions and Limitations--What the POS Options Do Not Cover"

     This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:

   - Required solely for purposes of career, education, sports or camp, career or employment, insurance, marriage or adoption

   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section G, "Additional Coverage Details Regarding the POS Options"

   - Related to judicial or administrative proceedings or orders

   - Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.

4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends

5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan

6. In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or the Annual Deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation

8. 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

9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as a treatment of obstructive sleep apnea

10. Non-surgical treatment of obesity, including morbid obesity

11. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section G, "Additional Coverage Details Regarding the POS Options"

12. Custodial Care or maintenance care

13. Domiciliary Care

14. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain

15. Private Duty Nursing received on an inpatient basis

16. 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 under *Hospice Care* in Section G, "Additional Coverage Details Regarding the POS Options"

17. Rest cures

18. Psychosurgery

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

20. Medical and surgical treatment of excessive sweating (hyperhidrosis)

21. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea

22. Appliances for snoring

23. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing

24. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.

25. Any charge for services, supplies or equipment advertised by the provider as free

26. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency

27. Any charges prohibited by federal anti-kickback or self-referral statutes

28. Chelation therapy, except to treat heavy metal poisoning

29. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services

30. Outpatient rehabilitation services, spinal treatment, manipulative treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring

31. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies

32. Speech therapy to treat stuttering, stammering, or other articulation disorders

33. 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 Procedures* in Section G, "Additional Coverage Details Regarding the POS Options".

34. Foreign language and sign language services

35. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section G, "Additional Coverage Details Regarding the POS Options"

36. Intracellular micronutrient testing.

Section I. Clinical Programs and Resources

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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path. For additional information, see *Cancer Resource Services (CRS)* under *Complex Medical Conditions Programs and Services* in Section I, "Clinical Programs and Resources".
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path. For additional information, see *Kidney Disease Programs* in Section I, "Clinical Programs and Resources".

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.

Consumer Solutions and Self-Service Tools

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.

Health Survey

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

Your health survey is kept confidential. Completing the survey will not affect 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, the Claims Administrator may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

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

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

Decision Support

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

This program offers:

- Access health care information.
    - Support by a nurse to help you make more informed decisions in your treatment and care.
    - Expectations of treatment.
    - Information on providers and programs.
- Conditions for which this program is available include:
    - Back pain.

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

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

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

Cancer Resource Services (CRS) Program

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

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

Coverage for oncology services and oncology-related services are based on Plan terms, exclusions, limitations and conditions, including eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Cancer Support Program

The Claims Administrator provides a program that identifies and supports a Covered Person who has cancer. You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies and treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on your ID card or call the program directly at 1-866 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see *Cancer Resource Services (CRS)* under *Complex Medical Conditions Programs and Services* in Section I, "Clinical Programs and Resources".

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.

Coverage for CHD surgeries and related services are based on 'Plan terms, exclusions, limitations and conditions, including '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.

For Travel and Lodging assistance, refer to the *Travel and Lodging Assistance Program*.

Kidney Disease Programs

Comprehensive Kidney Solution (CKS) Program

For Participants diagnosed with Kidney Disease, the Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) Stage 4/5 through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To find out more about Comprehensive Kidney Solutions, please visit www.myoptumhealthcomplexmedical.com or call the number on the back of your ID card.

Coverage for dialysis and kidney-related services are based on Plan terms, exclusions, limitations and conditions, including eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please advise CKS of your decision.

End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you will work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. The nurse can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on Plan terms, exclusions, limitations and conditions, including eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Transplant Resource Services (TRS) Program

The Plan offers the 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 Plan terms, exclusions, limitations and conditions, including eligibility requirements and coverage guidelines. Participation in this program is voluntary.

For Travel and Lodging assistance, refer to the provision below.

Travel and Lodging Assistance Program

Under certain circumstances, the Plan will provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated 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 patient, provided the patient is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider
- Reimbursement for certain lodging expenses for the patient and the patient's companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate
- The transplant, cancer and congenital heart disease 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 patient or the caregiver if the patient is in the Hospital.

- A per diem, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries
- Alcoholic beverages
- Personal or cleaning supplies
- Meals
- Over-the-counter dressings or medical supplies
- Deposits
- Utilities and furniture rental, when billed separate from the rent payment
- Phone calls, newspapers, or movie rentals.

- Transportation

  - Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider
  - Taxi fares (not including limos or car services)
  - Economy or coach airfare
  - Parking
  - Trains
  - Boat
  - Bus
  - Tolls.

Women's Health/Reproductive Programs

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.

Plan Benefits for Covered Health Services are described in Section G, "Additional Coverage Details Regarding the POS Options" and in Appendix 1, "Services Covered and Cost-Sharing under the POS Options", unless the service is excluded in Section H, "Exclusions and Limitations--What the POS Options Do Not Cover".

Wellness Programs

Rally® (Health Journey) Program

Under the Plan, you have access to Rally®[1], a user-friendly digital experience on myuhc.com that will engage you by using technology, gaming and social media to help you understand, learn about and feel supported on your health journey. Rally offers personalized recommendations to help you and your covered family members make healthier choices and build healthier habits — one small step at a time. You can access Rally at www.myuhc.com from your computer, tablet or smartphone anytime.

Real Appeal® (Weight Loss) Program

Under the Plan, you have access to Real Appeal®[2], a fun and engaging online weight loss and healthy lifestyle program. Based on the science of what really works to help people lose weight and keep it off, Real Appeal is available at no cost to you and your covered family members age 18 and older. Connect with Real Appeal anytime at www.realappeal.com from your computer, tablet or smartphone.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 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.

[1] "Rally" is a registered trademark of Rally Health, Inc.

[2] "Real Appeal" is a registered trademark of Real Appeal, Inc.

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, https://member.realappeal.com or at the number shown on your ID card.

Section J. Overview of the Prescription Drug Program

About the Program Generally

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

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

What's Covered Under the Prescription Drug Program

Overview

Generally, the Prescription Drug Program covers:

- Drugs prescribed by a Physician and provided by a pharmacist (but see below, "What's Not Covered", for exceptions)
- Birth control medications and contraceptive devices (including oral contraceptives, implants and injections)
- Insulin
- Disposable supplies ordered by a Physician for a diabetic patient, including needles and syringes
- Blood and urine testing supplies, and
- Prescription (not over-the-counter) smoking deterrents (including nicotine products such as inhalers and nasal sprays).

Prescription-Drug Formulary

The Prescription Drug Program uses the CVS Caremark formulary. A formulary is a list of commonly prescribed medications that have been shown to be clinically effective as well as cost effective. If your doctor prescribes formulary medications, you can help control rising health care costs while still maintaining high-quality care. The Formulary Drug List is available online at www.caremark.com or by calling CVS Customer Care at 1-800-240-9623.

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

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

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

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

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

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

Drugs Requiring Authorization

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

Drugs Subject to Quantity Limits

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

Specialty Medications

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

- Anemia
- Cancer
- Growth hormone deficiency
- Hepatitis C

- Multiple sclerosis, and
- Rheumatoid arthritis.

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

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

What's Not Covered Under the Prescription Drug Program

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

- Drugs and medicines provided (or that can be obtained) without a prescription from a Physician
- Non-federal legend drugs
- Prescription drugs with an over-the-counter (OTC) equivalent
- OTC contraceptives, jellies, creams, foams, and devices
- Plan B/Plan B One-Step through age 17 and older
- Diabetic blood testing monitors
- Isopropyl alcohol solution
- Insulin pumps
- Kutapressin
- Ostomy supplies
- Foreign drugs
- Mifeprex (but this might be covered under the POS Options or other medical portion of the Plan)
- Therapeutic devices or appliances
- Drugs used solely to promote hair growth for cosmetic purposes only
- Immunization agents, vaccines or biologicals (except if listed as covered)
- Allergy sera (serums)
- Blood or blood plasma (except if listed as covered)
- Patch, kit and most compounds
- Drugs labeled "Caution — limited by federal law to investigational use" or Experimental Drugs even if you are charged for those drugs
- Drugs used for Experimental or Investigational purposes
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or local governmental agency or any drug or medical service furnished at no cost to the covered individual
- Medication provided to a covered individual while a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility (for example, a Skilled Nursing Facility), convalescent Hospital, nursing home, Home Health Care Agency or similar institution that has a facility for dispensing pharmaceuticals on its premises
- Prescriptions filled in excess of the refill number specified by the Physician or any refill dispensed one year after the original prescription
- Charges for the administration or injection of any drug
- Nutritional dietary supplements

- Any drug or medicine not Medically Necessary to treat the condition, and
- Prescriptions filled at a non-CVS retail pharmacy that exceed the 30-day limit (90 days for insulin) or through the mail or at a CVS retail pharmacy that exceed the 90-day limit.

Cost Sharing

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

- Generic
- Preferred Brand, and
- Nonpreferred Brand.

Separate Out-of-Network Annual Deductible

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

Separate Out-of-Pocket Maximum

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

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

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

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

Section K. Filling Prescriptions

How to Fill a Prescription

The Prescription Drug Program offers you the following ways to fill prescriptions:

- At any retail pharmacy, or
- Using mail order through the CVS Caremark Mail Service Pharmacy.

Use a retail pharmacy for short-term prescriptions of up to 30 days (90 days for insulin). If you need to take a medication on an ongoing basis, you can receive refills of 90-day supplies at a time by using the mail order service or a CVS retail pharmacy.

Network Retail Pharmacies

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

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

To find a Network Retail Pharmacy near you:

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

Out-of-Network Retail Pharmacies

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

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

Mail Service Pharmacy

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

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

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

Prescription Drug Coverage Management Programs

Retail Refill Allowance

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

Member Pays the Difference Program (DAW Program)

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

The Caremark.com App

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

Section L. Other Prescription-Drug-Related Services

Drug Utilization Review

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

Toll-Free Prescription Drug Customer Service

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

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

Section M. The Employee Assistance Program (EAP)

Employee Assistance Program

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

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

Section N. Coordination of Benefits (COB); Overpayment and Underpayment of Benefits

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

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

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

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. 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.

Determining Which Plan is Primary

Order of Benefit Determination Rules

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

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

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

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

- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.

- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

What Happens When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

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

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

Determining the Allowable Expense if This Plan is Secondary

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

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

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 the Claims Administrator 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.

If this Plan is Secondary to Medicare

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

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

The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

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 under Part A of Medicare (hospital expenses) and to 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 the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. 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.

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 Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, 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 the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

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

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

of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Section O. When Coverage Ends

When Employee Coverage Ends

Your coverage under the Plan ends on the last day of the month in which any of the following events occurs:

Your employment with a Participating Company terminates or you otherwise cease to be an Eligible Employee
You do not make a required contribution toward coverage under the Plan
You request that your coverage be canceled, or you decline coverage, when permitted
The company you work for ceases to be a Participating Company, or
The Plan is terminated.

When your coverage ends, you may be able to continue coverage under certain circumstances. See Section Q., "COBRA Continuation Coverage" for more information.

When Dependent Coverage Ends

Your Eligible Dependent's(s') coverage under the Plan will end as follows:

If your coverage ends, your Eligible Dependent's(s') coverage will end on the same day.

If your Eligible Dependent Child attains age 26, such Child's coverage will end on the last day of the month in which the Eligible Dependent Child reaches age 26.

***Please note**: If your Dependent Child is an Adult Disabled Child within the meaning of the Plan, he or she may be able to continue his or her coverage regardless of age. This coverage is not automatic. The Medical Plan Claims Administrator must certify that the child is eligible for coverage. To apply for coverage, contact the Medical Plan Claims Administrator and notify the Nokia Benefits Resource Center of your intention to seek this coverage.*

If your Eligible Dependent's coverage ends for any other reason, coverage for the Dependent will end on the last day of the month in which the event occurs.

- If you and your Spouse divorce, your Spouse's coverage will end on the last day of the month in which the divorce becomes final.
- If your Domestic or Civil Union Partnership ends (or you and your Domestic or Civil Union Partner no longer satisfy the Plan's eligibility criteria for Domestic or Civil Union Partnership), your Domestic or Civil Union Partner's coverage, and coverage for any enrolled Child(ren) of your Domestic or Civil Union Partner, will end on the last day of the month in which the Domestic or Civil Union Partnership ends (or in which the eligibility criteria are no longer satisfied).

Section P. Employment-Related Events

If You Terminate Employment

Your coverage under the Plan ends on the last day of the month in which your employment ends. You may, however, be eligible for coverage under the group healthcare plan that the Company maintains for retired employees, provided you meet the eligibility criteria of that plan. The benefits provided by the group healthcare plan for retired employees may differ from the benefits provided for active Eligible Employees under this Plan. This Plan and the plan for retired employees are subject to amendment, modification, or termination by the Company at any time, including before or during your retirement.

When coverage under this Plan ends, you may be eligible to continue coverage for yourself and your eligible Covered Dependents under COBRA. For more information, see Section Q., "COBRA Continuation Coverage."

If You Transfer Employment to Another Nokia Group Company

If you transfer employment to another Nokia Group company, whether your coverage will continue depends on whether the other company is also a Participating Company with respect to this Plan. If you transfer employment to a Participating Company, your participation in the Medical Plan will not be affected. If, however. you transfer employment to a non-Participating Company, you will be treated as having had a termination of employment for purposes of the Plan and will no longer have coverage under the Plan. However, you may be eligible to continue coverage for yourself and your eligible Covered Dependents through COBRA. For more information, see Section Q., "COBRA Continuation Coverage."

If You Leave Nokia and Are Later Rehired by a Participating Company or If You Transfer Employment to Another Nokia Group Company and You Later Transfer Back to a Participating Company

If you leave Nokia and are later rehired by a Participating Company (after a break in service), you will be treated as a new-hire for purposes of the Plan; you will automatically be enrolled in coverage under the Plan as of your first day of active employment upon your return. For more information, see Section C., "Eligibility and Enrollment."

If You Become Disabled

If you are absent due to a disability, but still employed with a Participating Company, then your coverage under the Plan continues (provided you are still an Eligible Employee).

If You Take an Approved Leave of Absence

If you take an approved leave of absence--including, but not limited to, absence due to disability, leave under FMLA, and qualified military leave under USERRA--you can continue

Plan coverage for yourself and your Covered Dependents. In some instances, you might have to pay the full cost of Plan coverage.

State and Local Leave Laws

To the extent continued Plan coverage is required by state and/or local leave laws and is not otherwise preempted by federal law, the Plan will comply.

Section Q. COBRA Continuation Coverage

Overview

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer "qualified beneficiaries" (certain covered employees and certain of their covered dependents) the opportunity to continue their group health benefit coverage at their own expense for a limited period of time if they lose coverage due to a "qualifying event".

Note: Domestic or Civil Union Partners and their children are not typically eligible for continuation coverage under federal law, as they do not meet the definition of "qualified beneficiary" under COBRA. However, the Plan provides COBRA-like rights to covered Domestic or Civil Union Partners and to the Child(ren) of Domestic or Civil Union Partners as outlined in this section of the SPD. While not legally applicable in all cases, references herein to "COBRA" and to "qualified beneficiary" includes, respectively, "COBRA-like" coverage and Domestic or Civil Union Partners and the Child(ren) of Domestic or Civil Union Partners.

Qualifying Events

In order to become eligible for continuation coverage under the Plan's COBRA continuation of coverage provisions, you (or your Covered Dependents) must face a loss of Plan coverage due to a "qualifying event". The following constitute qualifying events under the Plan:

- Termination of your employment for any reason (other than for gross misconduct)
- A reduction in your work hours
- Your divorce or legal separation from your Spouse or the termination of your Domestic or Civil Union Partnership
- A child's loss of eligibility under the terms of the Plan (e.g., your Child turns age 26)
- Your death.

The qualifying event is deemed to occur on the date that coverage under the Plan would be lost due to the occurrence of the event. For example, because coverage under the Plan continues until the end of the month in which you experience an involuntary termination of employment, this qualifying event is considered to occur on the first day of the following month.

Notice Requirement

It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of a qualifying event (other than your termination of employment, reduction in hours of employment, or death, or your Covered Dependent child turns age 26) that makes you or your Covered Dependent(s) eligible for COBRA continuation coverage. The deadline for providing such notice is 60 days from the end of the calendar month in which the qualifying event occurs. For example, if you become legally separated from your Spouse on May 15, your Spouse and

covered dependents (or you on their behalf) will have until July 31 (60 days from the first day of the month immediately following the month in which this event occurs) to notify the Nokia Benefits Resource Center of this event. **Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, this 60-day period will not start until the end of the Outbreak Period.**

The individual eligible for COBRA continuation coverage must respond by the date on the notice of COBRA rights to be eligible for COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses/Domestic or Civil Union Partners, and parents may elect COBRA continuation coverage on behalf of their children.

Maximum Period of Continuation Coverage

The table below shows the maximum period of continuation coverage available under the Plan's COBRA continuation-of-coverage provisions:

If This Qualifying Event Occurs…	**COBRA Continuation Coverage Can Last for…**
• Termination of your employment for any reason other than gross misconduct; or • A reduction in your work hours.	Up to 18 months (for you and your Covered Dependents)
• Your divorce or legal separation • Termination of your Domestic or Civil Union Partnership	Up to 36 months (for your Covered Dependents)
• Your death	Up to 36 months (for your Covered Dependents)
• Your Child's loss of eligibility under the Plan	Up to 36 months (for your covered Child)
• You or your Covered Dependent becoming disabled at any time during the first 60 days of the COBRA continuation coverage period and such disability lasting at least until the end of the initial 18-month period of COBRA continuation coverage.	The continuation-of-coverage period may be extended from 18 months to up to 29 months (for the disabled qualified beneficiary). To be eligible for the additional period of coverage, the disabled person must call the Nokia Benefits Resource Center before the end of the initial 18-month period and within 60 days of receiving notice of disability from the Social Security Administration. The individual must also notify the Nokia Benefits Resource Center within 30 days after the Social Security Administration determines that he or she is no longer disabled.

If This Qualifying Event Occurs…	COBRA Continuation Coverage Can Last for…
	Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, the above deadlines will not start until the end of the Outbreak Period.

How COBRA Continuation Coverage Is Affected by Multiple Qualifying Events

A qualified beneficiary (other than you--the Eligible Employee or former employee) may be eligible for an additional period of COBRA continuation coverage, not to exceed a total of 36 months from the initial qualifying event, if there is a second qualifying event because of your death, the divorce or legal separation of you and your Spouse, the termination of your Domestic or Civil Union Partnership, or your child losing eligibility under the Plan. The second event can be a second qualifying event only if it would have caused a loss of coverage under the Plan in the absence of the first qualifying event.

For example, suppose you terminate employment on December 31, 2021, and you are eligible to continue coverage for 18 months (i.e., until June 30, 2023). Your Child, who is a Covered Dependent on December 31, 2021, reaches age 26 (a second qualifying event) on December 31, 2022. Your child is then eligible for an additional 18 months of COBRA continuation coverage from the date of the original qualifying event. In this case, your child may continue coverage through December 31, 2024, which is 36 months from December 31, 2021, the date of your termination of employment (the original qualifying event).

To be eligible for extended coverage after a second qualifying event, you or your qualified beneficiary must notify the Nokia Benefits Resource Center within 60 days of the date of the second qualifying event. **Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, this 60-day period will not start until the end of the Outbreak Period.**

Adding a Newborn or Newly Adopted Dependent During a Period of Continuation Coverage

If, while you are enrolled in COBRA continuation coverage, you have a baby, legally adopt a child or a child is placed with you for legal adoption and the child meets the Plan's rules for being an Eligible Dependent, the child will be a considered a "qualified beneficiary" and will be eligible for COBRA continuation coverage. The maximum coverage period for such a child will be the remainder of the maximum coverage period for that qualifying event.

Electing COBRA Continuation Coverage

Complete details about COBRA continuation coverage, including information about election and cost, are automatically sent to your preferred address if you (the employee):

- Terminate employment with a Participating Company,

- Experience a reduction in work hours, or
- Die,

or if your Covered Dependent child turns age 26.

For certain qualifying events, information regarding COBRA coverage is not automatically sent. It is your or your qualified beneficiary's responsibility to notify the Nokia Benefits Resource Center of the occurrence of the following qualifying events:

- Divorce from a Spouse
- Legal separation from a Spouse
- Termination of a Domestic or Civil Union Partnership, or
- A Child no longer satisfying the Plan's eligibility criteria, other than turning age 26.

You and/or your qualified beneficiaries must notify the Nokia Benefits Resource Center within 60 days of the occurrence of the qualifying event. **Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, this 60-day period will not start until the end of the Outbreak Period.**

What Does COBRA Coverage Cost?

COBRA participants must pay monthly contributions for coverage.

Generally, monthly contributions are based on the full cost per covered person, set at the beginning of the year, plus two percent for administrative costs. Covered Dependents making separate elections must contribute at the same rate as the former employee. If your COBRA continuation coverage is extended to 29 months due to a qualifying disability, you may be required to pay the full cost of COBRA continuation coverage plus a 50 percent administrative fee for each month beyond 18 months. **Note: Under the American Rescue Plan Act of 2021, certain individuals, defined as "assistance eligible individuals", are eligible to receive COBRA continuation coverage at no monthly contribution cost during the period April 1, 2021 through September 30, 2021 (or the expiration of their COBRA continuation period, if sooner). For more information about this limited-time zero-contribution coverage opportunity, contact the Nokia Benefits Resource Center. (The Nokia Benefits Resource Center will also send a separate communication to those who are eligible for this opportunity.)**

Payment is due at enrollment, but there is a 45-day grace period from the date you elect coverage to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the 10th of each month, but there is a 45-day grace period (for example, the June payment is due June 10th, but will be accepted if postmarked up to 45 days after that).

Note: As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, the above-referenced 45-day periods will not start until the end of the Outbreak Period.

Termination of COBRA Continuation Coverage Before the End of the Maximum Period of Continuation Coverage

COBRA continuation coverage will end before the end of the maximum continuation period if one of the following occurs:

- You or your Covered Dependent does not make timely premium payments or contributions as required
- The Company stops providing medical and prescription drug benefits to its employees, or
- You or any of your Covered Dependents become covered under another group healthcare plan not offered by a Nokia Group Company.

Continuation coverage also may be terminated for any reason where the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud).

Section R. Claims and Appeals

The Plan maintains claims and appeals procedures designed to afford you a fair and timely review of any claim you might have relating to the Plan. Generally, you are legally required to pursue all your claim and appeal rights on a timely basis before seeking any other legal recourse, including litigation.

For information regarding how to contact parties referenced in this section, see Section V., "Important Contacts".

Note: This section describes the periods in which you are required to take action in connection with claims and appeals. As a result of the declaration of a national emergency due to the Coronavirus (COVID-19) pandemic, these periods will not start until the end of the Outbreak Period.

Overview

Disagreements about eligibility to participate in the Plan (or in one of the Plan's programs) or about benefits provided under the Plan can and do arise. To resolve these disagreements, the Plan provides for a formal claims and appeals process.

Note: You must exhaust the claim and appeal procedures as described in this SPD before filing any legal action (whether in state or federal court) regarding your Plan dispute.

The Plan has separate claims and appeals procedures depending on whether you have:

- An eligibility claim
- A benefit claim under the POS Options
- A benefit claim relating to the Prescription Drug Program.

An eligibility claim is a claim by you (or your dependent) concerning the right to participate in the Plan. For example, you may believe an error was made during Annual Open Enrollment that resulted in your (or your dependent) being assigned incorrect coverage, or you may believe you (or your dependent) experienced a "qualified status change" that entitles you (or your dependent) to make a change in Plan coverage during the year, but you are being told to wait until the next Annual Open Enrollment to make the change. Another example of an eligibility claim is a claim to be included as a participant in the Plan (e.g., there is a disagreement regarding your employment status that affects your eligibility for Plan coverage). Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.

In contrast to eligibility claims, benefit claims (whether under the POS Options or the Prescription Drug Program) concern the question of benefits provided under the Plan. Such claims can include, for example, whether a procedure or course of treatment is covered under the terms of the Plan, the amount of Coinsurance or Copays payable under the Plan with respect to a particular service, or the extent to which Plan limits or other restrictions apply to the service at issue.

The claim and appeal procedures for eligibility claims, for benefit claims under the POS Options, and for benefit claims under the Prescription Drug Program are described separately below. (References to "you" refer to any claimant, including the authorized representative of any claimant.) To the extent you have a claim that does not neatly fall into one of these categories, address your claim using the Plan's eligibility claims procedures.

Decision-Making Authority

The authority to adjudicate claims and appeals has been assigned to different entities—for eligibility claims, to the Nokia Benefits Review Team (the "NBRT") and then to the Nokia Employee Benefits Committee (the "EBC"); for benefit claims under the POS Options, to the Claims Administrator for those Options; and for benefits claims under the Prescription Drug Program, to the Claims Administrator for that program. (For contact information for each of these entities, see Section V., "Important Contacts".) Each of these entities (NBRT, EBC, and Claims Administrators) is a fiduciary under ERISA and is required to review and decide your claim in accordance with the Plan's terms (the documents and instruments governing the Plan) and these procedures. In this regard, the Plan grants to each of these entities (as applicable) sole and complete discretionary authority to determine conclusively for all parties, and in accordance with such documents and instruments, any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to participation in the Plan and eligibility for Plan benefits, determination of all relevant facts, determination of the amount and type of benefits payable under the Plan, and construction of all Plan terms. In the case of an appeal, the EBC's and the Claims Administrator's decisions are final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the decision was an abuse of administrator discretion.

Eligibility Claims and Appeals Procedure

In instances where you are required to file a claim form (as opposed to the automatic submission with some benefit-related claims), you should submit claims within 60 days of the date the service is provided. If it's not reasonably possible to submit a claim within this time frame, an extension of up to 12 months from the date of service will be allowed. However, no benefits will be paid for claims submitted more than 12 months after the date of service.

Submitting an Eligibility Claim

If you have an eligibility claim, contact the Nokia Benefits Resource Center and request an eligibility claim form ("Claim Initiation Form" or "CIF"). Your eligibility claim is not filed until you complete and mail your CIF, including any supporting documentation to:

Nokia Benefits Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

If your eligibility claim is coupled with a claim for benefits, follow the benefits Claims Administrator's process, but also include a copy of the benefits claim information with your CIF. You should indicate on your CIF whether the benefits claim is a post-service claim, pre-service claim, an urgent (pre-service) claim, or a concurrent care claim.

When You Can Expect to Receive a Decision with Respect to Your Eligibility Claim

Since the vast majority of eligibility claims are post-service, you will receive a response within 30 days from the date that your CIF is received. The NBRT may extend the period for making the claim decision by 15 days if it determines that an extension is necessary and notifies you, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If your eligibility claim is being submitted in conjunction with a benefit claim, see the timing applicable to your "type" of claim or appeal in the *Benefit Claims and Appeals--POS Options* section or *Benefit Claims and Appeals--Prescription Drug Program* section, as applicable, of this SPD.

Special Rule: If you do not provide sufficient information to allow the NBRT to make a decision with respect to your eligibility claim, you will be notified of the need for the information. You will have at least 45 days from receipt of the notice to provide the specified information. In such an instance, the NBRT's deadline for rendering a decision is suspended from the date on which it sends notice of the need for necessary information until the date on which you provide the information. For example, if the NBRT notifies you on Day 10 of the initial 30-day review period that additional information is required, you will have 45 days from your receipt of the notice to provide the necessary information. If the NBRT then receives that information on, for example, Day 30 of your 45-day response time, the time within which the NBRT is required to decide your claim picks up as if it were Day 11 of its initial 30-day review period.

What You Will Be Told if Your Eligibility Claim Is Denied

If your claim is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal.

Eligibility Appeals Procedure and Deadline to Submit Your Appeal

If your eligibility claim is denied and you wish to have it re-reviewed, you must file an appeal. You must file your appeal within **180 days** from the date on the claim denial letter. To file an appeal, you must write to:

Nokia
Employee Benefits Committee ("EBC")
600–700 Mountain Avenue
Room 6C-402A
Murray Hill, NJ 07974

You should include a copy of your initial claim denial notification, the reason(s) for the appeal, and relevant documentation with your appeal request.

You may request access, free of charge, to all documents relating to your appeal. Your appeal will be reviewed "de novo," which means you get a "start fresh" to establish the merits of your claim and the EBC will not place deference upon the original decision. The EBC is a fiduciary who is not the individual who made the initial decision and who is not the subordinate of the initial reviewer.

When You Can Expect to Receive a Decision with Respect to Your Eligibility Appeal

You will be notified of the decision by the EBC within 60 days after receipt of your appeal.

Please Note: *If your eligibility appeal is coupled with a non-urgent pre-service benefits appeal, urgent pre-service benefits appeal, or concurrent care benefits appeal, as the case may be, an effort will be made to decide your eligibility appeal within the time frames applicable to the benefits claim.*

What You Will Be Told if Your Eligibility Appeal Is Denied

If your eligibility claim is denied on appeal, you will receive a written notice that contains all of the following:

- The specific reason(s) for the denial
- The Plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request)
- A statement about your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) and a statement about voluntary alternative dispute resolution options

The decision on your appeal is final. As a result, the EBC will not review your matter again, unless new facts are presented. Upon denial by the EBC, you have the right to bring a civil action in federal court. This option is available to you only after you have exhausted all the administrative remedies available to you through the Plan's claims and appeals process as described in this section.

Benefit Claims and Appeals--POS Options

The following is a summary of the benefit claims and appeals procedure.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Plan 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 the Claims Administrator at the phone number on your ID card for assistance.

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

Out-of-Network Benefits

If you receive a bill for Covered Health Services from an Out-of-Network provider, you (or the provider if they prefer) must send the bill to the Claims Administrator for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator at the address on the back of your ID card. The Claims Administrator's address is also shown in Section V, "Important Contacts".

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com** or 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 Participant.
- 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 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 the Claims Administrator at the address on your ID card.

After the Claims Administrator has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-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, the Claims Administrator, the Plan Administrator, or the EBC 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--see "Overpayment and Underpayment of Benefits" in Section N, "Coordination of Benefits (COB); Overpayment and Underpayment of Benefits").

Form of Payment of Benefits

Payment of Benefits under the Plan, including payment of any Benefit Amount, shall be in cash, in cash equivalents, or in such other form of consideration as the Claims Administrator in its discretion determines to be adequate. Where benefits under the Plan, including any Benefits Amount, are payable directly to a Provider, such adequate consideration shall include the forgiveness, in whole or in part, of amounts the Provider owes to other plans for which the Claims Administrator makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Explanation of Benefits (EOB)

You may request that the Claims Administrator send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section B, "Terms You Should Know", for the definition of Explanation of Benefits.

Important - Timely Filing of Out-of-Network Claims
You should submit a request for payment of Benefits within 90 days after the date of service. All claim forms for Out-of-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, at the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call the Claims Administrator at the number on your ID card before requesting a formal appeal. If the Claims Administrator 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 the Claims Administrator 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 medical 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

The Claims Administrator 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 the Claims Administrator 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 the Claims Administrator 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. The Claims Administrator will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal in

accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator'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).
- 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 the Claims Administrator'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). The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

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

Standard External Review

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

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

Within the applicable timeframe after receipt of the request, the Claims Administrator 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 the Claims Administrator may process the request.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review. The Claims Administrator will assign requests by either rotating 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.

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

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

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

Upon receipt of a Final External Review Decision reversing the Claims Administrator's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with the Claims Administrator'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, the Claims Administrator will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all 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 the Claims Administrator. 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 the Claims Administrator.

You may contact the Claims Administrator 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.

As noted above, 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 the Claims Administrator are required to follow.

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

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

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	**15 days**
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**

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

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

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. The Claims Administrator 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 Nokia 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 Nokia or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Nokia or the Claims Administrator.

You cannot bring any legal action against Nokia 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 Nokia or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Nokia or the Claims Administrator.

Benefit Claims and Appeals--Prescription Drug Program

Filing a Claim

If you use an Out-of-Network Pharmacy or are unable to prove your eligibility at a Network Retail Pharmacy, you'll need to pay the full cost for the prescription and file a claim for reimbursement.

Filing an Appeal

To appeal a decision under the Prescription Drug Program, call CVS Caremark at 1-800-240-9623 and ask for a CVS Caremark appeals form for Nokia employees. Your appeal will be reviewed, and you will be notified of the decision.

Section S. Your Rights Under ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA, as described below.

Your Right to Receive Information About the Plan and About Your Benefits under the Plan

Under ERISA, all Plan Participants have the right:

- To examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan and a copy of the latest Annual Return/Report (the Form 5500) filed by the Plan Administrator with the U.S. Department of Labor. The Plan's Annual Return/Report (Form 5500) is also available at the Public Disclosure Room, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.

- To obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan and copies of the latest Annual Return/Report (Form 5500) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for such copies.

Your Right to Prudent Actions by the Plan's Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and Beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know the reasons for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request a copy of Plan documents or the latest Annual Return/Report (Form 5500) from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials to you and also to pay you up to $110 a day until you receive the materials (unless the materials were not sent because of reasons beyond the control of the Plan Administrator). If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should

happen that the Plan's fiduciaries misuse the money belonging to the Plan, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement of your ERISA rights or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by going to www.dol.gov/EBSA or calling the publications hotline of the Employee Benefits Security Administration at (866) 444-EBSA (3272).

Section T. Other Information About the Plan

The Official Plan Documents Are Controlling

This booklet, called an SPD, is intended to summarize the material terms of the Management Plan design under the Plan. The SPD is for informational purposes only. The actual terms of the Plan are reflected in the official Plan document, a copy of which can be obtained by writing to the Plan Administrator (see Section V., "Important Contacts"). Every care has been taken to ensure that this summary is accurate. In the event of a conflict between this SPD and the terms of the official Plan document, the official Plan document will control.

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

The Company Has the Right to Modify, Suspend, or Terminate the Plan

The Company expects to continue the Plan. However, the Company has expressly reserved the right to modify, suspend, change or terminate the Plan at any time and for any reason .

The Plan is Not a Contract of Employment

Your participation in the Plan, and your right to amounts contributed to and earned under your Plan account, do not create a contract of employment, which is generally considered to be "at will."

Plan Funding and Payment of Benefits

The POS options, Prescription Drug Program, and Employee Assistance Program are provided as part of the Nokia Medical Expense Plan for Management Employees. The claims and expenses of these self-insured Medical Plan options are paid from employer and employee contributions.

The Company pays fees to outside organizations (i.e., United Healthcare, CVS Caremark, Magellan, and Alight) to process claims and provide recordkeeping and other third-party administrative services with respect to the Plan. The fees and all benefit payments are paid from company revenues. These self-insured Medical Plan options do not guarantee benefits under a contract or policy of insurance. The administrator of the self-insured Medical Plan options administers the benefits under the options.

Your Plan Benefits and Rights Are Not Assignable

Benefits payable under the Plan are not subject to assignment or alienation, nor may any Participant assign any cause of action relating to such benefits, nor any other rights with respect to the Plan, to any other person or entity, including any medical provider. Any such purported assignment or alienation shall be null and void. Notwithstanding the foregoing:

- in accordance with Section 609(b) of ERISA, payments for benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act; and

- the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan--see "Overpayment and Underpayment of Benefits" in Section N, "Coordination of Benefits (COB); Overpayment and Underpayment of Benefits").

Authority of Plan Administrator and Claims Administrator

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Medical Plan, to determine eligibility for Medical Plan benefits, to interpret and construe the terms and provisions of the Medical Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Medical Plan as the Plan Administrator may deem appropriate in accordance with the terms of the Medical Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Medical Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Medical Plan, including the discretionary authority to interpret and construe the terms of the Medical Plan, to direct disbursements, and to determine eligibility for Medical Plan benefits.

The Plan Administrator has delegated its responsibility to review claims relating to eligibility to participate in the Medical Plan to the Nokia Benefits Review Team. The Plan Administrator has delegated its responsibility to review appeals of denied claims relating to eligibility to participate in the Medical Plan to the Employee Benefits Committee. The Plan Administrator has delegated its responsibility to review all other claims and appeals relating to benefits under the Medical Plan to the Claims Administrator.

Section U. Administrative Information

Plan Name	The official name of the Plan is the Nokia Medical Expense Plan for Management Employees
Plan Sponsor Name and Address	The Plan Sponsor is Nokia of America Corporation. The address of the Plan Sponsor is: Nokia Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA
Plan Administrator Name and Address	The Plan is administered by Nokia of America Corporation. The address of the Plan Administrator is: Nokia Plan Administrator Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA The Plan Administrator has retained various third-party administrators (contract administrators) responsible for certain administrative activities, including administering claims and paying benefits under the terms of the Plan. For the POS Options, the Plan Administrator has retained UnitedHealthcare (also known as United HealthCare Services, Inc. and its affiliates); except that. for participants who reside in Massachusetts, Maine, or New Hampshire, United Healthcare has in turn retained HPHC Insurance Company (an affiliate of Harvard Pilgrim Health Care). The Plan Administrator has retained CVS Caremark to act as a third-party administrator (contract administrator) responsible for administering claims and paying benefits under the terms of the Prescription Drug Program. The Plan Administrator has retained Magellan to act as a third-party administrator (contract administrator) responsible for administering the Employee Assistance Program. The Plan Administrator has retained Alight Solutions LLC (using the name the Nokia Benefits Resource Center

	(NBRC)) as third-party administrator responsible for eligibility and enrollment under the terms of the Plan. For contact information for each of these third-party administrators, see Section V., "Important Contacts".
Type of Administration	The Plan is administered by the Plan Sponsor.
Type of Plan	The Plan is considered an "employee welfare benefit plan" under ERISA.
Plan Records and Plan Year	The Plan and all its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Agent for Service of Legal Process	The Nokia Legal & Compliance organization is the agent for service of legal process. Service of legal papers, including service of subpoenas, may be served directly to: Nokia Legal & Compliance Room 6D-401A 600-700 Mountain Avenue Murray Hill, NJ 07974 USA
Employer Identification Number	The Employer Identification Number assigned by the IRS to the Plan Sponsor is 22-3408857.
Plan Number	The Plan Number assigned by the Plan Sponsor to the Plan is 505.
Plan Trustee	None. Plan benefits are paid from the general assets of the Company.

Section V. Important Contacts

Here is a list of important contacts for the Plan:

Contact/Service Provided	Address
United Healthcare Medical Claims Administrator	www.myuhc.com 1-800-577-8539
Optum Inc. Mental Health/Substance-Related and Addictive Disorders Administrator	www.liveandworkwell.com 1-800-577-8539
Magellan Employee Assistance Program	www.MagellanAscend.com 1-800-327-7348
CVS Caremark Prescription Drug Program Claims Administrator	Caremark.com 1-800-240-9623
Your Benefits Resources (YBR)™ Website • View your current coverage • Review and compare your healthcare options and contribution costs • Enroll in coverage • Make changes to your coverage • Learn more about your Nokia benefits • Review, add or change your dependent's information on file • Understand how a Life Event may affect your benefits	You can access YBR at https://digital.alight.com/nokia, 24 hours a day, seven days a week. (Your Benefits Resources is a trademark of Alight Solutions LLC.)

Nokia Benefits Resource Center (NBRC) • Enroll in coverage • Make changes to your coverage • Review, add or change your dependent's information on file • Understand how a Life Event may affect your benefits • Get answers to your questions regarding eligibility and enrollment in the Plan	1-888-232-4111 (domestic) 1-212-444-0994 (if calling from outside the U.S., Puerto Rico or Canada) Representatives are available between 9:00 a.m. and 5:00 p.m., Eastern Time (ET), Monday through Friday. If you are hearing or speech impaired, please use a Relay Service when calling a representative. The mailing address of the NBRC is: Nokia Benefits Resource Center Dept. 07544 P.O. Box 64116 The Woodlands, TX 77387-4116 USA Overnight mail should be sent to: Nokia Benefits Resource Center Dept. 07544 8770 New Trails Drive The Woodlands, TX 77381 USA
Nokia BenefitAnswers Plus Website • See benefits news and updates • View plan-related documents such as Summary Plan Descriptions (SPDs), Summaries of Material Modifications (SMMs), and Summary Annual Reports • View enrollment materials • Find carrier contact information during the year	www.benefitanswersplus.com
Nokia Benefits Review Team • The team within the Nokia Benefits Resource Center assigned the responsibility to decide claims for eligibility to participate in the Plan	Nokia Benefits Review Team P.O. Box 1407 Lincolnshire, IL 60069-1407

Nokia QMCSO Administrator • Handles matters relating to Qualified Medical Child Support Orders ("QMCSOs") for the Plan	Send all draft or court-certified orders to: Nokia Qualified Order Team P.O. Box 1542 Lincolnshire, IL 60069-1542 USA You can also fax documents and inquiries to: 1 (847) 442-0899. For information or if you have questions: visit the Qualified Order Center website at www.QOcenter.com, email your questions to QOcenter@alight.com, or contact the Nokia Benefits Resource Center.

Appendix 1. Services Covered and Cost Sharing under the POS Options

This Appendix provides a high-level summary of common procedures covered under the POS Options of the Medical Plan. It does not list all covered services. For information on a particular service, which may not be listed in this section, contact UnitedHealthcare. Additional frequency limits, requirements and exclusions may apply.

For the medical services shown in the table on the following pages, where coverage is expressed as a percentage, it is a percentage of the provider's contracted rate for in-network Enhanced and Standard Point of Service (POS) services. When medical services are received from an Out-of-network provider, eligible expenses are an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law), or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service.

"In-Network" benefits refers to benefits when services are rendered by a participating provider. "Out-of-network" benefits refers to benefits when services are rendered by a non-participating provider.

Reminder: You might not be eligible for all of the coverage options shown on this table.

For information regarding how to contact parties referenced in this section, see the **Important Contacts** section of the SPD.

Feature	Enhanced POS		Standard POS	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Choice of Doctors	Select from within a network of medical providers	Select any medical provider	Select from within a network of medical providers	Select any medical provider
Annual Deductible	Not applicable	**Individual:** $1,000 **Two-person:** $2,000 **Family:** $3,000	Not applicable	**Individual:** $1,500 **Two-person:** $3,000 **Family:** $4,500
Annual Out-of-Pocket Maximum	**Individual:** $3,000 **Family:** $6,000	**Individual:** $5,000 (excludes deductible) **Family:** $15,000 (excludes deductible)	**Individual:** $4,000 **Family:** $8,000	**Individual:** $9,000 (excludes deductible) **Family:** $27,000 (excludes deductible)

Feature	Enhanced POS		Standard POS	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Lifetime Maximum Benefit	Unlimited (some exclusions apply)			
Annual Maximum Benefit	Not applicable			
Copayment/Coinsurance for Covered Services				
Acupuncture	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 30 visits/year	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 30 visits/ year
Ambulance — Emergency Air Ambulance	Plan pays 85%	Plan pays 85%	Plan pays 75%	Plan pays 75%
Ambulance — Emergency Use of Ambulance	Plan pays 85%	Plan pays 85%	Plan pays 75%	Plan pays 75%
Ambulance — From Hospital to Hospital (if admitted to first hospital)	Plan pays 85%	Plan pays 85%	Plan pays 75%	Plan pays 75%
Anesthesia	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Birth Control (prescription birth control or medication only)	See Appendix 2, "Cost Sharing Under the PDP Program".			
Birthing Center	Plan pays 85%	Plan pays 60% after deductible is satisfied and you pay $300 copayment/ admission	Plan pays 75% after you pay $300 copayment/ admission	Plan pays 50% after deductible is satisfied and you pay $500 copayment/ admission
Blood and Blood Derivatives	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Cardiac Rehabilitation (phase three maintenance not covered)	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Chemotherapy	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Chiropractic	You pay $40 copayment/ visit; limited to 30 visits/year (in- and out-of-network combined)	Plan pays 60% after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)	You pay $60 copayment/visit; limited to 30 visits/year (in- and out-of-network combined)	Plan pays 50% after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)

Feature	Enhanced POS		Standard POS	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Emergency Room — Emergency Use	You pay $150 copayment (waived if admitted)	You pay $150 copayment (waived if admitted)	You pay $200 copayment (waived if admitted)	You pay $200 copayment (waived if admitted)
Emergency Room — Nonemergency Use	Plan pays 60% after you pay $150 copayment	Plan pays 60% after you pay $150 copayment	Plan pays 50% after you pay $200 copayment	Plan pays 50% after you pay $200 copayment
Extended Care Facility (or Skilled Nursing Facility)	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 60 days/year	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 60 days/year
Hearing Aids	$2,500 allowance every three years (in- and out-of-network combined)	$2,500 allowance every three years (in- and out-of-network combined)	$2,500 allowance every three years (in- and out-of-network combined)	$2,500 allowance every three years (in- and out-of-network combined)
Home Healthcare	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 100 visits/year	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 100 visits/ year
Hospice Care	Plan pays 85%; limited to 210 days/ lifetime (in- and out-of-network combined)	Plan pays 60% after deductible is satisfied; limited to 210 days/ lifetime (in- and out-of-network combined)	Plan pays 75%; limited to 210 days/ lifetime (in- and out-of-network combined)	Plan pays 50% after deductible is satisfied; limited to 210 days/ lifetime (in- and out-of-network combined)
Inpatient Hospitalization	Plan pays 85%	Plan pays 60% after deductible is satisfied and you pay $300 copayment/ admission	Plan pays 75% after you pay $500 copayment/ admission	Plan pays 50% after deductible is satisfied and you pay $700 copayment/ admission
Maternity ▪ Office visits: pre/postnatal ▪ In-hospital delivery services	**Office visits:** Plan pays 85% after you pay first office copayment **In-hospital delivery services:** Plan pays 85%	**Office visits:** Plan pays 60% after deductible is satisfied **In-hospital delivery services:** Plan pays 60% after deductible is satisfied and you pay $300 copayment/ admission	**Office visits:** Plan pays 75% after you pay first office copayment **In-hospital delivery services:** Plan pays 75% after you pay $500 copayment/ admission	**Office visits:** Plan pays 50% after deductible is satisfied **In-hospital delivery services:** Plan pays 50% after deductible is satisfied and you pay $700 copayment/ admission

Feature	Enhanced POS		Standard POS	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health and Chemical Dependency	**Inpatient:** Plan pays 85% **Outpatient:** You pay $30 copayment/visit	**Inpatient:** Plan pays 60% after deductible is satisfied and you pay $300 copayment/ admission **Outpatient:** Plan pays 60% after deductible is satisfied	**Inpatient:** Plan pays 75% after you pay $500 copayment/ admission **Outpatient:** You pay $35 copayment/ visit	**Inpatient:** Plan pays 50% after deductible is satisfied and you pay $700 copayment/ admission **Outpatient:** Plan pays 50% after deductible is satisfied
Nutritionist	You pay $40 copayment/visit	Not covered	You pay $60 copayment/visit	Not covered
Outpatient Lab/X-Ray	Plan pays 85% (or you pay $30 copayment when included as part of office visit)	Plan pays 60% after deductible is satisfied	Plan pays 75% (or you pay $35 copayment when included as part of office visit)	Plan pays 50% after deductible is satisfied
Physician Hospital Visits and Consultations	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Physician Visits (virtual visits, primary care physician [PCP] office visits, specialist office visits and urgent care center visits) (non-preventive)	Virtual Visit: You pay $10 copayment/ visit PCP: You pay $30 copayment/ visit Specialist: You pay $40 copayment/visit Urgent Care Center: You pay $75 copayment/visit	Plan pays 60% after deductible is satisfied	Virtual Visit: You pay $20 copayment/visit PCP: You pay $35 copayment/ visit Specialist: You pay $60 copayment/ visit Urgent Care Center: You pay $100 copayment/visit	Plan pays 50% after deductible is satisfied
Podiatrist	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Private Duty Nursing	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 100 shifts/year	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 100 shifts/year
Radiation Therapy	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Rehabilitation Therapy (outpatient physical, occupational, speech)	You pay $40 copayment/visit	Plan pays 60% after deductible is satisfied; speech therapy limited to 100 visits/year for developmental delays and	You pay $60 copayment/visit	Plan pays 50% after deductible is satisfied; speech therapy limited to 100 visits/year for developmental delays and

Feature	Enhanced POS		Standard POS	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
		30 visits/year otherwise		30 visits/year otherwise
Second Surgical Opinion	You pay $40 copayment/visit	Plan pays 60% after deductible is satisfied	You pay $60 copayment/ visit	Plan pays 50% after deductible is satisfied
Smoking Deterrents (prescription only)	See *What's Covered Under the PDP* in Section J, "Overview of the Prescription Drug Program".			
Surgery — In-Office	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75% after you pay $250 copayment	Plan pays 50% after deductible is satisfied
Surgery — Inpatient	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75%	Plan pays 50% after deductible is satisfied
Surgery — Outpatient	Plan pays 85%	Plan pays 60% after deductible is satisfied	Plan pays 75% after you pay $300 copayment/ procedure	Plan pays 50% after deductible is satisfied
Wigs	Plan pays up to $300/year			
Routine Physical Exams	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Well-Child Care (including immunizations)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Well-Woman Care (ob-gyn exam)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Mammogram Screening	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Pap Smear (in doctor's office)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Digital Rectal Exam and Blood Test for PSA (in doctor's office — prostate cancer screening for men age 50 and older)	Plan pays 100%	Plan pays 60% after deductible is satisfied	Plan pays 100%	Plan pays 50% after deductible is satisfied
Newborn In-Hospital Care	Plan pays 100%	Plan pays 60% after deductible is satisfied; limited to one visit	Plan pays 100%	Plan pays 50% after deductible is satisfied; limited to one visit
Are You Responsible for Charges in Excess of the Allowable Amount?	No	Yes	No	Yes

Feature	Enhanced POS		Standard POS	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Who Is Responsible for Prior Authorization?	Your provider; check with your provider to ensure prior authorization is obtained	You	Your provider; check with your provider to ensure prior authorization is obtained	You
What Is the Penalty for Failure to Obtain Prior Authorization?	No benefits paid by plan	20% reduction in benefits, up to $400 maximum/ occurrence	No benefits paid by plan	20% reduction in benefits, up to $400 maximum/ occurrence
Do You Have to File Claim Forms?	No	Yes	No	Yes
Are Centers of Excellence Available?	Yes			

Appendix 2. Cost Sharing Under the Prescription Drug Program (PDP)

This Appendix provides a high-level summary of cost-sharing and other information regarding benefits available under the PDP.[3]

Additional frequency limits, requirements and exclusions may apply.

"In-Network" benefits refers to benefits when services are rendered by a Network Retail Pharmacy. "Out-of-network" benefits refers to benefits when services are rendered by other than a Network Retail Pharmacy.

Reminder: You might not be eligible for all of the coverage options shown on this table.

For information regarding how to contact parties referenced in this section, see the **Important Contacts** section of the SPD.

Feature	Enhanced POS[4]		Standard POS[4]	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Out-of-Pocket Maximum	**Individual:** $3,500 **Family:** $7,000	Not applicable	**Individual:** $4,000 **Family:** $8,000	Not applicable
Retail[5] (up to a 30-day supply using an in-network pharmacy)	**Generic:** $20 copayment **Preferred Brand:** $70 copayment **Nonpreferred Brand:** $100 copayment	Plan pays 60% after you pay separate deductible: **Individual:** $150 **Two-person:** $300 **Family:** $450	You pay $20 copayment for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of $20 and maximum of $120/ prescription	Plan pays 50% coinsurance for generic and brand-name drugs after you pay separate deductible: **Individual:** $200 **Two-person:** $400 **Family:** $600

[3] The deductibles and out-of-pocket maximums for the Prescription Drug Program are separate from the deductibles and out-of-pocket maximums for POS and Traditional Indemnity coverage. "Member Pays the Difference" program charges do not count toward prescription drug annual out-of-pocket maximums.

[4] Where prescription drug coverage is expressed as a percentage, it is a percentage of the plan's cost for the drug.

[5] Prescription drug copayments will double after the third time you receive a 30-day supply of a maintenance medication at a retail pharmacy; for cost savings, fill up to a 90-day supply through mail order or pickup at a CVS retail pharmacy.

Feature	Enhanced POS[4]		Standard POS[4]	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mail Order (up to a 90-day supply)	**Generic:** $50 copayment **Preferred Brand:** $175 copayment **Nonpreferred Brand:** $250 copayment	Not applicable	You pay $50 copayment for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of $50 and maximum of $300/ prescription	Not applicable
Member Pays the Difference	You will pay the generic copayment, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available.			
Other Important Information About Your Medical and Prescription Drug Coverage				
$0 Out-of-Pocket Cost for Certain Preventive Medications	Certain preventive medications, including some over-the-counter (OTC) medications, are covered 100% without imposing a copayment, coinsurance or deductible as long as they are presented with a prescription from a licensed health care provider. The list of eligible medications is subject to change as ACA guidelines are updated or modified. Please note that eligible vaccines are covered under the medical plan, not the prescription drug program. You must present your medical, not prescription drug, member ID card when visiting a provider for these immunizations. For information about the covered vaccines, please call UnitedHealthcare at 1-800-577-8539 or visit www.myuhc.com.			

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About Nokia

We create technology that helps the world act together. As a trusted partner for critical networks, we are committed to innovation and technology leadership across mobile, fixed and cloud networks. We create value with intellectual property and long-term research, led by the award-winning Nokia Bell Labs. Adhering to the highest standards of integrity and security, we help build the capabilities needed for a more productive, sustainable, and inclusive world.

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