RTXHR Human Resources | Total Rewards

2023

Health & Insurance

Summary Plan Description

Raytheon Technologies

FOR ELIGIBLE RAYTHEON TECHNOLOGIES EMPLOYEES

An important notice regarding eligibility for certain benefits

Important information for the following benefits-eligible employees:

- SCA
- RPS Field Operations
- ROTHR IAMAW Local 97
- IAM Local Lodge 25, Fort Irwin, California National Training Center

Consistent with your general eligibility for benefits under the heritage Raytheon benefit plans, please note the following:

Life Insurance

While you are eligible to purchase Employee Supplemental Life Insurance on an after-tax basis (from one to nine times your annual base pay, rounded up to the next $1,000), you are not eligible for company-paid Employee Basic Life Insurance as described in this document.

Accidental Death and Dismemberment (AD&D) Insurance

Similarly, while you are eligible to purchase Employee Supplemental (Voluntary) Accidental Death and Dismemberment (AD&D) Insurance on a pre-tax basis (from one to five times your annual salary, rounded up to the next $1,000), you are not eligible for company-paid Employee Basic AD&D Insurance as described in this document. Note that if you wish to purchase AD&D Insurance for your spouse/partner and/or child(ren), you must also purchase Employee Supplemental AD&D coverage.

Premiums

Since you pay 100% of the cost of all your benefits, please disregard the term “premium contribution” used throughout this document. Note that the amount of your annual base pay does not affect the amount you pay in medical premiums.

Salary Continuance

You continue to be eligible for any applicable salary continuance benefits; any references to severance benefits do not apply.

Retirement Benefits

All references to retirement benefits (such as retiree medical coverage) do not apply.

For new hires

If you don’t actively enroll in your benefits within 30 days of the date you are notified of your enrollment opportunity, you must wait until the next Annual Enrollment period to elect coverage. You can only make changes outside of Annual Enrollment if you experience a qualified change in status (described in this document) and are eligible to make benefit changes at that time. Any references to default coverage for the medical and dental plans do not apply.

Questions about your eligibility for the benefits described in this document?

Call the Raytheon Technologies Benefits Center (via **Access Direct**) at **800-243-8135**. Representatives are available 8:00 a.m. to 8:00 p.m. ET, Monday through Friday (excluding certain holidays).

Your **benefits**

Raytheon Technologies offers a wide range of benefits for you and your family. All plans you may be eligible for are shown on Your Gateway, the Raytheon Technologies benefits information and enrollment website. This Summary Plan Description (SPD) provides details about the benefits listed here. Separate SPDs are available for many of your other benefits, such as retirement plan benefits, on Your Gateway.

Health

Take care of your health and save on your out-of-pocket health care expenses with these benefits.

Medical | **Dental** | **Vision** | **Health Savings Account** | **Spending accounts**

Work & life

When you want help with work, life or personal issues, you have resources available to you.

LifeResources | **Healthy You Incentives**

Insurance

If something unexpected happens, it's nice to know protection is available.

Life insurance | **Accidental Death and Dismemberment insurance** | **Business Travel Accident insurance**

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About this Summary Plan Description

This document is a Summary Plan Description (SPD) for certain component plans under the Raytheon Technologies group benefits program, and is generally effective Jan. 1, 2023, unless otherwise noted. It applies to current employees who have met the defined eligibility requirements for each component plan. This summary supersedes and replaces any prior summaries, communications, rules, practices, standards and/or guidelines to the contrary, whether written or oral**.**

The Employee Group Health Plan of United Technologies Corporation is subject to applicable limitations and restrictions under the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs employee benefit plans, the Patient Protection and Affordable Care Act (PPACA) and the Internal Revenue Code (IRC) rules that govern certain health and insurance plans. It is also governed by all of its incorporated plan documents.

This document is intended to be a reference guide for your health and insurance benefit programs, including detailed information on eligibility requirements and how much the plans will pay for certain health care services and treatments. Coupled with the benefits information available on **Your Gateway**, this document can help you understand how to access the range of benefits and programs available and contains information on resources to help you manage your health care costs.

Receipt of this summary does not entitle you to a benefit from the health and insurance plans. To be entitled to a benefit from the health and insurance plans, you must meet all applicable requirements for such benefit.

The provisions of this summary do not establish enforceable employee rights, contractual or otherwise, and they do not establish an employment relationship enforceable by employees. The provisions aren't promises; they are subject to change at any time without notice and are subject to management's discretion in their application.

Nothing in this summary or any other Raytheon Technologies publication, policy or guideline will interfere with or limit in any way the right of the company to terminate an employee's employment without cause or notice at any time, confer upon any employee any right to continue in the employ of the company or change an employee's existing at-will employee status. Employees remain employed at will, and the at-will employment relationship can be changed only by an authorized company representative in writing.

We have made every effort to summarize the plans accurately in this summary. However, if there is any conflict or inconsistency between this summary and a plan document, the provisions of that plan document govern. If this summary doesn't address an issue, no inference should be drawn from that omission.

Some benefit programs will refer you to external resources, such as websites. It is your personal decision whether to use one of these external resources. Your use of these external resources is governed by the terms and conditions described on each site.

For convenience, the terms **Raytheon Technologies** and **company** are used to refer to Raytheon Technologies (the plan sponsor). The use of these terms does not mean you're an employee of Raytheon Technologies. You remain solely an employee of the company that directly pays your wages.

Raytheon Technologies has the right to modify, suspend or terminate the component plans under the Employee Group Health Plan of United Technologies Corporation at any time, without prior notice (except as required by law). Raytheon Technologies retains the sole discretion to interpret terms or language used in the Employee Group Health Plan of United Technologies Corporation documents or this summary.

Benefits for employees represented by a bargaining unit will be provided in accordance with their collective bargaining agreement.

This summary is provided in English. If you have difficulty understanding any part of this summary, contact the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** for assistance. Representatives are available 8 a.m. to 8 p.m. ET, Monday through Friday (excluding certain holidays)**.**

Eligibility and enrollment

Raytheon Technologies offers a wide range of benefits for you and your family. All plans you may be eligible for are shown on Your Gateway, the Raytheon Technologies benefits information and enrollment website.

In this chapter

You must elect certain benefits to have coverage. Others you receive automatically.

Benefits requiring an election
(These benefits are available when you first become eligible and during Annual Enrollment. Some can be elected when you experience a qualified change in status.)
	• Medical
	• Dental
	• Vision
	• Tax-advantaged accounts:
	  • Health Savings Account (HSA) If enrolled in an HSA-qualified medical plan and eligible to contribute to an HSA (not an ERISA plan). You can enroll in or make changes to your HSA at any time.
	  • Health Care Spending Account (HCSA) — limited to dental and vision expenses if enrolled in an HSA-qualified medical plan
	  • Dependent Care Spending Account (DCSA)
	• Supplemental Life Insurance
	• Dependent Life Insurance (spouse/partner and dependent child)
	• Voluntary Accidental Death and Dismemberment (AD&D) Insurance

Benefits you receive automatically when you become eligible	• Basic Life Insurance • Basic AD&D Insurance • Business Travel Accident (BTA) Insurance • LifeResources • Healthy You Incentives

Note

You must enroll in benefits by the applicable deadline, as outlined in this chapter. Please see the Default coverage section to understand what happens to your coverage if you don't submit your elections by the deadline.

Employee eligibility

Your eligibility for certain benefits depends on your work status.

- **Full-time:** An employee whose regularly scheduled hours are 36 or more per week is eligible for the benefits in this SPD
- **Part-time scheduled for at least 20 but fewer than 36 hours per week:** An employee who is regularly scheduled to work between 20 to 36 hours per week is generally eligible for the benefits in this SPD
- **Part-time scheduled for fewer than 20 hours:** An employee who is regularly scheduled hours are fewer than 20 per week generally isn't eligible for the benefits in this SPD, other than Business Travel Accident (BTA) Insurance
- **Temporary:** Temporary employees generally aren't eligible for the benefits in this SPD, other than BTA insurance
- **Intern or co-opt:** Certain intern populations are eligible for specific benefits
- **Co-op:** Co-op employees are not eligible for benefits
- **Heritage Raytheon Company retirees with retiree medical coverage who become employed by the company:** Retiree medical coverage will be suspended while they are actively employed. They will instead be eligible for coverage under the active employee medical plan — even if they are regularly scheduled for fewer than 20 hours per week. These retirees may resume retiree medical coverage after terminating employment with the company.

Generally, you're eligible for the benefits described in this SPD if you are a full-time employee who is regularly scheduled to work 20 hours or more per week and you are working for an employer who is participating in the benefits described in this SPD.

Note

You must meet the specific eligibility criteria for each individual benefit to be eligible.

When you're not eligible for benefits

You're generally not eligible for Raytheon Technologies benefits (other than BTA insurance) if you're an employee who is regularly scheduled to work fewer than 20 hours per week or a temporary employee.

If you're a U.S. outbound (expatriate) employee

Depending on the length of your assignment, if you're on international assignment, Raytheon Technologies also offers eligible expatriates Cigna Global Medical (which provides prescription drug, dental and vision coverage).

If you're age 65 or older

Active employees and their spouses/partners age 65 and older don't have to be enrolled in Medicare Parts A and B to enroll in a Raytheon Technologies medical plan available to active employees.

Note

You're responsible for contacting Medicare to confirm your eligibility and to apply for Medicare. Contact Medicare at **medicare.gov**.

Dependent eligibility

If you're eligible for benefits, you can also elect coverage for your eligible dependents. Your eligible dependents include:

- Your children up to the end of the month in which they reach age 26
- Your legal spouse (unless legally separated or divorced)
- Your civil union or domestic partner (same or opposite gender) as long as they meet the partner criteria (see below)
- Your children who are or become physically or intellectually disabled, regardless of their age, and who depend on you for support.

Note

To cover a disabled child past age 26, you must contact the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** to obtain the appropriate forms to begin the disabled dependent certification process within 30 days of the date your child's health care coverage would otherwise end. Return the completed forms to the health plan vendors at the address printed on the forms for review and approval. You will then receive an approval or denial letter from the health plan vendor.

Children

Your eligible children include:

- Your natural children or legally adopted children who are under age 26
- Your pre-adopted children (if you have assumed custody and have applied for adoption)
- Children for whom you are a court-appointed legal guardian
- Stepchildren
- Children of your civil union or domestic partner

Note

You must enroll a newborn in the plan within 30 days of birth by going online to **Your Gateway** or by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** for the plan to pay benefits for nursery charges and ongoing eligible medical expenses.

Note that if you don't add your newborn or newly adopted child, they won't be covered, even if you currently have family coverage.

Spouse or partner

Your spouse is your legally married spouse as recognized under applicable state law. A person is no longer your spouse as of the date your marriage is legally terminated by divorce or annulment, or your spouse is no longer considered your eligible dependent as of the date you're legally separated. Your ex-spouse is never eligible to be covered as your dependent, even if your divorce decree requires you to pay for or provide coverage for your ex-spouse.

For an individual to qualify as your civil union or domestic partner, they must:

- Be at least 18
- Have entered into a contractual commitment for financial responsibility or have joint ownership of significant assets and joint liability for debts
- Not be legally married to another person or part of another civil union or domestic partner relationship
- Intend to remain your sole civil union or domestic partner indefinitely
- Reside with you in the same principal residence and intend to do so indefinitely
- Not be related by blood closely enough to prohibit legal marriage in the state in which you live
- Be mentally competent to enter into contracts

Note

Raytheon Technologies offers equal benefits to spouses, domestic partners and civil unions; therefore, for the purposes of this SPD, the term **spouse** includes same- and opposite-gender civil unions and domestic partnerships, except where otherwise noted.

Dependent verification

When you add a dependent to coverage, you will be required to provide evidence of dependent eligibility, such as tax returns, marriage license, birth certificate, court order, adoption papers, proof of joint residency or certificate/affidavit of common-law marriage or eligibility for partner or other adult dependent status. More information about this process will be mailed to your home address if this applies to you.

If a dependent becomes ineligible

If a dependent becomes ineligible for coverage during the year, you must remove them from your coverage by going online to **Your Gateway** or by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**. The dependent who becomes ineligible for coverage will be dropped from your coverage and may be eligible for continuation or conversion coverage as described in the *Other important information* chapter.

If your dependent receives benefits from a plan after the date that coverage ends, you're responsible for reimbursing the plan for benefits provided during that period.

If you do not inform the Raytheon Technologies Benefits Center of a covered dependent's ineligibility within 60 calendar days after the date the dependent's coverage would be lost due to becoming ineligible, that dependent won't be offered COBRA, and no refund will be issued for any premiums paid for the ineligible dependent's coverage.

Providing false information

If you or an enrolled dependent give false information to get benefits you're not entitled to, the company may permanently cancel your coverage, including all dependent coverage. This applies to enrollment, changes in coverage and claims for benefits under all of our health and insurance plans. It also applies if you don't notify the Raytheon Technologies Benefits Center when a dependent is no longer eligible for coverage by going online to **Your Gateway** or by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**. (The company has the right to audit your dependent enrollment information at any time.)

The cancellation can be backdated to the point when you would have lost the coverage, which means pending claims won't be paid, and you'll have to pay back any benefits you shouldn't have received. In addition, you may find that the insurance company denies coverage in the future.

The company may also take disciplinary action, up to and including termination of employment.

If your benefits coverage is canceled because you or an enrolled dependent provided false information, you can appeal the decision.

Benefit-specific eligibility rules

The benefit-specific eligibility details below are in addition to the general eligibility rules described earlier in this section.

Medical

The medical plans available to benefits-eligible employees are determined by their home ZIP code. The specific medical plans available to you are shown on **Your Gateway** during new hire enrollment and Annual Enrollment. The amount of your premium contribution depends on your annual base pay and the level of coverage you choose (you only, you + spouse/partner, you + child(ren) or you + family). Visit **Your Gateway** for premium information.

Medical plan availability based on location

These plans have limited availability as determined by where you live.

Plan	Who it's offered to
Kaiser Permanente plans	Employees in these ZIP code-based service areas: California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington and Washington, D.C.
Out-of-area plan	U.S.-based employees who do not live in the Anthem Blue Cross Blue Shield network area
Cigna Global (includes medical and vision coverage)	Eligible U.S. outbound (expatriate) employees

Health Savings Account (HSA)

HSAs are individually owned, portable savings accounts that are used to save for out-of-pocket health care expenses. Raytheon Technologies-sponsored HSAs may be funded by eligible employees through pre-tax payroll contributions. Employee contributions are generally non-taxable at the federal level, but employee and/or employer contributions may be taxable at the state level. Raytheon Technologies also

makes an annual contribution to HSAs in January. The amount of the company's contribution varies by coverage tier.

Additional direct contributions may be made by or on behalf of the account holder. However, Raytheon Technologies doesn't have any visibility into or responsibility for the additional deposits. It's the responsibility of the account holder to manage the account and ensure compliance with all applicable IRS rules and regulations.

You're eligible to set up and contribute to an HSA if you meet the general benefits eligibility requirements described above and meet these additional requirements:

- You're enrolled in an HSA-qualified medical plan on the first day of the month.
- You're not eligible to be claimed as a dependent on another person's tax return.
- You're not covered by another medical plan (unless the other plan is also a qualifying high deductible health plan), including Medicare, TRICARE, Medicaid, a health plan available to retired federal employees or a non-high-deductible plan.
- You're not participating in any general purpose Health Care Spending Account (HCSA) through Raytheon Technologies or another employer (including a spouse's employer) or an HRA, such as through your spouse's employer. **Note:** If you're eligible to be covered under any general purpose HCSA, you won't be eligible to make contributions to an HSA. You will maintain access to the balance in an established HSA. Participation in an HCSA that's only limited for use to pay eligible dental and vision expenses will not make you ineligible to contribute to an HSA.

You may incur IRS fines or penalties if you enroll or are automatically enrolled in Medicare and continue to make or receive contributions to your HSA. See the Account contributions and coordination with other types of medical coverage section in the *Health Savings Account* chapter for more details about when you're not eligible to make HSA contributions.

Go online to **Your Gateway** or call the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** to stop your HSA contributions. You will maintain access to the balance in the account. Consult with your tax advisor to understand if any taxes apply to the pre-tax contributions you made while enrolled in Medicare or if you need to request a refund of excess contributions. Contact the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** to request a refund of excess contributions.

Upon termination of employment, your HSA will no longer be associated with Raytheon Technologies. You will be responsible for managing the account and paying any monthly maintenance fees. HSA coverage is not available through the COBRA continuation process since HSAs are individually owned savings accounts that are portable upon termination of employment and are not ERISA group health plans.

You're encouraged to identify an HSA beneficiary to ensure the balance is properly transferred in the event of your death. You can do this by contacting Fidelity Investments at **800-544-3716** for assistance.

These conditions are subject to change. For more information, please visit the U.S. Department of the Treasury website.

If you and your spouse/partner both work for the company

If you and your spouse/partner are both employees of Raytheon Technologies and are eligible for benefits, you may each have an HSA as long as you both enroll separately in an HSA-qualified medical plan. If one of you enrolls in an HSA-qualified medical plan and covers the other, only the one who enrolls

in the HSA-qualified medical plan can open an HSA. Before deciding, you should consider premiums, out-of-pocket costs and the company's HSA contribution associated with each option and coverage tier.

Health Care Spending Account (HCSA)

Generally, the HCSA is used to pay for out-of-pocket health care expenses incurred by you and/or your qualified dependents. Employee contributions are deducted from your pay and are generally excluded from taxable income; however, contributions may be taxed at the state level.

The HCSA is generally a "use it or lose it" type of account. That means if you do not incur enough in eligible expenses by the end of the grace period, you will forfeit any excess balance in your HCSA. See the *Spending accounts* chapter for details.

There is no HCSA beneficiary benefit other than any opportunity your covered dependents might have to elect COBRA continuation coverage with respect to any balance remaining in your HCSA upon your death.

You may elect to make post-tax contributions through COBRA to continue HCSA coverage at a premium when employment is terminated. This option is available through the last day of the calendar year in which the termination of employment occurs.

Note

If you are enrolled in an HSA-qualified medical plan and have an HCSA, the money in your HCSA can only be used to pay for out-of-pocket dental and vision care expenses incurred by you and/or your qualified dependents.

Life Insurance

Raytheon Technologies offers Basic Life Insurance, Supplemental Life Insurance and Dependent Life Insurance to benefits-eligible employees.

Accidental Death and Dismemberment (AD&D) Insurance

Raytheon Technologies offers Basic AD&D and Supplemental AD&D Insurance to benefits-eligible employees. Eligible employees may elect to cover their eligible family members under their Supplemental AD&D Insurance.

Note

Your children and spouse/partner must meet the eligibility requirements stated earlier in this section and be eligible under the terms of the plan to be covered under the Supplemental Life, Dependent Life and Supplemental AD&D Insurance benefit plans.

Business Travel Accident (BTA) Insurance

All employees, both full-time and part-time employees — including part-time employees who are regularly scheduled for fewer than 20 hours — are participants in this plan. No special enrollment is

necessary; employees are covered automatically by BTA Insurance. The cost is paid entirely by Raytheon Technologies.

Spouses/partners and dependent children are eligible for coverage while accompanying an employee on an authorized trip, while on the way to join an employee on an authorized trip or while relocating.

When coverage begins

When your benefits coverage begins depends on if you're a newly eligible employee or a rehired employee. See the individual plan sections for additional requirements and limitations that may apply.

Newly eligible employees

Coverage generally begins on the first day of your full-time active employment. For example, if you begin full-time employment on May 14 and decide to enroll, your benefits coverage will begin May 14.

Some benefits require you to be actively at work before your coverage starts (such as Short-term Disability). If you're not actively at work the day your benefits coverage is to start, the start date for those benefits won't happen until you are actively at work. **Actively at work** means you're performing all material duties of your job in the location where these duties are normally carried out. In addition, some benefits (such as Supplemental Life Insurance) may require approval from the insurance carrier before they become effective.

When contribution changes are effective

Generally, contribution changes are effective on the same date that your new benefits coverage is effective, as described in the section below.

When benefits coverage changes are effective

In general, your change in coverage is effective the date of the event. However, coverage added for newborn or adopted children is effective on the date of birth, adoption or placement for adoption for most benefits. Coverage dropped for deceased dependents is effective on the date of death.

Enrollment

After your initial enrollment as a newly eligible employee, you'll have the opportunity each year to make changes to your benefit elections for the upcoming year during Annual Enrollment, which is held each fall. The changes you make during Annual Enrollment generally will become effective Jan. 1 of the next year. You can only make changes outside of Annual Enrollment if you experience a qualified change in status and are eligible to make benefit changes at that time, as explained later in this section.

Default coverage

Certain benefits must be elected when you first become eligible and during Annual Enrollment. The table below describes the coverage you'll receive automatically if you're eligible — even if you don't submit benefit elections by the enrollment deadline.

When you become newly eligible for benefits

Benefit	Coverage you'll automatically receive if you don't enroll by the deadline shown in your enrollment materials as a newly eligible employee
Medical | Dental | Vision	
Medical	Anthem Gold with HSA (you only coverage)
Dental	Delta Dental Plus (you only coverage)
Vision	No coverage
Tax-advantaged accounts	
HSA	No employee contributions and no employer contribution until you open an HSA with Fidelity Investments on **Your Gateway**
Health Care Spending Account (HCSA)	No employee contributions
Dependent Care Spending Account (DCSA)	No employee contributions
Life Insurance	
Basic life insurance	Coverage equal to one times annual base pay
Employee supplemental life insurance	No coverage
Supplemental spouse/partner life insurance	No coverage
Supplemental dependent child life insurance	No coverage
Accidental Death and Dismemberment (AD&D) insurance	
Basic AD&D insurance	Coverage equal to one times annual base pay
Voluntary employee AD&D insurance	No coverage
Voluntary spouse/partner AD&D insurance	No coverage
Voluntary dependent child AD&D insurance	No coverage
Business Travel Accident (BTA) Insurance	Coverage equal to four times annual base pay
LifeResources EAP	Automatic enrollment on the first day of employment
Healthy You Incentives	Automatic enrollment on the first day of employment

During Annual Enrollment

Benefit	Coverage you'll automatically receive if you don't enroll by the Annual Enrollment deadline
Medical | Dental | Vision	
Medical	Current coverage if available (including no coverage)
Dental	Current coverage if available (including no coverage)
Vision	Current coverage if available (including no coverage)

Benefit	Coverage you'll automatically receive if you don't enroll by the Annual Enrollment deadline
Tax-advantaged accounts	
HSA	HSA goal amount currently in effect rolls over
Health Care Spending Account (HCSA)	HCSA election currently in effect rolls over
Dependent Care Spending Account (DCSA)	DCSA election currently in effect rolls over
Life Insurance	
Basic life insurance	Coverage equal to one times annual base pay
Employee supplemental life insurance	Coverage option currently in effect (including no coverage)
Supplemental spouse/partner life insurance	Coverage option currently in effect (including no coverage)
Supplemental dependent child life insurance	Coverage option currently in effect (including no coverage)
Accidental Death and Dismemberment (AD&D) insurance	
Basic AD&D insurance	Coverage equal to one times annual base pay
Voluntary employee AD&D insurance	Coverage option currently in effect (including no coverage)
Supplemental spouse/partner AD&D insurance	Coverage option currently in effect (including no coverage)
Supplemental dependent child AD&D insurance	Coverage option currently in effect (including no coverage)
Business Travel Accident (BTA) Insurance	Automatic enrollment on first day of employment
LifeResources EAP	Automatic enrollment on the first day of employment
Healthy You Incentives	Automatic enrollment on the first day of employment

Enrolling your dependents

You may enroll your eligible dependents in some of the benefits offered to you. If you enroll your eligible dependents at the same time you enroll yourself, their coverage begins when your coverage begins. You can enroll eligible dependents when you first become eligible for coverage, during Annual Enrollment or if your dependent has a qualified change in status. See Qualified change in status for more information.

You can elect one of four coverage tiers under the medical, dental and vision plans:

- You only
- You + spouse/partner
- You + child(ren)
- You + family (You + spouse/partner + child(ren))

You may elect different coverage tiers for medical, dental and vision plans. For example, you can choose medical coverage for your family and dental or vision coverage for yourself only.

Dependent coverage election

If your dependent child is a full-time employee of the company, they may enroll in benefits as an employee or may be enrolled in your plan as a dependent — or as a dependent on your spouse's/partner's plan if also an employee — if they meet the eligibility criteria. But they cannot be enrolled as both an employee and as your dependent at the same time.

If both you and a family member work at the company

If your spouse/partner also works for the company, you have one of three options when enrolling in medical, dental and/or vision plans:

Option 1	One of you may elect employee and spouse, or if applicable, family coverage and cover the other as a dependent. In this case, the "other" spouse/partner would waive coverage.
Option 2	You may each elect employee-only coverage.
Option 3	You may both elect employee and spouse or family coverage and cover the other as a dependent.

If you choose option two, the total deductibles and out-of-pocket maximums that both people combined would need to satisfy is greater than the deductible and out-of-pocket maximum that would need to be satisfied if one employee elects option one and the other waives coverage. For example, with option one, the deductibles and out-of-pocket maximums can be satisfied with claims by only one person or in any combination of two or more persons' claims.

If you choose option three, note that benefits are payable only up to what is available with employee-only coverage; there are no additional benefits.

Before deciding which option is best for you and your spouse, be sure to consider the premiums, out-of-pocket costs and the company's HSA contribution associated with each option and coverage tier.

Qualified change in status

After Annual Enrollment, your benefit elections remain in effect for the next plan year, which is also the calendar year (Jan. 1 through Dec. 31). You may not change your elections until the next Annual Enrollment period unless you have a qualified change in status during the plan year that allows for election changes, and you apply for the change within 30 calendar days of the event by going online to **Your Gateway** or by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**. Your requested change must be on account of and correspond with your qualified change in status. For example, after the birth of a child, you may add the child to your existing medical plan, but you may not reduce your HCSA contribution.

If you don't provide notification within 30 calendar days of the qualified change in status, you won't be able to make changes until the next Annual Enrollment.

The following are examples of a qualified change in status:

- You gain or lose a dependent (through marriage, birth, adoption, placement for adoption, death, divorce or legal separation)
- You have a change from benefits-eligible status to part-time regularly scheduled for fewer than 20 hours or temporary employee
- You transfer between different contracts or positions, providing there is a change in the plans that are available to you or a significant change in the cost of coverage
- You begin or return from an unpaid leave of absence
- You move to a new location outside your current medical or dental network
- You or your spouse or partner receive(s) a judgment, decree or court order requiring coverage to be provided for an eligible dependent child
- Your COBRA continuation coverage or your spouse's or partner's COBRA continuation coverage from another employer ends
- You lose eligibility under your parent's plan
- You, your spouse/partner, or your dependent(s) experience(s) a significant curtailment or termination of medical, dental or vision coverage
- You, your spouse/partner, or your dependent(s) become(s) enrolled in Medicare or Medicaid, or if you, your spouse/partner, or your dependent(s) become(s) ineligible for Medicare or Medicaid
- You or one of your eligible dependents dies
- Your dependent is no longer eligible for coverage
- Your spouse/partner or dependent gains or loses coverage through employment
- Your spouse/partner or dependent experiences a significant increase in coverage cost
- Your spouse/partner or dependent starts or returns from a strike or lockout
- Your spouse/partner or dependent changes coverage under another employer's plan due to a qualified change in status or during that plan's Annual Enrollment period that doesn't correspond with the company's Annual Enrollment period
- You gain eligibility for and enroll in health care coverage through another employer while on severance
- You, your spouse/partner, or your dependent(s) become(s) eligible for a special enrollment opportunity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- You need to open a Dependent Care Spending Account or change your contribution amount

Note

You must go online to **Your Gateway** or call the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** to process the qualified change in status within 30 days of the event.

Adding your partner to your benefits coverage after Annual Enrollment

If all requirements for a partnership described in the Dependent eligibility section are met, you may add your partner to your benefits coverage after Annual Enrollment by going online to **Your Gateway** or by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** within 30 days of the date your partner becomes eligible for coverage.

Effective date of coverage after timely notice of a qualified change in status

In general, if notification of a qualified change in status is provided within 30 days of the event, the effective date of the change in coverage will be the date of the qualifying event.

Please note that the Employee Group Health Plan of United Technologies Corporation governs election changes, and the plan has been established in accordance with Internal Revenue Code §125 and applicable regulations. If there is a conflict between information in this document and the terms of the Raytheon Technologies Flexible Benefits Plan, the terms of the plan will control.

Paying for coverage

You and Raytheon Technologies share the cost of your medical coverage. You pay your share in the following ways:

- When you seek care, such as deductibles and coinsurance
- With premium contributions through payroll deductions

The amount you contribute toward the cost of coverage is a percentage of the total cost of your coverage, which is based on:

- The medical plan you enroll in
- The health status of those enrolled in a particular plan
- To what extent participants use plan services

Your premium contribution is deducted from your paycheck. You pay no federal income taxes or Social Security taxes on your contribution amount for coverage for you, your spouse or your children. In most cases, you also pay no state income taxes.

Note

You make your contributions to your HSA and the HCSA and DCSA on a pre-tax basis as allowed by state law.

Calculating cost and coverage amounts for life and AD&D insurance benefits

The amount of your premium contribution depends on the level of coverage you choose (You only, You + spouse/partner, You + child(ren) or You + family). Visit **Your Gateway** for premium information.

Annual base pay

For certain benefits, your annual base pay is used to calculate your cost and coverage amount. If your annual base pay changes after the date used for Annual Enrollment or during the plan year, your costs and coverage amounts may also change. You must be actively at work the day that coverage, or an increase in coverage, becomes effective.

Imputed income

The cost of certain benefits is considered imputed income, which means you pay taxes on the cost of providing that coverage. You will have imputed income if your company-paid life insurance coverage is more than $50,000.

The cost of providing coverage for a partner and/or their child(ren) who aren't your tax dependents is considered imputed income for purposes of medical, dental, vision, life insurance and AD&D insurance to the extent you aren't paying the full value of such coverage on a post-tax basis. If you're enrolling a partner and/or their children who qualify as your dependents under federal law for purposes of health care coverage, notify the Raytheon Technologies Benefits Center by going online to **Your Gateway** or by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**.

If imputed income affects you, you'll see it on your pay notification and W-2 form. For more information, contact a tax advisor. Some states may have different rules for imputed income for state income tax purposes.

Tobacco-use status

The cost of employee or spouse optional life insurance is based in part on whether or not you are a tobacco user.

When your coverage ends

In general, your coverage will end when:

- Raytheon Technologies terminates the plan.
- You no longer meet the eligibility requirements.
- You fail to make any required premium payments.
- You commit an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact, including, but not limited to, providing false information regarding eligibility or status as a dependent.
- You die.

If you receive benefits from a plan after the date coverage ends, you're responsible for reimbursing the plan for benefits provided during that period. You may be eligible for continuation or conversion coverage as described in the *Other important information* chapter.

Changing to part-time regularly scheduled for fewer than 20 hours

If you change from a position working at least 20 hours per week to a position scheduled for fewer than 20 hours per week, you're no longer eligible for benefits. Your coverage for benefits ends on the last day of the pay period in which your status changes.

If you're enrolled in medical, dental or vision coverage or an HCSA, you may elect to continue coverage under COBRA. You may also be able to convert or port your life insurance. Please refer to Continuation and conversion coverage in the *Other important information* chapter.

Termination for nonpayment

If you are continuing coverage as a retiree or through COBRA, your coverage will end if you don't pay the required employee contributions toward the cost of coverage for 60 days of the payment due date. If this occurs, your coverage may be canceled retroactively as of the end of the last month you paid for coverage. Health plans may require you to repay any claims incurred and paid by the plan after the date your coverage is canceled.

Note

If your medical, dental, vision, HCSA or LifeResources coverage ends, you may elect COBRA continuation coverage. See the *Other important information* chapter for details.

Medical

Raytheon Technologies offers three HSA-qualified medical plans: Anthem Gold with HSA and Anthem Silver with HSA, which are available nationwide, and the Kaiser Gold HSA, which is available in some parts of the country.

In this chapter

The Anthem Gold with HSA and Anthem Silver with HSA medical plan options both cover the same services and include an HSA contribution from the company (see the *Health Savings Account* chapter for details). The differences are your paycheck premium, deductible and out-of-pocket maximum amounts.

Other plan options may be available to you based on where you live.

- If you live in California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington or Washington, D.C., you also have access to the Kaiser Gold with HSA medical plan option. With the exception of urgent and emergency care, these plans do not cover care outside the Kaiser Permanente network.
- If you live where the Anthem BCBS provider network is not available, you have access to the Out-of-Area Plan Gold HSA and Out-of-Area Indemnity Plan. Both plans are administered by Anthem Blue Cross Blue Shield.
- If you live in Hawaii, you're eligible for coverage through HMSA Blue Cross Blue Shield or Kaiser Permanente Hawaii HMO.
- If you are on an international assignment, the company offers eligible expatriates Cigna Global Choice with HSA and Cigna Global PPO.
- If you are covered by TRICARE, the company provides a supplement to help cover the cost.

See the medical plan summaries in the *Appendix* for more detailed information about how you and the plan share costs under each of the plan choices.

Note

Refer to the *Eligibility and enrollment* chapter for details about who you can cover and when you can enroll and make changes to your benefits.

How you pay for care

All the plans provide quality health care, a wide array of medical services, preventive care and prescription drug coverage with certain generic preventive prescriptions at no cost to you when purchased from an in-network pharmacy (based on health care reform guidelines).

If you are enrolled in one of the HSA plans, you pay the full negotiated rate for medical care (except for in-network preventive care and generic preventive prescription drugs) until you reach the deductible. After you reach the deductible, you pay coinsurance (within allowed amount limits) until you reach the out-of-pocket maximum. Once you meet the out-of-pocket maximum, the plan will pay 100% of any additional eligible expenses for the rest of the plan year.

There are instances that do not apply to the out-of-pocket maximum and for which you'll continue to pay health care expenses even after you've met the out-of-pocket maximum. For example, if you receive care from an out-of-network provider, you're responsible for paying any amount over the plan's allowed amount. You're also responsible for paying any penalties if you don't receive precertification for care that requires it. View the Precertification requirements section to learn more.

Plan benefits and costs

In addition to paying premiums with pre-tax dollars, you'll also pay for services you receive through your deductible and coinsurance percentage until you reach the annual out-of-pocket maximum. Deductibles, coinsurance and out-of-pocket maximums for each plan can be found in the *Appendix*.

Deductible

A deductible is a fixed dollar amount you need to pay for covered medical services each calendar year before the plan pays most benefits.

If anyone on the plan meets the family deductible or two or more family members combine to reach it, coinsurance begins for everyone in the family on the plan.

In-network expenses count toward the in-network deductible, and out-of-network expenses count toward the out-of-network deductible. The deductible counts toward your out-of-pocket maximum.

The following items don't count toward the deductible:

- Expenses above the allowed amount
- Prescription drug costs for the difference between the generic and brand name cost when a generic drug is available, but you request a brand name drug
- Noncovered expenses (treatments deemed not medically necessary as well as penalties and expenses for failure to precertify a treatment or procedure)
- Any amounts saved or not charged due to prescription coupons — other than specialty drug coupons — or discounts (only the amount paid will be credited toward the deductible). The value of specialty drug coupons will apply toward the deductible and out-of-pocket maximum.

Coinsurance

Coinsurance is the amount you pay for covered health care after you meet your deductible. This amount is a percentage of the total cost of care.

Coinsurance begins when two or more family members covered by the plan have costs that combine to meet the family deductible. When that happens, coinsurance begins for everyone covered by the plan.

Out-of-pocket maximum

The out-of-pocket maximum is the most you'll pay for covered medical expenses in a calendar year.

Generally, once you reach the out-of-pocket maximum, the plan pays 100% of the cost of covered medical services for the remainder of the year. All covered medical and pharmacy expenses, including the deductible, count toward the out-of-pocket maximum.

If you are enrolled in employee-only coverage and meet the employee-only out-of-pocket maximum, 100% of eligible costs are covered for the remainder of the year.

If one person covered under the family plan meets the embedded individual in-network out-of-pocket maximum, 100% of the costs for eligible services are covered for that person for the remainder of the year. You can find details on applicable embedded individual in-network out-of-pocket maximums in the Benefit Summaries located in the *Appendix*.

If another family member or a combination of family members incurs enough in covered in-network expenses to reach the family out-of-pocket maximum, 100% of the costs for eligible covered services are covered for everyone on the plan for the remainder of the year.

The out-of-pocket maximum doesn't include:

- Expenses above the allowed amount
- The difference between the generic and brand name cost when a generic drug is available, but you request a brand name drug
- Noncovered expenses (treatments deemed not medically necessary as well as penalties and expenses for failure to precertify a treatment or procedure)
- Any amounts saved or not charged due to prescription coupons — other than specialty drug coupons — or discounts (only the amount paid will be credited toward the deductible). The value of specialty drug coupons will apply toward the deductible and out-of-pocket maximum.

Claims for services you receive in network do not apply to the out-of-network deductible or out-of-network out-of-pocket maximum and vice versa.

Use participating providers

You receive the highest level of benefits when you use participating (i.e., network) providers. A participating provider is a physician, hospital, laboratory or facility that has agreed to participate in the plan's network of providers and accept the negotiated rates and deductible and coinsurance amounts as payment in full for services rendered. You will pay more when you use an out-of-network provider. For more information, refer to your plan's coverage table in the *Appendix*.

Note

If you are enrolled in a Kaiser Permanente plan, it's important to note that — with the exception of emergency care — your plan does not offer out-of-network coverage. If you choose to receive care from an out-of-network provider, those services will not be covered, and you will be responsible for the entire cost.

Medical ID cards

When you enroll in a company-sponsored medical plan, you and your covered dependents will receive a medical ID card that lists important information that your health care provider will need when you receive care, as well as the toll-free number that you can call if you have questions about your plan. You should carry your ID card with you at all times and refer to it whenever you need medical care.

Approaching age 65?

Be sure to understand your medical coverage options

While Medicare eligibility generally begins when you reach age 65, it's important to know that if you remain covered by a company-sponsored medical plan as an active employee, you are not required to enroll in Medicare Part A and/or Part B when you turn 65. In addition, you do not incur any Medicare premium penalties if you enroll in Medicare Part A and/or Part B during the eight-month period that begins the month after your employment ends or your coverage ends, whichever happens first.

Because the transition to Medicare has financial consequences, it's wise to consult your tax advisor before making any decisions about your post-65 medical coverage, such as whether or not to enroll in Medicare Part A and/or Part B when you are first eligible. Your tax advisor may recommend that you delay enrolling in Medicare until you leave the company. That's because doing so means you continue to be eligible to make and receive contributions to an HSA.

If you enroll in Medicare Part A and/or Part B as an active employee

If, in consultation with your tax advisor, you intend to enroll in Medicare Part A and/or Part B when you first become eligible, you can elect an HSA plan for the year you will become eligible and elect an HSA. In this case, you are eligible to receive the company's lump-sum contribution to your HSA in January (as long as the company contribution is made before you enroll in Medicare) and make your own contributions (not to exceed the annual federal limit listed in the *Health Savings Account* chapter) until you enroll for Medicare.

Note

If you apply for Medicare Part A coverage within six months of the month you turn 65, your coverage will begin the month you turn 65. If you apply for Medicare Part A coverage six or more months after you turn 65, your coverage will begin six months prior to the date you file your application. Either way, the IRS does not allow you to make or receive contributions to your HSA during the period you are retroactively covered by Medicare.

If the timing of your enrollment in Medicare means you were ineligible to receive that year's company contribution to your HSA, Payroll will withdraw the company contribution from your account. To withdraw any ineligible contributions you may have made to your HSA, contact Fidelity. Remember: If contributions are made to your HSA while you are enrolled in Medicare (either by the company or you), you will be subject to taxes and penalties. For more information, see the Taxes section in the *Health Savings Account* chapter.

While all contributions to your HSA must stop once you enroll in Medicare, your participation in an HSA plan will continue. For years where your Medicare status prohibits you from making or receiving contributions to your HSA, you can elect to contribute to a health care FSA. Note that if your spouse or dependents enroll in Medicare but you (as the employee) do not, you can continue making contributions and receiving company contributions to your HSA.

No matter which company-sponsored medical plan you participate in, your company-sponsored plan remains the primary payor and Medicare is the secondary payor on any claims incurred.

Important information for employees in Hawaii

Registered civil union partners

According to Hawaii state law, you are eligible to enroll your registered civil union partner in your company-sponsored medical plan. As a result, the term "spouse" includes your registered civil union partner.

As is the case elsewhere in the U.S., you and the company share the cost of your medical coverage, and you pay your share of premiums with pre-tax dollars through payroll deduction. However, there are tax consequences if you purchase coverage for a:

- Registered civil union partner who does not meet the Internal Revenue Service (IRS) definition of a dependent
- Child of a registered civil union partner whom you have not adopted

In this case, you pay their share with after-tax dollars, and you are taxed on the value of their coverage. Because you pay for this coverage on an after-tax basis, you may add or drop coverage for an eligible registered civil union partner or a child of a registered civil union partner whom you have not adopted at any time during the year. To make changes, visit **Your Gateway** or call the Raytheon Technologies Benefits Center to request the required forms.

Medical coverage options

The medical coverage options available in Hawaii vary from medical plan options available elsewhere in the U.S. Employees in Hawaii may choose from two medical plans — the HMSA Blue Cross Blue Shield (HMSA) plan or the Kaiser Permanente Health Maintenance Organization (Kaiser HMO).

HMSA

If you enroll in the HMSA plan available in Hawaii, you are required to elect a primary care physician (PCP). You'll receive care from your PCP or a doctor to whom your PCP refers you. If you do not select a PCP when you first enroll, one will be selected for you. You can change your PCP at any time.

It's important to note that with the exception of emergency care, the HMSA plan does not offer coverage if you use an out-of-network provider. If you enroll in this plan and choose to receive care from

a nonparticipating provider, those services will not be covered, and you will be responsible for the entire cost.

Preventive care is generally covered at 100% with no copay. General office visits are covered at 100% after you pay a copay.

For more information about the HMSA plan — including how the plan covers preventive care — refer to the Plan Certificate. Details are also available on **Your Gateway**.

Kaiser Permanente Hawaii HMO

With the Kaiser Permanente HMO available in Hawaii, you are required to elect a PCP. You receive care from your PCP or a doctor to whom your PCP refers you. If you do not select a PCP when you first enroll, one will be selected for you. You can change your PCP at any time.

It's important to note that with the exception of emergency care, this plan does not offer coverage if you visit an out-of-network provider. If you enroll in this plan and choose to receive care from a non-participating provider, those services will not be covered, and you'll be responsible for the entire cost.

With the Kaiser Permanente HMO, your eligibility for wellness and preventive-care benefits may vary. Refer to the plan's Evidence of Coverage for more information.

- Preventive care is generally covered at 100% with no copay
- General office visits are covered at 100% after you pay a copay

To be eligible for coverage, all services and supplies must be medically necessary, as defined by the plan.

For more information on the Kaiser Permanente HMO, refer to the plan's Evidence of Coverage. Details are also available on **Your Gateway**.

Note for new hires

As is the case elsewhere in the U.S., you must enroll in medical coverage within 30 days of the later of:

- Your date of hire or
- If a Personalized Enrollment Worksheet is mailed to you, the date that appears on the worksheet[1]

Your coverage becomes effective on your first day of work.

If you live in Hawaii and do not enroll within this 30-day period, you will automatically be enrolled in the HMSA plan at the employee-only coverage level. This coverage remains in effect for the remainder of the calendar year. You may change your plan and/or coverage level during the next benefits Annual Enrollment period, held each fall. You're permitted to make certain changes sooner if you experience a qualified change in status.

Note: In accordance with the Hawaii Prepaid Health Care Act, if you wish to waive company-sponsored medical coverage, you must submit a completed HC-5 form to the Raytheon Technologies Benefits Center every year. If you do not submit an HC-5 form, the Hawaii Prepaid Health Care Act requires that you be enrolled and pay for coverage in the HMSA plan for yourself only. Once the Raytheon Technologies Benefits Center receives notification of your intent to waive coverage, an HC-5 form will be sent to you.

[1]Personalized Enrollment Worksheets are mailed to employees who do not have an email address on file.

Anthem Gold HSA and Anthem Silver HSA

While benefits coverage varies among medical plan options, the following features are common to all company-sponsored Anthem medical plan options.

Preventive care — All the medical plans cover the full cost of in-network preventive care (as identified by the Affordable Care Act (ACA) under the Preventive Care Services benefit) at 100% with no out-of-pocket expense. Note that wellness and preventive care received from an out-of-network provider is subject to the deductible and coinsurance.

Covered preventive services may include:

- Annual wellness screenings
- Breastfeeding support
- Certain types of counseling (refer to Covered medical services)
- Colon cancer screenings
- Contraceptive prescription drugs
- Diagnostic x-rays and lab tests including bone density testing, cholesterol screenings
- Flu shot
- Mammograms, including 3D mammograms and Pap smears
- Routine prenatal office visits (excludes ultrasounds, labs and visits to monitor pregnancy related conditions)
- Preventive lab tests and x-rays (diagnostic labs and x-rays are covered at 80% after the applicable deductible and coinsurance, if applicable)
- Prostate screenings–PSA
- Routine immunizations according to the medical plan schedule
- Medications for the prevention of breast cancer if you're determined to be at high risk
- Lung cancer screenings if you're determined to be at high risk
- Gestational diabetes screening
- Screening for tobacco use and programs to help you quit using tobacco

Covered services beyond preventive testing are subject to the deductible and coinsurance.

Note

If an illness or condition is found during the preventative treatment, it may no longer be considered preventative in terms of billing.

The plans cover routine physical exams each calendar year for all plan participants, including:

- Routine adult physical
- Well-woman exams
- Well-child exams up to age 19

The following services aren't covered as part of a physical exam:

- Employment-related exams
- Exams given while the person is confined in a hospital or other facility for medical care

- Medicines, drugs, appliances, equipment or supplies
- A physician's office visit in connection with immunizations that's in addition to your annual preventive exam
- Psychiatric, psychological, personality or emotional testing or exams
- Services not provided by a physician or under their direct supervision
- Services to diagnose or treat a suspected or identified injury or disease
- Travel immunizations
- Vision, hearing or dental exams

Preventive services to help with weight management include:

- Obesity counseling
- Healthy diet counseling, including visits to a dietician when billed with the appropriate diagnosis codes

The preventive limits are as follows:

- Obesity/healthy diet counseling for children: no limit
- Obesity for adults: 26 visits per calendar year

Visit anthem.com for more information**.**

Primary care — Your primary care physician (PCP) is generally the first person you'll call when you have a health care need. Although the Anthem BCBS plans do not require you to choose a PCP or obtain a PCP referral to see a specialist, it's always recommended.

Your PCP is a critical member of your health care team who:

- Knows you and sees you for regular checkups when you're healthy
- Works with you when you're sick
- Is your partner in the health care system, referring you to specialists and arranging for hospitalization when necessary

Seeing your PCP first helps you build a stronger relationship with your doctor and ensures you get the most effective and efficient care possible.

You have the flexibility to choose a different PCP for each member of your family. For example, you may want to choose a pediatrician for your child and an internist for yourself. This way, all family members have access to a PCP who can best serve their health care needs.

If you are establishing yourself as a new patient with a PCP, it is a good idea to schedule an appointment for a new patient exam. This will help your PCP get to know you when you are in good health and establish a baseline for treating you in the future.

Even if your medical plan does not require you to choose a PCP, **it is your responsibility to confirm in advance that the services you receive are eligible for payment from your plan and that the provider you're seeing is part of your plan's network (if applicable)— even in cases of a referral**. If your plan uses a network and you go outside the network for non-emergency care, your benefits will be reduced or not paid at all, and you may be subject to higher out-of-pocket costs.

Specialty care — The medical plans offer access to specialists, including:

- Cardiologists
- Chiropractors
- Dermatologists

- Ear/nose/throat doctors
- OB/GYNs (**Note:** Routine annual exams, pap smears and mammograms with a network OB/GYN specialist are covered as preventive care, as described earlier)
- Physical, speech, occupational, cardiac rehabilitation and pulmonary therapists
- Podiatrists

To receive the highest level of benefits from the Anthem Gold and Anthem Silver medical plan options, you must receive care from a network specialist.

For information about how your plan covers specialty care, refer to the Benefits Summary charts in the *Appendix* for your plan or call the toll-free Customer Service number listed on your medical ID card.

Total Health and Wellness Solutions from Anthem

If you enroll in one of the available Anthem plans, you'll have access to the following services.

24/7 NurseLine

You may have emergencies or questions for nurses around the clock. The 24/7 NurseLine provides you with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, you can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team of RNs (BSN preferred) that helps plan participants assess systems, understand medical conditions, ensure plan participants receive the right care in the right setting and refer you to programs and tools appropriate to your condition
- Bilingual RNs, language line and hearing-impaired services
- Access to the Audio Health Library, containing hundreds of audiotapes on a wide variety of health topics
- Proactive callbacks within 24 to 48 hours for plan participants referred to 911 emergency services, poison-control and pediatric plan participants with needs identified as either emergent or urgent
- Referrals to relevant community resources

Anthem Health Guide

Anthem Health Guide provides you with enhanced member services support. You can contact a health guide with questions about benefits, programs for your health, help scheduling doctor's appointments, comparing costs for procedures and more. Health guides can connect you with knowledgeable health professionals to help you manage chronic conditions, deal with an illness or provide support for emotional concerns like anxiety or depression. Reach out to Member Services and our health guides via phone, email, app or chat online.

Autism Spectrum Disorders (ASD) Program

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a member who has a diagnosis of ASD. Anthem provides specialized case management services for plan participants with autism spectrum

disorders and their families. The program also includes precertification and medical necessity reviews for Applied Behavior Analysis, a treatment modality targeting the symptoms of autism spectrum disorders.

For families touched by ASD, Anthem's Autism Spectrum Disorders Program provides support for the entire family, giving assistance wherever possible and making it easier to understand and use care, resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

- Education
  - Educates and engages the family on available community resources, helping to create a system of care around the member
  - Increases knowledge of the disorder, resources, and appropriate usage of benefits
- Guidance
  - Applied Behavior Analysis management, including clinical reviews by experienced licensed clinicians
  - Precertification delivers value, ensuring that the member receives the right care, from the right provider, at the right intensity
  - Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning and referrals
  - Assure that parents and siblings have support to manage their own needs
- Coordination
  - Enhanced member experience and coordination of care
  - Assistance in exploration of medical services that may help the member, including referrals to medical case management
  - Licensed behavior analysts and program managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child

Behavioral Health Resource Center

Extra support can make a big difference when facing issues such as anxiety, depression, eating disorders or substance use. Behavioral Health Resource Center experts will work with you at no extra cost to find treatment programs and arrange confidential counseling and support services every day of the year that meet your individual and family needs.

Cancer Concierge Care

After a cancer diagnosis, it may be difficult to know what the next step is or which treatment plan will work best for you. That's where Cancer Concierge Care comes in. It helps you through each step of your cancer journey by giving you the support and resources you need. We'll go over your options, answer your questions, check in with you along the way and take as much of the burden off you as we can. All so you can focus on what matters most — your health and recovery.

Expert guidance: A virtual second opinion program helps ensure you receive the right care. You'll also have regular check-ins with cancer experts throughout your journey.

Premier treatment: Get treatment from hospitals specialized in the care you need. Learn about promising, cutting-edge treatments available for your specific condition.

Peace of mind: When you complete the virtual second opinion, you'll receive digital exam equipment you can use to check your symptoms and side effects anytime, anywhere via LiveHealth Online.

When you or your dependent uses a Concierge Cancer Care Center of Excellence for a clinical trial or complex oncologic care, and the treatment has been preapproved by Anthem, you may be eligible for travel and lodging benefit.

Travel & lodging benefits are economy-class unless otherwise noted, and:

- Are limited to (client maximum ($10,000 per lifetime), combined total for all related travel expenses)
- Include transportation to and from a program Center of Excellence that is at least 75 miles from your residence
- Include transportation for a companion (or parent/legal guardian for a minor)

Travel & lodging benefits do not include charges for:

- Transportation, lodging and food associated with services at a facility other than program Centers of Excellence
- Air ambulance travel
- Laundry bills
- Telephone bills
- Alcohol or tobacco products
- Entertainment
- Personal expenses and upgrades

Medical travel benefits may be considered taxable income by the IRS. A Form 1099 will be issued for any taxable benefits related to travel. Please consult a tax professional.

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at the highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You'll receive:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions
- *Your Pregnancy Week by Week*, a book to show you what changes you can expect for you and your baby over the next nine months
- Useful tools to help you, your physician and your Future Moms nurse coach track your pregnancy and spot possible risks

Inclusive Care

Every group, including the LGBTQIA+ members, face unique healthcare challenges. Anthem advocates for and connects with the LGBTQIA+ community to provide the right healthcare solutions. Inclusive Care takes a caring and effective approach to services and access to meet the needs of the whole person. We'll help you find providers that understand your circumstance, answer your questions, and help you get the get the care you need with dignity and respect. Inclusive Care removes barriers and increases confidence so that everyone in the LGBTQIA+ community has access to safe, compassionate, and best-in-class healthcare.

Equitable and Empathetic Care: Support to find providers who are LGBTQIA+-friendly, competent, and subject matter experts. Virtual health tailored to LGBTQIA+ community.

Expert guidance: A multidisciplinary team committed to helping across your medical and emotional needs and a virtual second opinion program helps ensure you're getting the right care and support.

Premier treatment: Get family support and specialty care at Centers of Excellence specializing in gender affirmation surgery, with a virtual second opinion, travel services, and consultation by Chief LGBTQIA+ Health Officer available to support your journey.

Inclusive Care takes a caring and effective approach to services and access to meet the needs of the whole person. The program includes:

- Support to find providers who are LGBTQIA+ friendly, competent, and subject matter experts
- Virtual behavioral health tailored to LGBTQIA+ community
- A multidisciplinary team committed to helping across your medical and emotional needs and virtual second opinion program helps ensure you're getting the right care and support
- Family support and specialty care at Centers of Excellence specializing in gender affirmation surgery, with a virtual second opinion, travel services, and consultation by a Chief LGBTQIA+ Health Officer available to support your journey

Travel and lodging benefits

When using an Inclusive Care Center of Excellence, and the treatment has been preapproved by Anthem, you may be eligible for travel and lodging benefits.

Travel and lodging benefits are economy class unless otherwise noted, and:

- Are limited to $10,000 per a lifetime combined total for all related travel expenses
- Includes transportation to and from a program Center of Excellence that is at least 75 miles from your residence
- Includes transportation for a companion (or parent/legal guardian for a minor)

Travel and lodging benefits do not include charges for:

- Transportation, lodging and food associated with services at a facility other than a program Centers of Excellence
- Air ambulance travel
- Laundry bills
- Telephone bills
- Alcohol or tobacco products
- Entertainment
- Personal expenses and upgrades

Medical travel benefits may be considered taxable income by the IRS. A Form 1099 will be issued for any taxable benefits related to travel. Please consult a tax professional.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you and your bank account healthier. Here's how it works: Anthem will review your incoming health claims to see if the plan can save you any money. Anthem can check to see what medications you're taking and alert your physician if Anthem finds a potential drug interaction. Anthem also keeps track of your routine tests and checkups, reminding you to

make these appointments by mailing you MyHealth Notes. MyHealth Notes summarizes your recent claims. From time to time, Anthem will offer tips to save you money on prescription drugs and other health care supplies.

Quick Care Options

Quick Care Options helps to raise your awareness about appropriate alternatives to hospital emergency rooms (ERs). When you need care right away, retail health clinics (e.g., CVS Minute Clinic) and urgent care centers can offer appropriate care for less cost and leave the ER available for actual emergencies. Quick Care Options educates you on the availability of ER alternatives for non-urgent diagnoses and includes the Provider finder website to support searches for ER alternatives.

Sydney Health

Discover a powerful and more personalized health app. View all your benefits and access wellness tools to improve your overall health with the Sydney Health app.

The Sydney Health mobile app works with you by guiding you to better overall health — and for you by bringing your benefits and health information together in one convenient place. You can chat with a Member Services Health Guide about claims or health questions, keep track of health care spending, find network doctors and urgent care centers, or use online wellness tools. Sydney Health provides everything you need to make the most of your benefits while taking care of your health including:

- Reminding you about important preventive care needs
- Guiding you with insights based on Your history and changing health needs
- Empowering you with personalized tools to find and compare healthcare providers and check costs

Download the Sydney Health app by searching “Sydney Health” in the app store.

Raytheon Technologies Select

With Your unique health plan Total Health, Total You, helpful benefits and health information are always at your fingertips. Total Health, Total You can help you:

- Manage pain or chronic conditions, like asthma or diabetes
- Understand your medications and prescriptions
- Navigate hospital stays or major medical decisions
- Work through a difficult life situation — such as depression or a death in the family
- Stay healthy through wellness resources

We have a team ready to help — from nurses to social workers, dietitians, respiratory therapists, pharmacists, exercise physiologists, and more. It’s all included in your plan, at no cost to you. Reach out to a supportive Member Services Health Guide.

Covered medical services

The following section provides specific information about medical plan benefits provided under the Anthem Gold with HSA, Anthem Silver with HSA, Out-of-Area with HSA and Out-of-Area Indemnity plans. Throughout this section, these medical plan options are referred to as **the plans**.

Note

Anthem, the claims administrator, makes the final decision as to whether or not a particular service is covered. To determine what is and is not covered under your plan, see your plan's Summary of Benefits in the *Appendix* as well as the list of limitations and exclusions, or contact the plan administrator.

For information about how to appeal a denied claim, see the *Claims* chapter of this SPD.

Unless otherwise noted, the plans cover certain services and supplies for medically necessary care, including:

- Specialty and outpatient care
- Inpatient services
- Surgical benefits
- Emergency care
- Maternity care
- Family planning
- Mental health and chemical dependencies
- Bariatric surgery
- Transplants
- Oncology
- Telemedicine

Acupuncture

Outpatient institutional, professional and office professional — includes **naturopathy services** when services are rendered by a licensed provider.

Alcohol/substance abuse

- Inpatient and residential
  - Inpatient accommodations and ancillaries
  - Includes detox
- Outpatient
  - Partial hospitalization and intensive outpatient are considered outpatient

Ambulatory surgical centers

Institutional outpatient ambulatory surgery center. Nonroutine polyp removal performed in-network during a routine and/or nonroutine colonoscopy will be covered in full, subject to the deductible.

Attention Deficit Disorders

Includes Autism Spectrum Disorder (ASD), Intellectual Disability, Developmental Delays and Learning Disabilities.

Autism Spectrum Disorder (ASD) and Applied Behavior Analysis (ABA) therapy

The following section applies to coverage of ABA for children diagnosed with ASD.

In addition to covering medical services to treat ASD, the Anthem plans cover behavioral services, including Applied Behavior Analysis (ABA) therapy. Behavioral services must:

- Focus on the treatment of core deficits of ASD;
- Be provided by a board-certified behavior analyst (BCBA) or other qualified provider under appropriate supervision;

- Focus on treating maladaptive/stereotypic behaviors and impairment in daily functioning.

Benefits are available for the following levels of care:

- Inpatient treatment,
- Residential treatment,
- Partial hospitalization/day treatment,
- Outpatient treatment (including intensive outpatient treatment); services include the following:
- Diagnostic evaluations, assessment and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Crisis intervention
- Provider-based case management services

If you have questions related to our benefits and coverage, contact the Anthem Behavioral Health Resource Center at **844-451-2059** (this phone number is also listed on the back of your member ID card).

Precertification is required prior to a scheduled admission for — or as soon as is reasonably possible for a non-scheduled admission (including an emergency admission) — neurobiological disorders–ASD services (including partial hospitalization/day treatment and services at a residential treatment facility).

In addition, you must provide notification before receiving the following services: Intensive outpatient treatment programs; psychological testing; extended outpatient treatment visits with or without medication management. Prenotification is also required for benefits provided for intensive behavioral therapy, including ABA.

For a description of limitations and exclusions related to the treatment of ASD, including a definition of habilitative services, see later in this section. For more information, or if you have any questions, contact the Anthem Behavioral Health Resource Center as noted above.

Blood processing and storage

- Processing and storage
- Includes blood transfusions

Chiropractic care

Includes care provided on an inpatient or outpatient basis for rehabilitation following an injury or surgery, or for some chronic or acute medical conditions.

Contraceptives

- Services not included in Women’s Health provision
  - Spermicide, vaginal ring, hormone patch Depo — Estradiol Cypionate — up to 5 MG, and other covered contraceptives included in Women’s Health provision, but not meeting required Women’s Health diagnosis restrictions
  - Covered for birth control as well as medical conditions
- Covered under Women’s Health provision
  - IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA-approved birth control devices (other than those listed above as not included in Women's Health)
  - Covered based on the diagnosis restriction within the Women’s Health provision

Dental

Covered for treatment of an injury to sound and natural teeth, mouth or face if treatment is started within 12 months of the accident. Injury as a result of chewing or biting will not be considered an accidental injury.

Dental implants are covered only if the result of an accident, injury or congenital condition as determined by medical diagnosis codes or a complication from a congenital condition resulting in tooth loss as determined by an Anthem medical director.

Diabetes maintenance

Diabetic education/nutritional counseling — When part of Health Care Reform (HRC), services refer to Preventive Care Benefits. Limited to six visits per year.

Limit combined with:

- In- and out-of-network
- Institutional/professional
- Non-diabetic nutritional counseling conditions

Diabetic supplies — Diabetic supplies covered by the pharmacy plan are not covered under medical, including lancets, syringes, insulin etc.

Durable medical equipment

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for medical necessity, and applicable precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the member's medical condition. The equipment must be ordered and/or prescribed by a physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use
- It is manufactured solely to serve a medical purpose
- It is normally not useful to a person not ill or injured
- It is ordered by a physician
- The physician certifies in writing the medical necessity for the equipment
- The physician states the length of time the equipment will be required (the Plan may require proof at any time of the continuing medical necessity of any item)
- It is related to the member's physical disorder

Covered durable medical equipment includes the following. Contact Anthem for more details, including other durable medical equipment that may be covered.

- Purchase and rental of equipment
- Medical supplies
- Prosthetics subject to medical necessity
- Orthotics subject to medical necessity; includes custom-fitted orthotics
- Hearing aid services
  - Evaluation/exam — Limit combined for both ears; one occurrence every 36 months
  - Hearing aids — Limit $3,000 every three years

- Wigs/toupees
  - Subject to medical necessity
  - Hair loss must be due to a medical condition, including but not limited to chemotherapy, radiation or alopecia
  - Limit one unit per year

Note

Supplies, equipment and appliances that include comfort, luxury or convenience items or features that exceed what is medically necessary in your situation will not be covered.

Reimbursement will be based on the maximum allowed amount for a standard item that is a covered service, serves the same purpose and is medically necessary. Any expense that exceeds the maximum allowed amount for the standard item that is a covered service is your responsibility.

Emergency care

If Prudent Layperson guidelines apply, all true emergency services will be paid at the in-network level of benefit (accidental injury and medical emergency diagnoses pay as emergency). Services billed by a provider other than the hospital will be paid according to the appropriate benefit category level.

Fertility benefits

Fertility benefits are available for those wishing to start or expand their family. A covered member who is unable to conceive or produce conception physiologically is eligible for the fertility benefit. No diagnosis of infertility is required; therefore, no timeframe to demonstrate the inability to conceive is required. These benefits include (but are not limited to the following):

- Testing and treatment in connection with an underlying medical condition,
- In vitro fertilization (no cycle or dollar limits),
- Artificial insemination (no cycle or dollar limits),
- Donor sperm and donor eggs,
- Cryopreservation (of eggs, donor eggs, embryos, sperm or donor sperm) for up to 12 months.

Contact Anthem at the phone number on your medical ID card for full details regarding all coverage provisions for fertility benefits.

Gender confirmation surgery (also called gender affirmation surgery)

This is an option for an individual experiencing gender dysphoria. This surgery is determined to be medically necessary when all criteria in the health plan's clinical guidelines are met for each surgical procedure being undertaken. For more information regarding transgender medical care, see the Transgender medical services section.

Home health/home infusion/private duty nursing

Private duty nursing is only covered in the home.

Hospice/bereavement

Respite care includes licensed agencies only.

Injections

Includes administration charge

Inpatient care

- Accommodations and Ancillaries:
  - Accidental injury
  - General illness
  - Inpatient surgery
  - Maternity
  - Sick newborn
  - Well newborn — no separate deductible applied; deductible is applied to mother's claims only.
  - Semi-private room accommodations, private room paid at semi-private rate unless medically necessary; emergency admissions will be paid in-network.
- Physical medical rehab
- Skilled nursing facility
- Professional medical care
  - General medical care consultation, second opinion maternity
  - Intensive care, monitoring
  - Newborn care (**Note:** For well newborn, no separate deductible is applied.)
  - Includes newborn vision/hearing screening when rendered in an inpatient setting.

Maternity care

- Office and outpatient
  - Includes therapeutic and elective abortion
  - Dependents are covered
  - Includes licensed and certified birthing centers
  - Licensed and certified midwives are eligible providers
  - Home births are not covered, even if attended by a midwife

Mental health

- Inpatient and residential
  - Inpatient accommodations and ancillaries
  - Eating disorders are covered
- Outpatient
  - Partial hospitalization is considered outpatient
  - Eating disorders are covered

Nutritional counseling (non-diabetic)

- Limited to six visits per year
- When part of HCR, services refer to Preventive care benefits below
- Limit combined
  - In- and out-of-network
  - Institutional/professional
  - Mental health diagnosis has no visit limits
  - Diabetic and non-diabetic nutritional counseling
- Covered for medical conditions that require a special diet.

Preventive care benefits

- Routine adult physical
- Routine prenatal office visits (excludes ultrasounds, labs and visits to monitor pregnancy related conditions)
- Well-woman exam
- Well-child care up to age 19
- Immunizations
  - Child and adult
  - Travel immunizations are not covered
- COVID-19 vaccination
- Flu shot
- Diagnostic x-rays and lab tests (routine)
  - Bone density testing
  - Cholesterol screenings
  - Hearing and vision screenings
- Lung cancer screenings
- Prostate cancer screening — PSA (routine)
- Colon cancer screenings (routine)
  - Routine fecal occult blood test
  - Routine barium enema
  - Member can choose one of the following: fecal occult blood test, sigmoidoscopy or colonoscopy
  - Facility and anesthesia billed for routine sigmoidoscopy/colonoscopy are covered at the same level as the routine sigmoidoscopy/colonoscopy
- Pap smear (routine)
- Mammography (routine) includes 3D mammograms
- Biometric services/Diabetic prevention Program (DPP) through Virta Health (available to participants ages 18–79).

Surgery

- Assistant surgeon
- Oral surgery
  - Excludes removal of impacted teeth
  - Limited to charges made for continuous course of dental treatment within 12 months of injury to sound, natural teeth
- Office and outpatient

Therapies

- Cardiac rehab
- Chemotherapy
- Dialysis/hemodialysis
- Infusion
- Occupational
- Physical

- Respiratory
- Speech

Temporomandibular joint dysfunction (TMJ)

Coverage is provided for surgical treatment of temporomandibular joint dysfunction if due to accident, congenital defect or developmental defect.

Transgender medical services

Inclusive Care

Every group, including the LGBTQIA+ members, face unique healthcare challenges. Anthem advocates for and connects with the LGBTQIA+ community to provide the right healthcare solutions. Inclusive Care takes a caring and effective approach to services and access to meet the needs of the whole person. We'll help you find providers that understand your circumstance, answer your questions, and help you get the get the care you need with dignity and respect. Inclusive Care removes barriers and increases confidence so that everyone in the LGBTQIA+ community has access to safe, compassionate, and best-in-class healthcare.

Equitable and Empathetic Care: Support to find providers who are LGBTQIA+-friendly, competent, and subject matter experts. Virtual health tailored to LGBTQIA+ community.

Expert guidance: A multidisciplinary team committed to helping across your medical and emotional needs and virtual second opinion program helps ensure you're getting the right care and support.

Premier treatment: Get family support and specialty care at Centers of Excellence specializing in gender affirmation surgery, with virtual second opinion, travel services, and consultation by Chief LGBTQIA+ Health Officer available to support your journey.

Inclusive Care takes a caring and effective approach to services and access to meet the needs of the whole person. The program includes:

- Support to find providers who are LGBTQIA+ friendly, competent, and subject matter experts
- Virtual behavioral health tailored to LGBTQIA+ community
- A multidisciplinary team committed to helping across your medical and emotional needs and virtual second opinion program helps ensure you're getting the right care and support
- Family support and specialty care at Centers of Excellence specializing in gender affirmation surgery, with virtual second opinion, travel services, and consultation by Chief LGBTQIA+ Health Officer available to support your journey.

Travel and lodging benefits

When using an Inclusive Care Center of Excellence, and the treatment has been preapproved by Anthem, you may be eligible for travel and lodging benefits.

Travel and lodging benefits are economy class unless otherwise noted, and:

- Are limited to $10,000 per a lifetime combined total for all related travel expenses
- Includes transportation to and from a program Center of Excellence that is at least 75 miles from your residence
- Includes transportation for a companion (or parent/legal guardian for a minor)

Travel and lodging benefits do not include charges for:

- Transportation, lodging and food associated with services at a facility other than a program Centers of Excellence
- Air ambulance travel
- Laundry bills
- Telephone bills
- Alcohol or tobacco products
- Entertainment
- Personal expenses and upgrades

Medical travel benefits may be considered taxable income by the IRS. A Form 1099 will be issued for any taxable benefits related to travel. Please consult a tax professional.

Gender Affirming Surgery benefit

This Plan provides benefits for many of the services related to Gender Affirming Surgery for members diagnosed with Gender Dysphoria. Gender Affirming Surgery must be approved by the health plan for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the Gender Affirming Surgery requested will not be considered Covered Services. Some conditions apply, and all services must be authorized by the health plan as outlined in the Precertification Requirements section. Your Provider can contact the health plan for authorization at the number on Your ID card. If you have coverage questions, please contact Anthem Health Guide at **866-251-1803** to discuss coverage details.

Transplant benefits

- Live donor health services
  - Donor benefits are limited to benefits not available to the donor from any other source
  - Medically necessary charges for the procurement of an organ from a live donor are covered up to the maximum allowed amount, including complications from the donor procedure for up to six weeks from the date of procurement.
- Bone marrow donor search fee
  - Covered only in network
- Organ transplants
  - Donor expenses are covered
- Travel and lodging

  If you or your dependent elects to use an organ transplant Blue Distinction Center for Transplant (BDCT) facility, and the treatment and facility have been preapproved by Anthem, you may be eligible for the travel and lodging benefit. The transplant recipient is defined as the person covered under the plan who receives preapproved transplant-related services during evaluation, candidacy, transplant event or post-transplant care.

  - Travel and lodging benefits are limited to $10,000 per transplant
  - Travel expenses for the person receiving the transplant include charges for:
    - Transportation to and from the transplant site or other preapproved medical facility for the patient and companion
    - Lodging while at or traveling to and from the transplant site for the patient (while not confined) and companion

Note

The plans pay up to a combined maximum of $10,000 per transplant for travel and lodging per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s). Transportation and lodging charges are considered travel expenses for one companion at any time in addition to the actual transplant recipient. If the transplant recipient is a minor, these travel expenses can be considered for both parents. The term companion includes a spouse, family member, partner, legal guardian of you or your enrolled dependent or any unrelated person actively involved as a caregiver.

Travel expenses don't include charges for:

- Transportation, lodging and food associated with an organ transplant performed at a facility other than the approved organ transplant facility
- Food while at or traveling to and from the transplant site
- Air ambulance travel
- Laundry bills
- Telephone bills
- Alcohol or tobacco products
- Entertainment

Organ transplant travel benefits may be considered taxable income by the IRS. A Form 1099 will be issued for any taxable benefits related to travel. Please consult with a tax advisor for more information.

Travel and lodging benefits for pre-approved care not available within 120 miles of where you live

When care is not available at an in-network facility within 120 miles of where you live you may be eligible for travel and lodging benefits. Expenses for travel and lodging for the recipient and a companion should be verified by the plan and may be available as follows:

- Transportation to and from a network facility that is at least 120 miles from your residence for an evaluation, a surgical procedure or necessary post-discharge follow-up (personal car mileage is reimbursed at the current federal rate of reimbursement)
- Transportation for a companion (or parent/legal guardian for a minor) traveling on the same day as the patient
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion:
  - Expenses are limited to a maximum of $50 per day ($100 per day if a companion joins the patient)
  - Maximum of $3,000 in travel and lodging expenses per occurrence (a combined total if a companion joins the patient)

Note

If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-day rate.

Travel and lodging benefits do not include charges for:

- Transportation, lodging and food associated with services provided at a facility not approved by the plan
- Air ambulance travel
- Laundry bills
- Telephone bills
- Meals
- Alcohol or tobacco products
- Entertainment
- Personal expenses and upgrades
- Valet parking
- Convenience items
- Furnishing for apartments, including cooking utensils, appliances and furniture
- Gratuities of any kind
- Groceries

Contact Anthem at the phone number on your medical ID card for full details regarding travel and lodging benefits.

Medical travel benefits may be considered taxable income by the IRS. A Form 1099 will be issued for any taxable benefits related to travel. Please consult a tax professional.

For the plan to pay benefits for transportation and lodging expenses, you must submit itemized receipts in a form satisfactory to Anthem when you file a claim. Anthem will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Note

The travel and lodging benefits described above are in addition to the other travel and lodging benefits detailed in the Raytheon Technologies **2022 Health & Insurance SPD**, such as for transplants and gender-affirming care.

Vision

- Glasses/contacts after cataract surgery
  - Includes initial frames, lenses, or contacts following cataract surgery
  - Limit combined In- and out-of-network
  - Limit one occurrence per surgery

Precertification requirements

Typically, network providers know which services need precertification and will get any precertification when needed. Your primary care physician (PCP) and other network providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, facility or attending doctor (“requesting provider”) will get in touch with Anthem to ask for precertification. However, you may request precertification, or you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Using an out-of-network provider may result in significant additional financial responsibility for you because your medical plan can't prohibit out-of-network providers from billing you for the difference between the service provider's charge and the benefit amount the plan will pay.

The following table outlines who is responsible for precertification and under what circumstances.

Provider network status	Who is responsible for requesting precertification
In-Network Provider • BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI) • Anthem Blue Cross (CA) • Empire Blue Cross Blue Shield • Anthem Blue Cross Blue Shield (GA) • Any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the claims administrator's parent company.	The Provider must request precertification when required.
Out-of-Network/Non-Participating Provider	The member must request precertification when required (call Member Services). The member may be financially responsible for some or all charges related to the service if the service is found not to be medically necessary.
BlueCard Provider Outside the service areas of the states listed above and BlueCard Providers in other states not listed.	Except for inpatient admissions, the member is responsible for requesting precertification when required (call Member Services). The member may be financially responsible for some or all charges related to the service if the service is found not to be medically necessary. BlueCard Providers must obtain precertification for all inpatient admissions.

Note: For an emergency care admission, precertification is not required. However, you, your authorized representative or doctor must notify the claims administrator no later than two business days after admission or as soon as possible within a reasonable period.

Note

Using an out-of-network provider may result in significant additional financial responsibility for you because your health benefit plan can't prohibit out-of-network providers from billing you for the difference between their charge and the benefit the plan provides.

To avoid denial of services for hospital/medical benefits, please call before receiving services or no later than two business days after an emergency admission.

Precertification is required before receiving certain services, such as:

- Diagnostic x-ray, lab and diagnostic services (nonroutine)
  - Cardiac ion channel genetic testing
  - Chromosomal microarray analysis (CMA) for developmental delay, autism spectrum disorder, intellectual disability (intellectual developmental disorder) and congenital anomalies
  - Gene expression profiling for managing breast cancer treatment
  - Gene mutation testing for solid tumor cancer susceptibility and management genetic testing for breast and/or ovarian cancer syndrome
  - Preimplantation genetic diagnosis testing
  - Prostate saturation biopsy
  - Wireless capsule for the evaluation of suspected gastric and intestinal motility disorders
- Durable medical equipment
  - Augmentative and alternative communication (AAC) devices/speech generating devices (SGD)
  - Electrical bone growth stimulation
  - Functional electrical stimulation (FES)
  - Implantable infusion pumps
  - Lower limb prosthesis and microprocessor-controlled lower limb prosthesis
  - Oscillatory devices for airway clearance including high-frequency chest compression and intrapulmonary percussive ventilation (IPV)
  - Pneumatic compression devices for lymphedema
  - Prosthetics: Electronic or externally powered and select other prosthetics (myoelectric-UE)
  - Standing frame
  - Transtympanic micropressure for the treatment of Ménière's disease
  - Ultrasound bone growth stimulation
  - Wheeled mobility devices: Wheelchairs — powered, motorized, with or without power seating systems — and Power Operated Vehicles (POVs)
- Gender affirmation surgery
- Human organ and bone marrow/stem cell transplants (BDCT facility and non-BDCT facility)
  - Inpatient admits for **all** solid organ and bone marrow/stem cell transplants (including kidney only transplants)
  - Outpatient: All procedures considered to be transplant or transplant related, including but not limited to:
    - Donor leukocyte infusion
    - Intrathecal treatment of spinal muscular atrophy (SMA)
    - Stem cell/bone marrow transplant (with or without myeloablative therapy)
    - (CAR) T-cell immunotherapy treatment including Axicabtagene Ciloleucel (Yescarta™), Tisagenlecleucel (Kymriah™) and Brexucabtagene Autoleucel (Tecartus)
  - Gene therapy treatment and replacement
- Inpatient admission
  - Acute inpatient
  - Acute rehabilitation
  - Long-term acute care hospital (LTACH)
  - Skilled nursing facility
  - OB delivery stays beyond the federal mandate minimum length of stay (including newborn stays beyond the mother's stay)
  - Emergency admissions (requires plan notification no later than two business days after admission)

- Mental health/substance abuse (MHSA)
  - Acute inpatient admissions
  - Transcranial magnetic stimulation (TMS)
  - Residential care
  - Behavioral health in-home programs
  - Applied behavioral analysis (ABA)[1]
  - Intensive outpatient therapy (IOP)[1]
  - Partial hospitalization (PHP)[1]
- Other outpatient and surgery services
  - Air ambulance (excludes 911 initiated emergency transport)
  - Abdominoplasty, panniculectomy, diastasis recti repair
  - Ablative techniques as a treatment for Barrett's esophagus
  - Allogeneic, xenographic, synthetic and composite products for wound healing and soft tissue grafting
  - Hyperbaric oxygen therapy (systemic/topical)
  - Autologous cellular immunotherapy for the treatment of prostate cancer
  - Axial lumbar interbody fusion
  - Balloon and self-expanding absorptive sinus ostial dilation
  - Bariatric surgery and other treatments for clinically severe obesity
  - Blepharoplasty
  - Bone-anchored and bone conduction hearing aids
  - Brachioplasty
  - Breast procedures, including reconstructive surgery, implants and other breast procedures
  - Bronchial thermoplasty for treatment of asthma
  - Cardiac resynchronization therapy (CRT) with or without an implantable cardioverter defibrillator (CRT/ICD) for the treatment of heart failure
  - Carotid, vertebral and intracranial artery angioplasty with or without stent placement
  - Cervical and thoracic discography
  - Chin implant, mentoplasty, osteoplasty mandible
  - Cochlear implants and auditory brainstem implants
  - Computer-assisted musculoskeletal surgical navigational orthopedic procedures of the appendicular system
  - Corneal collagen cross-linking
  - Cryosurgical ablation of solid tumors outside the liver
  - Deep brain, cortical and cerebellar stimulation
  - Diaphragmatic/phrenic nerve stimulation pacing systems
  - Electric tumor treatment field (TTF)
  - Endovascular techniques (percutaneous or open exposure) for arterial revascularization of the lower extremities)
  - Functional endoscopic sinus surgery
  - Immunoprophylaxis for respiratory syncytial virus (RSV)/synagis (palivizumab)
  - Implantable ambulatory event monitors and mobile cardiac telemetry
  - Implantable or wearable cardioverter-defibrillator
  - Implanted (epidural and subcutaneous) spinal cord stimulators (SCS)
  - Implanted devices for spinal stenosis

[1]Check benefits for any exclusions or specific pre-certification requirements

- Insertion/injection of prosthetic material collagen implants
- Percutaneous vertebral disc and vertebral endplate procedures
- Intraocular anterior segment aqueous drainage devices (without extraocular reservoir)
- Keratoprosthesis
- Leadless pacemaker
- Liposuction/lipectomy
- Locoregional and surgical techniques for treating primary and metastatic liver malignancies
- Lower esophageal sphincter augmentation devices for the treatment of gastroesophageal reflux disease (GERD)
- Lumbar discography
- Lysis of epidural adhesions
- Mandibular/maxillary (orthognathic) surgery
- Manipulation under anesthesia of the spine and joints other than the knee
- Mastectomy for gynecomastia
- Mechanical circulatory assist devices (ventricular assist devices, percutaneous ventricular assist devices and artificial hearts)
- Mechanical embolectomy for treatment of acute stroke
- Meniscal allograft transplantation of the knee
- Oral, pharyngeal and maxillofacial surgical treatment for obstructive sleep apnea or snoring
- Outpatient cardiac hemodynamic monitoring using a wireless sensor for heart failure management
- Ovarian and internal iliac vein embolization as a treatment of pelvic congestion syndrome
- Partial left ventriculectomy
- Penile prosthesis implantation
- Percutaneous and endoscopic spinal surgery
- Percutaneous neurolysis for chronic neck and back pain
- Percutaneous vertebroplasty, kyphoplasty and sacroplasty
- Perirectal spacers for use during prostate radiotherapy (space oar)
- Photocoagulation of macular drusen
- Presbyopia and astigmatism-correcting intraocular lenses
- Private duty nursing
- Procedures performed on male or female genitalia
- Procedures performed on the face, jaw or neck (including facial dermabrasion, scar revision)
- Procedures performed on the trunk and groin
- Reduction mammaplasty
- Repair of pectus excavatum/carinatum
- Sacral nerve stimulation (SNS) and percutaneous tibial nerve stimulation (PTNS) for urinary and fecal incontinence and urinary retention
- Sacral nerve stimulation as a treatment of neurogenic bladder secondary to spinal cord injury
- Sacroiliac joint fusion (minimally invasive)
- Skin-related procedures
- Subtalar arthroereisis
- Surgical and ablative treatments for chronic headaches
- Surgical and minimally invasive treatments for benign prostatic hyperplasia (BPH) and other GU conditions
- Surgical treatment of obstructive sleep apnea and snoring
- Therapeutic apheresis
- Total ankle replacement

- Transanal hemorrhoidal dearterialization (THD)
- Transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation (radiofrequency and cryoablation)
- Transcatheter closure of patent foramen ovale and left atrial appendage for stroke prevention
- Transcatheter heart valve procedures
- Transcatheter uterine artery embolization
- Transendoscopic therapy for gastroesophageal reflux disease and dysphagia
- Transmyocardial/perventricular device closure of ventricular septal defects
- Treatment of hyperhidrosis
- Treatment of osteochondral defects of the knee and ankle
- Treatment of temporomandibular disorders
- Treatment of varicose veins (lower extremities)
- Treatments for urinary incontinence
- Vagus nerve stimulation
- Venous angioplasty with or without stent placement/venous stenting
- Viscocanalostomy and canaloplasty

- Out-of-network referrals — For consideration of payment at in-network benefit level (may be authorized, based on network availability and/or medical necessity).
- Radiation therapy/radiology services
  - Intensity-modulated radiation therapy (IMRT)
  - MRI guided high intensity focused ultrasound ablation for non-oncologic indications
  - Single-photon emission computed tomography (SPECT) scans for noncardiovascular indications
  - Proton beam therapy
  - Radiofrequency ablation to treat tumors outside the liver
  - Stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT)
  - Transcatheter arterial chemoembolization (TACE) and transcatheter arterial embolization (TAE) for treating primary or metastatic liver tumors
  - Transcatheter arterial chemoembolization (TACE) and transcatheter arterial embolization (TAE) for malignant lesions outside the liver — except CNS and spinal cord
  - Wireless capsule endoscopy for gastrointestinal imaging and the patency capsule

For a complete listing of precertification requirements, visit anthem.com — search using the keyword "**precertification**." Or call the phone number on your plan ID card.

All coverage is subject to medical necessity review. If the plan determines that any medical service wasn't medically necessary, then no charges for that service will be covered, and those charges will be your responsibility to pay.

In-network precertification

When you receive in-network care, your in-network provider must submit the precertification request.

Outpatient mental health and chemical dependency therapy doesn't require precertification. However, precertification is required for all inpatient mental health and chemical dependency care and all alternatives to inpatient care, including residential treatment centers, partial hospitalization and intensive outpatient programs.

Out-of-network and out-of-area plans precertification

It's your responsibility to ensure that precertification has been received before receiving services.

Service	Precertification requirement
Hospital stay	You must receive precertification for hospital stays. Your non-emergency inpatient hospitalizations require you to receive preadmission certification in advance of your hospital stay. Your emergency inpatient hospitalizations require precertification within 48 hours of admission. For inpatient preadmission certification, call the number listed on your plan ID card.
Outpatient mental health and chemical dependency treatment	You don't need to precertify for most outpatient mental health and chemical dependency treatments. However, precertification is required for these outpatient alternatives to inpatient care: residential treatment programs, partial hospitalization and intensive outpatient programs.
Inpatient mental health and chemical dependency treatment	Precertification is required for all inpatient care and all alternatives to inpatient care, including residential treatment centers, partial hospitalization and intensive outpatient programs. Refer to the Hospital stay row above for information on timing and penalty for failure to precertify.

Traveling outside the country

When traveling outside the country, medical coverage is only available in the event of an emergency. No travel or evacuation coverage is provided. If an emergency illness or injury takes place, seek immediate treatment. If you're admitted to an inpatient facility, notify your plan immediately by calling the number listed on your medical ID card.

When seeking emergency care, any services received must be covered under the terms of your plan. See the definition of Emergency care in this section.

Note: U.S.-based employees who travel abroad

When traveling outside the country for business, Medical Benefits Abroad (MBA) coverage offered by Cigna Global provides medical coverage for U.S.-based employees who travel outside the U.S. for up to six months.

To review a description of how coverage works and/or print an ID card, go to cignaenvoy.com (see your travel itinerary for login information). If you need assistance while traveling, dial the International Access Code, available at att.com/traveler, and then **800-234-1348** or call **302-797-3535** collect.

If travel or evacuation is required while outside the U.S., call AIG Travel at **877-249-5187** or +**1-715-295-9624** (call collect/reverse charge) for assistance.

Medical expenses not covered

Unless otherwise noted, the plans do not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of or given in connection with the following:

- Acupressure
- Adoption or surrogacy

- Allergy services — specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity and urine autoinjections
- Alternative treatments, such as art therapy, music therapy, dance therapy, horseback therapy and other forms as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to non-manipulative osteopathic care as allowed in the plan documents
- Aromatherapy
- Artificial reproductive treatments for gender or trait selection
- Autopsies and other coroner services and transportation services for a corpse
- Services or supplies received before an employee or their dependent becomes covered under the plan
- Biofeedback
- Biomicroscopy, field charting or aniseikonic investigation
- Breast reduction surgery that is determined to be a cosmetic procedure. This exclusion does not apply to breast reduction surgery that:
  - The claims administrator determines is requested to treat a physiologic functional impairment;
  - Is covered by the Women's Health and Cancer Rights Act of 1998; or
  - Meets Anthem's guidelines
- Charges for missed appointments; room or facility reservations; completion of claim forms; record processing or services; or supplies or equipment that are advertised by the provider as free
- Charges for which a provider waives the deductible or coinsurance amounts
- Charges prohibited by federal anti-kickback or self-referral statutes
- Chelation therapy, except to treat heavy metal poisoning
- Services ordered or delivered by a Christian Science practitioner
- Charges made by a hospital for confinement in a special area of the hospital that provides non-acute care, by whatever name, including but not limited to the type of care given by the following facilities:
  - Adult or child day care center
  - Halfway house
  - Treatment center
  - Vocational rehabilitation center
  - Any other area of a hospital that renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons

If the facility is otherwise covered under the Anthem plan, then benefits for that covered facility that is part of a hospital, as defined, are payable at the coverage level for that facility — not at the coverage level for a hospital.

- Services for a surgical procedure to correct refraction errors of the eye, including radial keratotomy, laser surgery and any confinement, treatment, services or supplies in connection with or related to the surgery
- Cosmetic surgery or treatment — these are procedures or services (surgery or treatment) primarily to change or improve appearance without significantly improving physiological function. Examples include pharmacological regimens; nutritional procedures or treatments; tattoo or scar removal, or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); 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 surgery in the General limitations section for further details); varicose vein treatment of the lower extremities (including vein stripping, ligation and sclerotherapy); and treatment of benign gynecomastia (abnormal breast enlargement in males). It does not matter whether or not it is for psychological or emotional reasons (**Note:** Certain cosmetic procedures are covered to treat gender dysphoria; see the entry for gender dysphoria later in this section.)

- Custodial or maintenance care — this is care made up of services and supplies that meet one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; and/or
  - Care that does not seek a cure or can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional

  Care that meets one of these conditions is custodial care regardless of any of the following:

  - Who recommends, provides or directs the care;
  - Where the care is provided; and
  - Whether or not the patient or another caregiver can be or is being trained to care for himself/herself
- Daily room charges while the plan is paying for an intensive care, cardiac care or other special care unit
- Dental services — with the exception of accident-related dental services described under General limitations earlier in this section, Anthem does not cover the following dental services:
  - Dental care that is required to treat the effects of a medical condition but that is not necessary to directly treat the medical condition. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication and any treatment to improve the ability to chew or speak
  - Endodontics; periodontal treatment or surgery; and restoration and replacement of teeth
  - Diagnosis or treatment of or related to the teeth or gums unless due to accidental injury. Examples include extractions (including wisdom teeth); restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes;
  - Preventive dental care
  - Services to improve dental clinical outcomes
  - Dental implants, bone grafts (unless due to accidental injury) and other implant-related procedures;
  - Dental braces (orthodontics)
  - Dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia
- Expenses incurred by a dependent if the dependent is also a company employee and has coverage for the same services under their company-sponsored plan
- Diagnostic tests that are delivered in other than a physician’s office or health care facility, and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests
- Domiciliary care, meaning living arrangements designed to meet the needs of people who cannot live independently, but do not require skilled nursing facility services
- Services provided by a doula or other labor aide
- The following durable medical equipment (DME) services are not covered:

- Devices used specifically as safety items or to affect performance in sports-related activities[1]
- Orthotic appliances and devices, including, but not limited to foot orthotics, shoe orthotics, shoes or any braces that can be obtained without a physician's order (**Note:** Orthotic appliances and devices are covered only if prescribed by a physician for a medical purpose and are custom-manufactured or custom fitted to the individual covered person)
- Blood pressure cuff/monitor
- Enuresis alarm
- Home coagulation testing equipment
- Non-wearable external defibrillator
- Trusses
- Ultrasonic nebulizers
- Devices and computers to assist in communication and speech, except for dedicated speech-generating devices and tracheoesophageal voice devices
- Oral appliances for snoring (other than CPAP machines, which are covered)

This exclusion does not apply to insulin pumps, breast prosthesis, mastectomy bras and lymphedema stockings for which benefits are provided.

- Ecological or environmental medicine, including diagnosis and for treatment
- Education, training and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
- Elective services received outside the U.S.
- Expenses for health services and supplies that exceed eligible expenses or any specific limitation in this Summary Plan Description
- Any expense submitted more than 12 months from the date the service or supply was received
- Excision or elimination of hanging skin on any part of the body. Examples include abdominoplasty and other procedures or surgery to remove fatty tissue, such as panniculectomy, thighplasty, brachioplasty or mastopexy. The exception is if a covered person has had bariatric surgery and requires excess skin to be removed. Any procedure to remove excess skin must meet Anthem's medical criteria guidelines
- Eyeglasses, contact lenses and eye refractions, unless required due to an accidental injury or following cataract surgery
- Food of any kind, unless it is prescribed to treat inborn errors of metabolism, such as phenylketonuria (PKU), and/or is the required source of nutrition. Foods that are not covered include:
  - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
  - Oral vitamins and minerals
  - Meals you can order from a menu, for an additional charge, during an inpatient stay
  - Other dietary and electrolyte supplements
  - Infant formula available over the counter
  - Other nutritional and electrolyte formulas
- Foot care, including the following:
  - Routine foot care, except when needed for severe systemic disease. Routine foot care services that are not covered include cutting or removal of corns and calluses, nail trimming or cutting, and debriding (removal of dead skin or underlying tissue)

[1]Durable medical equipment that allows plan participants to perform lifestyle activities including sports-related activities is covered.

  - Hygienic and preventive foot care. Examples include cleaning and soaking the feet, applying skin creams in order to maintain skin tone, and other services that are performed when there is not a localized sickness, injury or symptom involving the foot
  - Treatment of flat feet, except foot orthotics for flat feet when prescribed by a physician and custom manufactured or custom fitted to the individual covered person
  - Treatment of subluxation (joint or bone dislocation) of the foot
  - Shoes (standard or custom not prescribed by a physician for diabetes or other systemic diseases), lifts and wedges
  - Foot orthotics or shoe orthotics that are not prescribed by a physician
- Foreign language and sign-language services.
- Full-body scans and EBCT (heart scans)
- Certain services related to gender dysphoria, when the services are cosmetic and do not meet the criteria for being reconstructive, such as[1]:
  - Abdominoplasty
  - Blepharoplasty
  - Breast enlargement, including augmentation mammoplasty and breast implants
  - Body contouring, such as lipoplasty
  - Brow lift
  - Calf implants
  - Cheek, chin and nose implants
  - Face-lift, forehead lift, or neck tightening
  - Hair removal
  - Hair transplantation
  - Injection of fillers or neurotoxins
  - Lip augmentation
  - Lip reduction
  - Liposuction
  - Mastopexy
  - Pectoral implants for chest masculinization
  - Rhinoplasty
  - Skin resurfacing
  - Voice lessons and voice therapy
- Membership costs for health clubs, weight loss clinics and similar programs
- Health education classes, such as those for asthma, birthing, parenting, prenatal, smoking/tobacco cessation or weight control
- Hemodialysis and peritoneal dialysis are not covered out-of-network
- Herbal medicine, holistic or homeopathic care, including drugs
- Hypnotism
- Ineligible hospital charges — any services rendered, or supplies provided while you are confined in an ineligible hospital
- Ineligible provider charges — any services rendered, or supplies provided while you are a patient or receive services at or from an ineligible provider

[1]Many of these procedures can be approved when they are deemed to be medically necessary for the treatment of gender dysphoria. See the Transgender medical services section for further details.

- The following infertility treatment-related services:
  - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue
  - Donor services and non-medical costs of oocyte or sperm donation, such as donor agency fees;
  - Ovulation predictor kits
  - Fees for the use of a gestational carrier or surrogate
  - Pregnancy services for a gestational carrier (a woman who agrees to have a couple's fertilized egg implanted in her uterus. A gestational carrier carries the pregnancy for the couple, who usually has to adopt the child. The carrier does not provide the egg and is therefore not biologically related to the child) or surrogate (a woman who becomes pregnant usually by artificial insemination or surgical implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman) who is not covered by the plan
  - Reversal of voluntary sterilization
  - Artificial reproductive treatments for gender or trait selection
- Intracellular micronutrient testing
- Upper and lower jawbone surgery, except as required for direct treatment of acute traumatic injury, tumor, cancer or congenital anomaly
- Liposuction, except in some cases related to gender dysphoria
- Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies
- Massage therapy
- Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)
- Services, supplies, medical care or treatment given by one of the following members of the employee's immediate family:
  - The employee's spouse/partner; or
  - The child, brother, sister, parent or grandparent of either the employee or the employee's spouse/partner
- Megavitamin and nutrition-based therapy.
- The following mental health (including Autism Spectrum Disorder (ASD) services)/substance-related and addictive disorders services are not covered:
  - 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 the *Diagnostic and Statistical Manual of the American Psychiatric Association*
  - 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*
  - Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, gambling disorder and paraphilic disorder
  - 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*

- Non-medical 24-hour withdrawal management as per the American Society of Addiction Medicine (ASAM)
- Transitional living services for mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in the ASAM criteria, and are either:
  - Sober-living arrangements, such as drug-free housing or alcohol/drug halfway houses, that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. Sober-living arrangements may be used as an addition to ambulatory treatment when that treatment does not offer the intensity and structure needed to help with recovery; or
  - Supervised living arrangements, such as facilities, group homes and supervised apartments, that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be used as an addition to treatment when that treatment does not offer the intensity and structure needed to help with recovery
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges) and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the mental health/substance-related and addictive disorders administrator
- Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements, unless preauthorized by the mental health/substance-related and addictive disorders administrator
- Routine use of psychological testing without specific authorization
- Services and supplies for the diagnosis or treatment of mental illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the mental health/substance-related and addictive disorders administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective, or are not consistent with:
  - Prevailing national standards of clinical practice for the treatment of such conditions;
  - Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; or
  - The mental health/substance-related and addictive disorders administrator's level of care guidelines as modified from time to time
- Treatment that is not clinically appropriate for the patient's mental illness, substance use disorder or condition, based on generally accepted standards of medical practice and benchmarks
- Mental health services as treatments for V-code conditions as listed in the current edition of the Diagnostic and Statistical Manual of American Psychiatric Association
- Mental health services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis
- Treatments for the primary diagnosis of learning disabilities
- Educational/behavioral services that are focused on primary building skills and capabilities in communication, social interaction and learning
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act

  - Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
  - Intellectual developmental disorder defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
  - Intensive behavioral therapies other than Applied Behavior Analysis (ABA) therapy for Autism Spectrum Disorders (ASD)
  - Any treatments or other specialized services designed for Autism Spectrum Disorders that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered experimental, investigational or unproven services

- Never events — the plan will not pay for errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The provider will be expected to absorb such costs. This exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure or operating on the wrong patient.
- Safe surroundings — care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury
- Services for which coverage is available while on active military duty and for treatment of military service-related disabilities when the covered person is legally entitled to other coverage and facilities are reasonably accessible
- Services or supplies that are not covered health services, including any confinement or treatment given in connection with a service or supply that is not covered by Anthem
- Services and supplies for which the covered person is not legally required to pay
- Occupational injury or sickness, meaning an injury or sickness that is covered under a workers' compensation act or similar law. For persons whose coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected
- Oral contraceptives (check with your prescription drug plan for available oral contraceptive coverage)
- Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment otherwise qualifies as a covered health service
- Services given by a pastoral counselor
- Personal convenience or comfort items, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, dehumidifiers, humidifiers, saunas and hot tubs, beauty/barber service, guest service, air purifiers and filters, batteries and battery charger, ergonomically correct chairs, non-hospital beds and comfort beds, devices and computers to assist in communication and speech, and home remodeling to accommodate a health need, including, but not limited to, ramps, swimming pools, elevators, handrails and stair glides
- Phototherapy devices used to treat seasonal affective disorder (SAD)
- Physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion of general motivation
- Benefits are not provided by Anthem for the following types of prescription drugs:
  - Prescription drugs for outpatient use that are filled by a prescription order or refill
  - Self-administered or self-infused medications (**Note:** This exclusion does not apply to medications that, due to their characteristics (as determined by Anthem), must typically be administered or

  - directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion also does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to covered persons for self-infusion)
  - Non-injectable medications given in a physician's office, except as required in an emergency
  - Over-the-counter drugs and treatments
- Prescription medications or products approved by the U.S. Food and Drug Administration (FDA) administered in connection with a covered health service by a physician and/or new dosage forms are excluded until the date they are reviewed by Anthem
- Private-duty nursing services, while confined in a facility
- Services ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in the covered person's medical care prior to ordering the service or after the service is received (**Note:** This exclusion does not apply to mammography testing.)
- Charges by a provider who is sanctioned under a federal program for reason of fraud, abuse or medical competency
- Psychosurgery (lobotomy)
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a covered person under the plan and is undergoing a covered transplant
- Rest cures
- Reversal of voluntary sterilization
- Rolfing (holistic tissue massage)
- Sales tax
- Sensitivity training, education training therapy or treatment for an education requirement
- Expenses for health services and supplies that are received after the date your coverage under the plan ends, including health services for medical conditions that began before the date the covered person's coverage under the plan ends. Anthem will provide benefits for an inpatient confinement through the date of discharge if the patient was confined prior to the patient's termination date
- Services covered by another plan, except as described under Subrogation and right of recover provisions in the *Administration information* chapter
- Services ordered by a provider who is not actively involved in your care before ordering the service or after the service is received. Note that this exclusion does not apply to mammography testing
- Services performed at a diagnostic facility (hospital or otherwise) without a written order from a provider
- Services performed by a provider with the employee's same legal residence
- Services performed by an unlicensed provider or a provider who is operating outside the scope of their license
- Rehabilitation services and manipulative treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter
- Treatment of smoking/tobacco dependency, including services and supplies for smoking/tobacco cessation

- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring, other than CPAP machines, are excluded.
- Spinal treatment to treat a condition unrelated to the alignment of the vertebral column, such as asthma or allergies, or for maintenance/preventive manipulative treatment
- Standby services required of a physician
- Storage of blood, umbilical cord or other material for use in a covered health service, except if needed for an imminent surgery
- Toupees, hair transplants, hair weaving or any drug, if such drug is used in connection with baldness
- Travel and/or lodging expenses of a physician or a patient, except as specified earlier in this section
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatment for purposes of education, career, employment, school, camp, travel outside the U.S., insurance, marriage or adoption, medical research, judicial or administrative proceedings or orders; for obtaining or maintaining a license of any kind; or as the result of incarceration
- Treatment received while confined in a state, federal or Veterans Affairs hospital for which charges are not imposed
- Anthem does not provide coverage for the following vision care services:
  - Routine vision exam, including refractive examinations to determine the need for vision correction
  - Purchase cost and associated fitting charges for eyeglasses or contact lenses
  - Implantable lenses used only to correct a refractive error (such as Intacs corneal implants)
  - Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
- Services given by volunteers or persons who do not normally charge for their services
- Services or supplies that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country (**Note:** This exclusion does not apply to covered persons who are civilians injured or otherwise affected by war or any act of war or terrorism in a non-war zone.)
- Weight reduction or control, unless there is a diagnosis of morbid obesity and the services meet Anthem's guidelines (in this case, only surgical treatment is covered). The following treatments for obesity are not covered: nonsurgical treatment, even if for morbid obesity, and surgical treatment of obesity unless there is a diagnosis of morbid obesity. For information regarding Anthem's clinical policy, call Anthem at the number on your medical ID card. Anthem also does not provide benefits for any weight-loss programs, whether or not they are under medical supervision or for medical reasons
- Wigs, except when needed for hair loss due to cancer treatment or alopecia areata
- Treatment of wisdom teeth

General limitations

No payment will be made for expenses incurred for:

Act of war/military duty — Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy; also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.

Custodial/convalescent care — Services for custodial care; services for confinement for custodial or convalescent care, rest cures or long-term custodial hospital care.

Dental services — Dental care and treatment and oral surgery (by physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants unless otherwise noted on the plan design; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth-related service except otherwise specified as covered.

Eligibility — Charges for treatment received before coverage under this option began or after it is terminated.

Experimental/investigational

- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") that are considered experimental or investigational for the diagnosis for which the participant is being treated
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the claims administrator

Foot care

- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toenails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for medically necessary foot care required as part of the treatment of diabetes and for plan participants with impaired circulation to the lower extremities
- Shoe inserts, orthotics (will be covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary)

Government agency/laws/plans

- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the member had applied for such benefits; services that can be provided through a government program for which you as a member of the community are eligible for participation, such as, but not limited to, school speech and reading programs
- With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the member has enrolled in Medicare Part B
- Services covered under workers' compensation, no-fault automobile insurance and/or services covered by similar statutory programs
- Court-ordered services, or those required by court order as a condition of parole or probation (unless medically necessary and approved by the plan)

Medications

- Services for prescription and nonprescription medications unless provided by a hospital in conjunction with admission
- Drugs, devices, products or supplies with over-the-counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter drug, device, product or supply

Medically necessary

- Care, supplies, or equipment not medically necessary, as determined by Anthem, for the treatment of an injury or illness. This includes, but is not limited to, care that does not meet Anthem's medical policy, clinical coverage guidelines or benefit policy guidelines
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be medically necessary for the treatment of a specific illness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary
- Services for hospital confinement primarily for diagnostic studies
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect or to treat gender dysphoria

Miscellaneous

- Donor search/compatibility fee (except as otherwise indicated in the plan's Benefits Summary in the *Appendix*)
- Contraceptive drugs, except for any above stated covered contraceptive services
- Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance or prescriptions or medications related to hair growth
- Services and supplies primarily for educational, vocational or training purposes, including treatment of developmental and learning disorders
- Religious, marital and sex counseling, including services and treatment related to religious counseling unless otherwise noted in the plan's Benefits Summary, marital/relationship counseling and sex therapy
- Christian Science practitioner
- Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products
- Services provided in a halfway house
- Treatment or services provided by a non-licensed provider, or that do not require a license to provide; services that consist of supervision by a provider of a non-licensed person; services performed by a relative of a member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the member by a local, state or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the plan participant is not required to pay for them or they are provided to the plan participant for free.

Special charges/services

- Services or supplies are provided by a member of your family or household
- Charges or any portion of a charge in excess of the maximum allowable amount as determined by the claims administrator; fees or charges made by an individual, agency or facility operating beyond the scope of its license
- Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage
- Services for any form of telecommunication; unless otherwise noted in the Benefits Summary in the *Appendix*

- Administrative charges — Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for physician or hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by physicians or other providers (Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results; specific medical reports including those not directly related to the treatment of the participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.)
- Separate charges by interns, residents, house physicians or other health care professionals who are employed by the covered facility, which makes their services available
- Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses and take-home supplies

Surgery

- Reversal of vasectomy or tubal ligation
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne

Therapies — Services for outpatient therapy or rehabilitation other than those specifically noted; excluded forms of therapy include, but are not limited to primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless medically necessary.

Vision care — Vision care services and supplies include, but are not limited to, eyeglasses, contact lenses and related or routine examinations and services; eye refractions; analysis of vision or the testing of its acuity; and service or devices to correct vision or for advice on such service.

- Orthoptic training is covered (**Note:** This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e., diabetes.)
- Vision surgeries — Related to radial keratotomy or keratomileusis or excimer laser photorefractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem

Weight-reduction programs — Services for weight-reduction programs, services and supplies. Weight-loss programs, including but not limited to, commercial weight-loss programs, such as WW (Weight Watchers), Jenny Craig and LA Weight Loss.

Submitting claims

You do not have to file claim forms for services provided by an in-network provider. The physician and/or facility will file these claims with Anthem for you.

You must submit a claim form for out-of-network and out-of-area services within 12 months of receiving the service.

Emergency/urgent care

If you receive treatment out-of-network or outside of the network service area for emergency or urgent care, you will have to submit claims to receive payment. You may also need to pay for services up front and be reimbursed after you submit your claim. To request reimbursement, call Anthem at the number on your medical ID card.

Note

Charges for emergency services received outside of the network will be reimbursed at the in-network level. Charges for **non-emergency urgent care** received outside of the network will be reimbursed at the out-of-network level.

Out-of-network and out-of-area care

You must complete and file a claim form within 12 months of the date of service to receive benefit payments if you use an out-of-network or out-of-area provider. Instructions for filing claims also appear on the claim form.

You are responsible for keeping personal records of your medical expenses. Be sure to keep copies of everything you send to your health plan vendor and all Explanation of Benefits (EOB) forms that you receive from your health plan vendor.

You must complete a claim form each time you or a covered family member has out-of-network medical expenses to submit. To file a claim, you should follow these steps:

- Request a claim form from your health plan vendor.
- Complete the form. Use your ID number and account number (shown on your medical ID card) whenever you file a claim or call the claim office.
- Send your completed claim form to the address shown on the form.

Your doctor must complete their portion of the claim form, or you must attach the original itemized bill that contains the following information:

- Name of patient
- Nature of illness or injury
- Type of service or supply furnished
- Date or dates service was rendered
- Itemized charges for each service or supply

Note

Simple receipts (i.e., cash register receipts, etc.), labels from containers and balance-due statements are not acceptable.

Please allow 30 days from the date the claim is received for a response.

You will receive an EOB form directly from your health plan vendor for each claim that you submit. Alternatively, you may designate that your doctor be paid directly. In this case, you will receive an EOB indicating how much your doctor has been paid by the plan. You will be responsible for any balance due to the doctor.

In the case of an alternate recipient under a court order known as a Qualified Medical Child Support Order (QMCSO), approved by the plan administrator, reimbursement will be made to the recipient, custodial parent or guardian.

If you have any questions, call Anthem at the number on your medical ID card.

Important reminders when submitting claims

- You have one calendar year from the date of service to submit medical claims for processing for out-of-network services under the plan.
- Each incorrectly or unnecessarily submitted claim increases the administrative cost of your plan.
- If a clerical error results in a claim overpayment, your medical plan carrier has the right to recover the overpayment from you and/or the provider. If a provider doesn't reimburse the plan for the overpayment, it's your responsibility to reimburse the plan.

If you're disabled and enrolled in Medicare Parts A and B

If you're disabled (and not actively working) and are eligible for Medicare because of your disability, Raytheon Technologies-sponsored medical plan assumes you're enrolled in Parts A and B of Medicare and that you use providers who accept Medicare. Medicare will pay benefits first, and Raytheon Technologies-sponsored medical plan will be the secondary payor.

Your hospital and physician bills must first be sent to Medicare. Medicare processes the claim and sends you an explanation of the payment. Once you receive this, submit a copy of the same medical bills and the Medicare explanation of payment, along with a claim form, to the claims processing center.

If you have end-stage renal disease (ESRD) and are eligible for Medicare coverage because of your ESRD, Raytheon Technologies-sponsored medical plan assumes that you're enrolled in Parts A and B of Medicare and use providers who accept Medicare. During the coordination period, Raytheon Technologies-sponsored plan will pay benefits first. Once the coordination period is over, Medicare will pay benefits first, and Raytheon Technologies-sponsored medical plan will be the secondary payer.

Note

If you or your covered dependent(s) are eligible for Medicare and don't enroll in Medicare or don't use providers who accept Medicare, you'll be responsible for paying the portion of medical expenses Medicare would have paid.

You're responsible for contacting Medicare to confirm your eligibility and to apply for Medicare and Social Security benefits. Contact Medicare at medicare.gov.

Claims appeal

If a claim is denied, you have the right to request a review of the claim by contacting the claims administrator. See the Claiming your benefit section of the *Claims* chapter for details.

CVS Caremark prescription drug coverage

You automatically receive coverage for prescription drugs when you enroll in any company-sponsored medical plan. There is no additional cost to you for this coverage. You cannot elect prescription drug coverage separately from medical coverage.

If you are enrolled in the Anthem Gold, Anthem Silver, Out-of-Area with HSA or Out-of-Area Indemnity plan, your prescription drug coverage is provided by CVS Caremark.

Your out-of-pocket cost for prescription drugs varies based on your medical plan; if you need a short-term or long-term prescription; and, in most cases, whether your prescription is for a generic, preferred brand or non-preferred brand name drug.

If you have specific questions about your CVS Caremark prescription drug coverage, or for more information about covered services and supplies, go to caremark.com or call Customer Care toll-free at **800-897-6435**.

CVS Caremark-administered prescription drug program

The CVS Caremark-administered prescription drug program provides benefits for a wide range of prescription drugs. The amount you pay for your prescription depends on your medical plan and whether you are purchasing a generic, preferred brand or non-preferred brand name drug.

For short-term prescriptions — those prescribed for up to 30 days — you have access to CVS Caremark's national network, which includes over 65,000 retail locations, such as Walgreen's, Rite-Aid, Walmart, Kroger and CVS Pharmacy (including those located in Target stores). Your out-of-pocket costs are lower when you use a CVS Caremark network pharmacy. Note that you are not required to use a CVS Pharmacy when you purchase a 30-day supply of a prescription.

For long-term prescriptions — maintenance drugs you take on an ongoing basis, prescribed for 90 days, plus refills — you have access to Maintenance Choice. This program gives you the flexibility to choose how to fill your maintenance prescriptions:

- Through the CVS Caremark Mail Service Pharmacy, or
- At any CVS Pharmacy, including those located in Target stores, for the same cost as the mail service (**Note:** In-network benefits are extended to additional pharmacies where there isn't a strong CVS Pharmacy presence, as described below.)

Note that your out-of-pocket costs are lower when your doctor prescribes up to a 90-day supply because the percentage you pay is based on lower contracted rates for mail-service prescriptions.

Important note: Under the plan provisions, you may only purchase up to three 30-day supplies of each maintenance drug prescribed at any network pharmacy. Before your third refill, if you are using a CVS Pharmacy, CVS Caremark will remind you to obtain a 90-day prescription from your provider. You must get a 90-day prescription before the fourth time you attempt to refill your prescription at a network pharmacy. If you do not, beginning with the fourth fill, your claim will be rejected, and you will be charged 100% of the drug's non-negotiated cost.

CVS Caremark prescription drug ID card

If your prescription drug benefits are administered by CVS Caremark, you and your eligible dependents will receive a CVS Caremark prescription drug ID card(s). Be sure to show this card to the pharmacist each time you fill a prescription.

Your prescription drug ID card includes the toll-free Customer Care number, which is available 24 hours a day, seven days a week.

Want to save money on prescription drugs?

Before you head to the pharmacy to fill your next prescription, do a little research and talk with your doctor to see if the drug you take is available in a less costly generic alternative or go to caremark.com (click on Check Drug Costs). Many times, alternative generics are just as effective and can be purchased for a fraction of the cost. It pays to check for less costly alternatives, especially since CVS Caremark frequently reviews and updates its list of generic alternatives.

In addition, some brand name drugs are available in an over-the-counter version. Purchasing the over-the-counter version directly (not using your prescription drug benefit through CVS Caremark) can often mean significant savings.

To find the best price on both prescription and over-the-counter versions of brand name drugs, go to goodrx.com. Enter the name and strength of the drug, and you'll see the cost of the drug at a number of pharmacies in your area. This website even provides access to manufacturers' coupons, if available.

For all drugs **except specialty drugs**, if you do purchase an over-the-counter version or use a manufacturer's coupon, the amount you pay will not count toward your medical plan's deductible or out-of-pocket maximum.

In-network prescription drug benefits

With the Anthem medical plans, including the out-of-area plans, eligible prescriptions are covered at a certain percentage after you meet the plan's deductible (see the chart below). The only exceptions are for certain prescriptions that qualify as preventive care as mandated by the Affordable Care Act (ACA) and those on the Treasury Guidance list, specifically:

- **Generic preventive prescription drugs** to treat chronic conditions, including high cholesterol, high blood pressure and asthma (covered at 100%, no out-of-pocket cost)
- **Oral and insulin diabetic medications** (and supplies, if purchased at the same time) (covered at 100%, no out-of-pocket cost). **Note: To avoid extra steps, your pharmacist must submit the charges for the insulin/medication first (before the supplies).** If the supplies are submitted first, you will be charged for them. Should this happen, you'll need to ask your pharmacist to reprocess the charges in the appropriate order before you pick up your medications/supplies or call Customer Care to request that the charges be reprocessed
- **Brand name preventive prescription drugs** — including those used to treat high blood pressure, cardiovascular diseases, osteoporosis and mental health disorders (while not subject to the deductible, coinsurance applies)

To review the Treasury Guidance list, go to caremark.com or call Customer Care.

You will pay the full cost of prescription drugs until you meet your deductible. Once you have met your deductible, you'll pay 20% of the cost, and the plan pays 80% of the cost. In most cases, the full cost you pay for a prescription drug before you meet the deductible and any coinsurance you pay toward the cost of a prescription drug after you have met the deductible apply to your plan's in-network deductible and/or in-network out-of-pocket maximum. This helps you receive a higher level of benefits sooner.

Note that if your provider prescribes — or you request — a preferred brand name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available,

you pay the difference between the retail costs of the brand name drug and its generic equivalent plus the applicable coinsurance. The cost difference you pay does not apply to your plan's deductible or out-of-pocket maximum.

Out-of-network prescription drug benefits

If you choose to fill a prescription at a retail pharmacy that does not participate in CVS Caremark's national network, your claim will be reimbursed at a lower rate.

Your prescription is covered the same at an out-of-network pharmacy regardless of whether you fill a generic, preferred brand name or non-preferred brand name prescription.

You must pay for your out-of-network prescription at the pharmacy, complete a Prescription Drug Reimbursement Form (Direct Claim Form) and submit it to CVS Caremark. Prescription Drug Reimbursement Forms (Direct Claim Forms) are available at caremark.com or by calling Customer Care.

Using the CVS Caremark website

To learn how to get the most from the CVS Caremark-administered prescription drug benefit, go to caremark.com, where you'll find convenient, time-saving features. From here you can locate network providers and see how much certain medications will cost you (click on Check Drug Costs). Note that you will need to register with caremark.com to access this site.

First-time users will need to register to customize the site. To register, have your prescription drug ID card handy, click on the Not Registered link on the homepage and fill in the required information. Once you have registered, you can:

- Refill, renew or request new CVS Caremark Mail Service Pharmacy prescriptions
- Track the status of CVS Caremark Mail Service Pharmacy orders
- Determine your out-of-pocket cost for brand name drugs
- Compare pricing and benefits for brand name and generic drugs — for both CVS Caremark Mail Service Pharmacy and retail pharmacies
- Determine if your prescription requires prior authorization from CVS Caremark before it can be filled;
- Keep track of your prescription history and related expenses
- Review your account summary and pay any balance due
- Look up the plan's specific guidelines
- Print CVS Caremark Mail Service Pharmacy Order Forms
- Request that CVS Caremark Mail Service Pharmacy Order Forms be mailed to you
- Request claim forms for prescriptions filled at non-participating pharmacies
- Locate and get directions to a participating retail network pharmacy
- Choose to receive email notices so that you can stay informed about your prescription orders
- Learn about your prescription medications and your plan's benefits
- Take charge of your health with a variety of wellness information, tools and resources

CVS Caremark includes educational and safety information with every new prescription ordered through the CVS Caremark Mail Service Pharmacy. By logging on to caremark.com, you can access this same information as well as other health-related facts and resources. To take advantage of personalized health alerts, news and information, be sure to register with CVS Caremark by completing the registration information.

Prescription drug support on the go

When you download the CVS and/or Caremark apps (available for either iPhone or Android platforms) to your smartphone, you can find pharmacies, request a refill or new prescription, check your order status, determine your out-of-pocket costs and view your prescription history. Find the app in your app store.

Learn more by telephone

CVS Caremark's interactive phone service gives you a convenient way to get information or materials at any time of the day or night. Also, with the voice-activated feature, you don't even have to press numbers on the telephone.

Before you call Customer Care, you should have your prescription drug ID card, prescription number and your credit card handy.

When you call Customer Care, for security purposes, you will be asked to enter or speak your prescription drug ID card number. (This information is confidential and will not be shared.) Through the interactive telephone service, you can, for example:

- Locate a participating retail network pharmacy
- Refill a prescription
- Check the status of an order
- Request a CVS Caremark Mail Service Pharmacy Order Form
- Request a Prescription Drug Reimbursement Form (Direct Claim Form)

Be sure to write down the confirmation number after the telephone order is completed in case you need to call Customer Care with any follow-up questions.

Filling short-term prescriptions

When you need to fill a short-term prescription — for example, if you need an antibiotic to treat an infection — you have access to more than 65,000 retail pharmacy locations nationwide. The CVS Caremark network includes independent pharmacies and chains such as Walgreen's, Rite-Aid, Walmart, Kroger and CVS Pharmacy (including those located in Target stores). Note that you are not required to use a CVS Pharmacy when you purchase a 30-day supply of a prescription.

While your benefits are accepted at any retail pharmacy nationwide, your out-of-pocket costs are lower when you use a pharmacy in the CVS Caremark network. To find out if a pharmacy participates in the CVS Caremark network:

- Ask your retail pharmacist;
- Use the online pharmacy locator at caremark.com; or
- Call Customer Care at **800-897-6435**

If you purchase a prescription drug at a participating pharmacy, simply:

- Show your prescription drug ID card at the pharmacy; and
- Pay your share of the cost when you pick up your prescription

Note that for maintenance medications (described below), you have the option of purchasing up to three 30-day supplies of each maintenance drug at a CVS Caremark network pharmacy before you select a

Maintenance Choice option. If you do not, beginning with the fourth fill, your claim will be rejected, and you will be required to pay 100% of the drug's non-negotiated cost at a retail pharmacy — including a CVS Pharmacy.

No access to a CVS Pharmacy or Maintenance Choice?

Plan participants who reside in Arkansas, Colorado, Idaho, New Mexico, Oregon or Washington do not have access to a CVS Pharmacy or Maintenance Choice. You can fill your 90-day supply of maintenance prescriptions at any participating Walmart or Kroger pharmacy for the same out-of-pocket cost as with the CVS Caremark Mail Service Pharmacy.

Using a CVS Pharmacy to fill long-term prescriptions

If you purchase a long-term (maintenance) prescription drug at a CVS Pharmacy, simply:

- Show your prescription drug ID card; and
- Pay your share of the prescription's cost when you pick it up

Remember: You may purchase up to three 30-day supplies of a maintenance drug at a pharmacy that participates in the CVS Caremark network. Before your third refill, if you are using a CVS Pharmacy, CVS Caremark will remind you to obtain a 90-day prescription from your provider and choose a Maintenance Choice option as described previously. **You must get a 90-day prescription and select a Maintenance Choice option before the fourth time you attempt to refill your prescription at a network pharmacy. If you do not, beginning with the fourth fill, your claim will be rejected, and you will be charged 100% of the drug's non-negotiated cost.**

If you are eligible for in-network coverage with a pharmacy other than a CVS Pharmacy, contact that pharmacy for information on filling a prescription there.

CVS Caremark's FastStart® program

FastStart® is designed to make it easier to manage chronic conditions. Through FastStart, CVS Caremark can contact your doctor for a new prescription for most common maintenance medications used for chronic conditions or long-term therapies, such as high blood pressure, high cholesterol or diabetes.*

To find out if FastStart can help you:

- Call **800-378-5697.** FastStart representatives are available Monday through Friday from 9 a.m. to 5:30 p.m. ET, or
- Go to caremark.com (You will need to register before your participation begins.)

When contacting FastStart, please have your prescription drug ID card number, name of your medication, your doctor's contact information and your payment information ready.

Your doctor can fax your prescription to **800-378-0323**.

*FastStart complies with pharmacy law and aims to ensure appropriate drug therapy. As such, some medications — such as controlled substances and specialty drugs — are not eligible for this program. Please contact your doctor directly for a new prescription for a controlled substance.

Maintenance Choice (long-term prescriptions)

If you need medication on an ongoing basis — such as to manage high blood pressure, asthma, diabetes or high cholesterol — Maintenance Choice offers flexibility in how you can purchase maintenance drugs. With Maintenance Choice, you choose whether to fill up to 90-day supplies of your maintenance prescriptions:

- Through the CVS Caremark Mail Service Pharmacy, or
- At any CVS Pharmacy, including those located in Target stores, for the same cost as the mail service (**Note:** In-network benefits are extended to additional pharmacies where there isn't a strong CVS Pharmacy presence, as described earlier.)

You may purchase **up to three 30-day supplies** of each maintenance drug at a CVS Caremark network pharmacy. Before your third refill, if you are using a CVS Pharmacy, CVS Caremark will remind you to obtain a 90-day prescription from your provider and choose a Maintenance Choice option. **You must get a 90-day prescription and select a Maintenance Choice option before the fourth time you attempt to refill your prescription at a network pharmacy. If you do not, beginning with the fourth fill, your claim will be rejected, and you will be charged 100% of the drug's non-negotiated cost.** No matter which option you choose, you have access to support services shown in the following table.

Service	Contact information		
	Any retail pharmacy participating in the CVS Caremark network	**CVS Pharmacy[1]**	**CVS Caremark mail service pharmacy**
Online access to manage or refill your prescription(s)	Check with your pharmacy of choice	cvs.com	caremark.com (see Using the CVS Caremark Website earlier in this section for more information)
Refills available by phone	Call your pharmacy of choice	Call your local CVS Pharmacy	Call the toll-free phone number on your prescription drug ID card 24/7
Access to pharmacists	Available in person whenever your pharmacy of choice is open	Available in-person whenever your local CVS Pharmacy is open	Call the toll-free phone number on your prescription drug ID card 24/7

You can access many of these services on the go by downloading the CVS and/or Caremark apps (available in your app store for either iPhone or Android platforms) and following the prompts.

[1]If you are eligible for in-network coverage with a pharmacy other than a CVS Pharmacy, contact that pharmacy for customer service details.

Take advantage of ScriptSync™

Do you take three or more maintenance medications each month? To help you avoid making multiple trips to the pharmacy, CVS Caremark offers ScriptSync, a service that saves you time, simplifies the process and helps you stay on your medications.

With ScriptSync, CVS Caremark works with you to identify the eligible prescriptions* you'd like to pick up together — whether for yourself or someone you're caring for.

Your refills will be coordinated for pickup on one date each month, saving you trips to the pharmacy. Before each pickup date, you'll receive a reminder call or text message letting you know your prescriptions are ready.

Note that this program is currently available only at CVS Pharmacy locations. For more information, go to CVS.com/ScriptSync or call Customer Care at **800-897-6435**.

*Eligible prescriptions include 30-day medications taken on a regular basis for an ongoing medical condition. Controlled substances are not eligible for this service.

Using the CVS Caremark Mail Service Pharmacy

When you fill a maintenance prescription through the CVS Caremark Mail Service Pharmacy, your medications are dispensed by the CVS Caremark Mail Service Pharmacy and shipped to you by standard delivery at no additional cost (express shipping is available for an additional charge).

Since your medication can take from seven to 11 days to be delivered, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for an additional prescription for a 14-day supply that you can fill at a retail pharmacy.

The CVS Caremark Mail Service Pharmacy can be used with either a new prescription or to refill an existing prescription.

For a new prescription, ask your doctor to write it for up to a 90-day supply, plus refills (if appropriate) for up to one year. Then follow these steps:

Ordering a new prescription

Method	Steps
Through your health care provider	Ask your health care provider to electronically submit your prescription and any refills directly to CVS Caremark.
Online	1. If you are ordering a prescription online for the first time, you will need to register at caremark.com. (See Using the CVS Caremark website earlier in this section for instructions.) 2. After you have registered with CVS Caremark, simply log on and enter your email address and password 3. Click on Start a New Prescription on the homepage and follow the instructions. You will need to have your prescription drug ID card number.
With your smartphone	Download the CVS and/or Caremark apps (available in your app store for either iPhone or Android platforms) and follow the prompts.

Method	Steps
By mail	1. Fill out a CVS Caremark Mail Service Pharmacy Order Form. 2. Mail the form with your prescription and your share of the prescription's cost to CVS Caremark. 3. To determine your share of the cost, or request additional order forms and envelopes, go to caremark.com or call Customer Care.

Refilling an existing prescription

Method	Steps
Online	1. If you are ordering a prescription refill online for the first time, you will need to register at caremark.com. (See Using the CVS Caremark website earlier in this section for instructions.) 2. After you have registered with CVS Caremark, simply log on and enter your email address and password and follow the instructions. You will need to have your prescription drug ID card number and your prescription number. 3. Each time you log on, you can view your available prescription refills and renewals.
By phone	Call the automated refill service at **866-329-4023**. You will need your prescription drug ID card number and the prescription number.
With your smartphone	Download the CVS and/or Caremark apps (available in your app store for either iPhone or Android platforms) and follow the prompts.
By mail	1. Complete the refill label that accompanied your last order and attach it to a CVS Caremark Mail Service Pharmacy Order Form. 2. Mail this information with your share of the prescription's cost to CVS Caremark using the return envelope provided. 3. To determine your share of the cost, or request additional order forms and envelopes, go to caremark.com or call Customer Care.

Paying for your prescriptions

While you can use any retail pharmacy, your out-of-pocket costs are lower when you use a CVS Caremark network pharmacy. Refer to the *Contacts* chapter to see if your local pharmacy participates in your prescription administrator's network or to find a participating pharmacy in your area.

You may pay for your medication at an in-network pharmacy with cash; a credit or debit card (e.g., Visa®, MasterCard®, Discover®/NOVUS® or American Express®); a check; or a money order. You can also use your HSA to pay for eligible prescription drug expenses using the funds in your HSA. See the *Health Savings Account* chapter for more information.

If you use the CVS Caremark Mail Service, you also may choose to pay with electronic check processing (note that preregistration is required through caremark.com or by calling Customer Care).

In most cases, any amount you pay toward the cost of a prescription drug applies to your plan's in-network deductible and in-network out-of-pocket maximum. This helps you receive a higher level of benefits sooner. However, if your provider prescribes — or you request — a preferred brand name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available, you pay the difference between the retail costs of the brand name drug and its generic equivalent plus the applicable coinsurance. The cost difference you pay does not apply to your plan's

deductible or out-of-pocket maximum. You'll find information about coinsurance in the Benefit Summaries located in the *Appendix*.

Preventive care drugs

In accordance with the ACA, the company's medical plans provide 100% coverage with no out-of-pocket cost for certain prescriptions that qualify as preventive care, including contraceptives for women, iron supplements for infants and oral fluoride supplements for preschool children. For a complete list and more information, contact CVS Caremark.

Generic drugs

Many prescription drugs have two names: the trademark or brand name, and the chemical or generic name. Be assured that a generic drug and its brand name counterpart have the same active ingredients and are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size or shape, but the Food and Drug Administration (FDA) requires that they meet the same standards for safety, strength, purity and quality as the brand name alternatives.

Prescriptions filled with generic drugs will have lower out-of-pocket costs at participating retail pharmacies or through the mail service. Therefore, you can get the same health benefits at a lower cost. Whenever your provider writes you a prescription, you should check to see if a generic equivalent is available. If your provider prescribes — or you request — a brand name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available, you will be responsible for paying the cost difference between the brand name and the generic equivalent plus the applicable coinsurance (copay if applicable). In this case, the cost difference does not apply to your medical plan's out-of-pocket maximum.

Primary/preferred drug list

Although generic drugs should always be considered first, the CVS Caremark prescription drug benefit includes a formulary, which is a list of preferred drugs that the FDA has determined to be safe and effective. This list includes a wide selection of drugs and is preferred because it offers you choices while helping to keep the cost of your prescription drug benefit affordable. Each drug is approved by the FDA and reviewed by an independent group of doctors and pharmacists for safety and efficacy.

CVS Caremark may contact your doctor to request that they consider prescribing either a generic equivalent or a medicine on the formulary. Of course, the final decision about which prescription to use is yours and your doctor's. However, your out-of-pocket costs are affected by your decision.

CVS Caremark's Pharmacy Advisor

A more personal approach to diabetes care

Living with a chronic condition adds a few more "to-do" items to your everyday lists. To help make it easier to get the best possible treatment, CVS Caremark offers the Pharmacy Advisor Program to employees and their covered family members living with diabetes.

Once CVS Caremark receives information that you have filled a medication typically associated with diabetes, you have the option to be connected with a pharmacy advisor representative who is familiar with your individual medication history and who is educated to help you stay on track with your medications and offer one-on-one advice. Here's how the program works.

CVS Caremark's Pharmacy Advisor

- **Medication counseling.** With every medication, all CVS Pharmacy pharmacists will provide information such as the medication dosage, possible side effects and the benefits of the prescription. However, when a prescription for diabetes treatment is filled, CVS Pharmacy pharmacists take it a step further and talk about why it's important to take the medication exactly as it's prescribed as well as explain any available cost-savings opportunities. (If you fill your prescription through the CVS Caremark Mail Service Pharmacy, you'll receive information by mail and receive a follow-up phone call.)
- **Gaps in care counseling.** CVS Caremark will review your medication history with clinical guidelines to ensure you're getting the recommended treatment. If a CVS Caremark pharmacist has concerns or suggestions about your treatment plan, they will ask your permission to contact your provider. For example, most patients with diabetes should be taking a medication that protects the kidneys. If you're not currently prescribed such a medication, the pharmacist and your provider can discuss the importance of including it in your treatment plan, if appropriate.

It's important to note that this service is provided at no out-of-pocket expense to you as part of your CVS Caremark prescription drug coverage. You do not have to enroll in the Pharmacy Advisor Program — you will be contacted if you are currently eligible or if you become eligible in the future.

For more information about living with diabetes, go to info.caremark.com/dig/ managingdiabetes. Once you register with CVS Caremark, you can also access information about your prescription benefit plan. If you have any questions, call Customer Care.

Experimental, investigational or unproven prescription drugs

This plan does not cover any expenses incurred for treatments, drug therapies or devices that, at the time CVS Caremark makes a determination regarding coverage in a particular case, are determined to be:

- 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 U.S. Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
- The subject of an ongoing clinical investigation to determine FDA approval, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Note: Coverage may be denied even if the treatment, drug therapy or device has received FDA approval. Please check with CVS Caremark to confirm coverage.

Prior authorization for certain prescription drugs

Some medications are covered only for certain uses or in certain quantities, and/or may require prior authorization or step therapy. (For example, a drug may not be covered when it is used for cosmetic purposes. Also, the quantity covered may be limited to certain amounts over certain time periods.)

Note

The dispensing of certain controlled substances and other prescribed drugs is governed by the pharmacist's judgment and dispensing restrictions, such as quantities allowable. Federal law prohibits the return of dispensed controlled substances.

Coverage for drugs that are administered in a hospital or other medically supervised setting (as they must be injected into the body via a route that is not the bloodstream, such as into the fluid surrounding the spinal cord) may be obtained from the prescription drug benefit or medical plan benefit. Plan limitations, such as prior authorization, may apply. These limits are based on clinically approved prescribing guidelines that are routinely reviewed by CVS Caremark.

If you present a prescription for a medication that requires prior authorization, it cannot be filled until your doctor calls the Clinical Prior Authorization Department at **866-329-4023** to provide additional clinical information.

To see if your prescription requires prior authorization, go to caremark.com and enter the name of the prescription, or call Customer Care. If you know in advance that your prescription requires prior authorization, ask your doctor to call the prior authorization unit before you go to the pharmacy.

CVS Caremark Specialty Pharmacy Program

The CVS Caremark Specialty Pharmacy Program provides benefits for your and/or your eligible enrolled dependents' special pharmacy products, often in the form of injected or infused medicines as well as the corresponding supplies, equipment and care coordination needed.

These medications often are used to treat complex, chronic conditions, including asthma, hepatitis C, cancer, HIV, infertility, multiple sclerosis, osteoporosis, pulmonary arterial hypertension (high blood pressure), pulmonary disorders and rheumatoid arthritis. (Go to caremark.com or call Customer Care for a complete list.)

When you participate in the CVS Caremark Specialty Pharmacy Program, you have access to:

- **Personalized, expert attention**, including help identifying coverage for new drugs and therapies; assistance with insurance paperwork and preauthorization; access to a personalized Care Team that is led by either a pharmacist or a nurse; and counseling programs on living with a chronic condition.
- **Education and support**, including access to information about your condition, telephone training and support groups; evaluations to assess your progress while on a particular therapy; opportunities to speak with a pharmacist or nurse to discuss any concerns; and 24-hour-a-day access to emergency consultations with a pharmacist.
- **Convenient features**, including fast, confidential mail service delivery of your medications; refill reminders; and easy online or phone enrollment.

When you are prescribed a specialty drug for the first time, you may use a retail pharmacy to fill the prescription and to obtain one refill. You will then receive a letter from CVS Caremark introducing the specialty pharmacy. Going forward, in order to receive benefits for your specialty prescription, you must follow the instructions in the letter. Otherwise, you will pay 100% of the cost of future refills at a retail pharmacy.

Protecting your privacy and safety

CVS Caremark promotes the safe and effective use of medications. When your prescription is filled through a CVS Caremark network pharmacy or the CVS Caremark Mail Service Pharmacy, CVS Caremark pharmacists use the health and prescription information they have on file for you to consider many important clinical factors, including drug selection, dosing, interactions, duration of therapy and allergies. If there is a potential problem, an experienced, registered pharmacist may contact your doctor. If you have any questions about your prescriptions, call Customer Care and talk to a CVS Caremark pharmacist.

CVS Caremark includes educational and safety information with every new prescription ordered at a participating retail pharmacy or through the CVS Caremark Mail Service Pharmacy. In addition, CVS Caremark may contact your prescribing doctor to discuss certain clinical factors and benefit management matters. CVS Caremark may also contact you from time to time with information about the prescription drug(s) you are taking.

Other important information

When coverage normally ends

CVS Caremark-administered prescription drug benefits for you and your covered dependent ends when your company-sponsored medical coverage ends. If you continue your medical coverage through COBRA, your prescription drug benefits will also be continued. Prescription drug coverage cannot be converted to an individual or non-group plan.

Claims appeal

If a claim is denied, you have the right to request a review of the claim by contacting the administrator. See the *Claims* chapter for details.

Glossary

Below are definitions to terms found in this chapter.

Accidental Injury — Bodily Injury sustained by a member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care that the plan member receives. Such care must occur while this plan is in force. It does not include Injuries for which benefits are provided under any workers' compensation, employer's liability or similar law.

Allowed Amount (negotiated rates) — Allowed amounts are fees set each year by your medical plan with its providers. This is the most the plan will pay for covered services. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital bill is $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. You aren't responsible for the difference between the billed amount and the negotiated rate for in-network providers. You or your physician may request a predetermination of benefits from your medical plan. If you discuss fees in advance, some doctors are willing to accept the allowed amount as full payment.

Ambulance Services — A state-licensed emergency vehicle that carries injured or sick persons to a hospital. Services that offer non-emergency, convalescent or invalid care do not meet this definition.

Annual Enrollment — The time period each fall during which you may make your benefit elections for the coming year. The amount of your associated contributions depends on the options you choose.

Balance Billing — Balance billing happens after you've paid your deductible, coinsurance or copay and your insurance company has also paid everything it's obligated to pay toward your medical bill. If there is still a balance owed on that bill and the doctor or hospital expects you to pay that balance, you're being balance billed.

- If your doctor is out of network and charges more than the allowed amount, the plan won't pay for any amount above the allowed amount. You're responsible for paying this difference, which is shown on the Explanation of Benefits (EOB) you receive from your medical plan.
- If you're enrolled in an out-of-area plan, there's no network of providers. You may use any licensed, eligible provider and receive the same level of coverage. If your doctor charges more than the allowed amount, the plan won't pay for any amount above the allowed amount. You're responsible for paying the difference.

Bariatric Surgery — Surgery for the treatment of clinically severe obesity is an operation that may be an appropriate treatment option in a select group of extremely obese people who have not been able to lose weight in any other way. In determining if there is coverage for these operations, specific medical necessity criteria will need to be met.

Bariatric Surgery Providers

- **Designated Bariatric Surgery Provider** — A provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for bariatric surgery procedures
- **PAR Bariatric Surgery Provider** — Hospitals participating in the claims administrator's networks; also known as "Network" or "PAR" (are **not** designated as either Blue Distinction Center+ or Blue Distinction Center)
- **Non-PAR Bariatric Surgery Provider** — Any provider that does not hold a contractual agreement with Blue Cross Blue Shield Plans to provide bariatric surgery services; also known as "Out-of-Network."

Blue Distinction Center (BDC) Facility — Blue Distinction Facilities meet or exceed national quality standards for care delivery (quality only).

Blue Distinction Center + (BDC+) Facility — Blue Distinction Facilities meet or exceed national quality standards for care delivery and have demonstrated that they operate more efficiently (quality and cost).

Behavioral Health Care — Includes services for mental health and substance abuse. Mental health and substance abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Brand Name Drugs — Brand name drugs are drugs that are protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the drug by other companies without consent of the innovator for as long as the patent remains in effect.

Case Management — A service coordinated by the health plan to provide assistance to a patient who is at risk of developing medical complications or for whom a health incident has precipitated a need for rehabilitation or additional health support.

Centers of Medical Excellence (CME) Network — A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency and effectiveness. For example, an organ transplant managed care program wherein plan participants access types of benefits through a specific network of medical centers. A network of health care professionals contracted with the claims administrator or one or more of its affiliates to provide transplant or other designated specialty services.

Coinsurance — Your share of the cost for covered services, which is a percent of the maximum allowed amount. You normally pay coinsurance after you meet your deductible. For example, if the plan lists 20% coinsurance on office visits, and the maximum allowed amount is $100, your coinsurance would be $20 after you meet the deductible. The plan would then cover the rest of the maximum allowed amount. See your plan's Schedule of Benefits in the *Appendix* for details. Your coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Company — Raytheon Technologies and any of its subsidiaries that participate in this plan.

Complications of Pregnancy — Complications of pregnancy result from conditions requiring hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy that is terminated is considered a complication of pregnancy.

Complications of pregnancy will not include false labor, cesarean section, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as complications of pregnancy.

Congenital Anomaly — A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits — A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Cosmetic Surgery — Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of cosmetic surgery.

Covered Expenses — The expenses that the plan will pay for, either partially or in full, to the extent that the services or supplies are recommended by a physician for medically necessary care and treatment for an injury or illness that is (a) defined as covered services in the member's plan, (b) not excluded under the plan, (c) not experimental or investigative and (d) provided in accordance with the plan. In-network benefits are limited to the rates negotiated with network providers. Out-of-network and out-of-area covered expenses are limited to the maximum allowable amount determined for providers and services in your geographic area.

Covered Transplant Procedure — Any medically necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the claims administrator including necessary acquisition procedures, collection and storage, and medically necessary preparatory myeloablative therapy.

CVS Caremark Formulary — The comprehensive list of drugs that have been reviewed and selected by the CVS Caremark Pharmacy and Therapeutic Committee based on clinical and economic parameters. The prescription benefits plan provided by CVS Caremark is a closed formulary, meaning that the plan only allows coverage of formulary medications. You will be responsible for paying the full cost of any medications that are not included in the formulary for which you have not received prior authorization.

CVS Caremark Performance Drug List (PDL) — The PDL is a subset of the most commonly prescribed drugs. The medications listed on the PDL are either generic drugs or preferred brand name drugs and are included for their clinical effectiveness and economic value in a therapeutic class with multiple options of similar efficacy. Drugs that are not listed on the PDL, for the most part, are brand name drugs of lesser clinical effectiveness or increased cost. They will be available at the highest coinsurance or copay amounts. Certain drugs that are not listed on the PDL, but do not have an equivalent generic or brand alternative available to you, will be available at a lower coinsurance or copay amount, although they are more costly.

Drugs can be added to or removed from the PDL at any time throughout the year based on changes to the plan, clinical data or the release of new and more cost-effective medications.

Deductible — The amount of covered expenses you pay out-of-pocket each year before the plan starts paying benefits (for health care services other than in-network preventive care). The current year's deductible cannot be applied to the next calendar year. The following expenses do not count toward the annual plan deductible:

- Expenses that are not covered by the plan,
- Expenses in excess of the maximum allowable amount for out-of-network or out-of-area benefits, *and*
- Any reduced benefits or penalties for failure to follow pre-admission certification/continued stay review procedures.

Please refer to specific plan sections for more information on the annual deductible.

Durable Medical Equipment (DME) — Equipment, such as crutches, wheelchairs, dialysis machines, oxygen tents and hospital beds, which is designed to withstand repeated use by more than one person and is not disposable.

The plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for medical necessity, and applicable precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the member's medical condition. The equipment must be ordered and/or prescribed by a physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use
- It is manufactured solely to serve a medical purpose
- It is normally not useful to a person not ill or injured
- It is ordered by a physician
  - The physician certifies in writing the medical necessity for the equipment
  - The physician states the length of time the equipment will be required
- It is related to the member's physical disorder

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary will not be covered. Reimbursement will be based on the maximum

allowed amount for a standard item that is a covered service, serves the same purpose, and is medically necessary. Any expense that exceeds the maximum allowed amount for the standard item which is a covered service is the member's responsibility.

The plan may require proof at any time of the continuing medical necessity of any item.

Detoxification — The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay — The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age-appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an injury.

Elective Surgical Procedure — A surgical procedure that is not considered to be an emergency and may be delayed by the member to a later point in time.

Emergency Medical Condition — Emergency services, emergency care or medical emergency is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 one of the following conditions:

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

Experimental/Investigative — Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which the claims administrator determines to be unproven or that:

- Cannot be legally marketed in the U.S. without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use;
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation

The claims administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigative.

Explanation of Benefits (EOB) — A form sent to you by your health plan vendor (or available on your health plan vendor's member website) after you receive health care services that shows how much of the provider's original charge was disallowed, how much of the cost is payable by you and credited to your

deductible and/or medical out-of-pocket maximum and how much of the cost is being paid by the plan. For any amounts owed by you, you should generally be billed directly by your health care provider.

Gender Dysphoria — The distress a person feels due to a mismatch between their gender identity: their personal sense of their own gender and their gender assigned at birth.

Generic Drugs — A generic drug is a chemically equivalent form of a brand name drug whose patent has expired. A generic is generally less expensive than its brand name counterpart and is sold under the common or "generic" name for the medication. Generic drugs are designated as generic according to the FDA guidelines.

Health Care Spending Account (HCSA) — An account that allows you to set aside pre-tax dollars from each paycheck to use for eligible health care expenses during the year.

Health Plan Vendor — The company that creates and administers a network of health care providers, pays the claims and provides Member Services.

Health Savings Account (HSA) — An HSA is a tax-advantaged account available when enrolled in an HSA qualified medical plan, that allows you to set aside pre-tax money from each paycheck to use to pay for qualified health care expenses on a tax-free basis. Money in your HSA may also be invested, and any earnings are tax-free as well.

Home Health Care — Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending physician. It must be licensed and accredited by the appropriate agency.

Hospice — A provider that provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician. It must be licensed and accredited by the appropriate agency.

Hospital — A licensed institution that provides medical and surgical treatment on an inpatient basis under the supervision of physicians; provides 24-hour nursing services by registered graduate nurses; qualifies as a hospital or psychiatric hospital and a provider of services under Medicare; and is accredited by the Joint Commission on the Accreditation of Health Care Organizations. A hospital does not include an institution that is primarily a place for rest, a place for the aged or a nursing home. A patient is considered hospital-confined if they are a registered bed patient, upon the recommendation of a physician.

Hospital Professional — Radiologists, anesthesiologists, surgeons and other professionals (other than your physician) who may provide care during an inpatient hospital stay. Any services rendered by an out-of-network professional during an inpatient stay will be paid at the in-network coinsurance amount.

HSA-qualified medical plan — A medical option, with an IRS-defined minimum deductible, that allows participants to open a Health Savings Account. The High Deductible Health Plan provides coverage for medical services, prescription drugs and mental health/substance abuse treatment.

Ineligible Charges — Charges for health care services that are not covered services because the services are not medically necessary or precertification was not obtained. Such charges are not eligible for payment.

Infertility — The condition of a presumably healthy member who is unable to conceive or produce conception.

Injury — Injury means accidental bodily injury.

In-Network Care — Care you receive from participating providers within a network created and administered by a health care vendor. You generally pay less for in-network care than for out-of-network care.

Inpatient Care (Mental Health/Substance Abuse) — Care that consists of more intensive types of treatment, including Acute Inpatient, Residential Treatment Center, Partial Hospitalization, Intensive Outpatient and Structured Outpatient. Acute care consists of a person who will be confined to a bed for 24 hours during the inpatient stay.

Intensive Outpatient and Structured Outpatient Programs (Mental Health/Substance Abuse) — Programs in which the patient participates, on an outpatient basis, in a prescribed formalized treatment program, which includes an intensive phase involving more than once-weekly treatment, as well as an aftercare component, which includes weekly follow-up/support visits. In addition, substance abuse structured outpatient programs often include elements such as participation in Alcoholics Anonymous or Narcotics Anonymous type support groups.

Maintenance Medication — A long-term medication that does not require frequent monitoring by a physician and is taken on a regular basis.

Mandatory Generic Program — The pharmacist will fill your prescription with a generic drug unless there is no generic equivalent or your doctor specifies that a generic drug may not be substituted for a brand name drug.

However, whenever a generic equivalent is available and you order a brand name drug, even if your physician indicates no substitutions, you will be required to pay the generic coinsurance (or cost if in an HSA-qualified medical plan) plus the difference in cost between the brand name and the generic medication. If you are enrolled in an HSA-qualified medical plan, this difference in cost will not be applied toward your deductible or out-of-pocket maximum. If you have met your deductible or out-of-pocket maximum, you are still responsible for paying the difference in cost.

Maternity Care — Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's hospital stay is a covered benefit, and the newborn infant is an eligible member under the plan.

Maximum Allowable Amount — This amount is based on data resources that reflect typical competitive charges and/or payments for a service charged by the medical professionals in the geographic area in which they practice. (The maximum allowable amount does not apply for in-network coverage.) If your doctor charges more than the maximum allowable amount, you will be responsible for paying the difference. Any charges in excess of the maximum allowable amount will not apply toward your annual out-of-pocket maximum. You are responsible for paying any amounts exceeding the maximum allowable amount charges, and these amounts do not count toward your deductible or out-of-pocket maximum.

Medicaid — A state program of medical aid established under Title XIX of the Social Security Act of 1965, as amended.

Medical Coinsurance Maximum — The most you pay in one year for coinsurance for eligible costs after you meet your deductible.

Medically Necessary/Medical Necessity — A service or supply that is provided for and consistent with the symptoms, diagnosis or treatment of a medical condition, and is consistent with generally accepted standards of medical practice. Services and benefits must be medically necessary to be covered under the plan. The procedures for determining medical necessity vary, according to the type of service or

benefit requested. Medical necessity determinations are made on either a preservice, concurrent, post-service or urgent care basis.

Medically necessary services are provided for documented medical reasons and not for personal convenience or comfort. Medically necessary covered services and supplies are deemed to be:

- Appropriate for the symptoms, diagnosis, or treatment of a medical condition
- Given for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice within the organized medical community
- Not mainly for the convenience of the doctor or another provider
- The most appropriate procedure, supply, equipment or service that can be safely given

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

- There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and
- Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
- For hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting

The most appropriate procedure, supply, equipment or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean the lowest cost. It does mean that as to the diagnosis or treatment of your illness, injury or disease, the service is: (a) not more costly than another service or group of services that is medically appropriate, or (b) the service is performed in the least costly setting that is medically appropriate. For example, the plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a physician's office or the home setting.

- Required to meet your essential health needs,
- Consistent with the diagnosis of the condition for which they are required,
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines as determined by medical research,
- Required for purposes other than the convenience of the provider or the comfort and convenience of the patient, *and*
- Rendered in the least intensive setting that is appropriate for the delivery of health care

Medical Out-of-Pocket Maximum — The maximum amount of covered medical and surgical expenses — subject to coinsurance — you and your family could pay each year after you have met the annual deductible (if applicable). Medical out-of-pocket maximum amounts include the deductible. Once you have reached your medical out-of-pocket maximum, the plan pays 100% of covered in-network medical and prescription expenses for the remainder of the calendar year**.** There is an in-network individual limit for the out-of-pocket maximum. No individual covered under a family plan will ever pay more than $7,500 toward their deductible and coinsurance combined for the Anthem Gold, Anthem Silver or Out-of-Area with HSA medical plan options.

Medicare — The program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Member — Individuals, including the subscriber and their dependents, who have satisfied the plan's eligibility requirements, applied for coverage and been enrolled for plan benefits.

Network Providers — A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the claims administrator to provide covered services to plan participants through negotiated reimbursement arrangements. A network provider for one plan may not be a network provider for another.

Non-Covered Services — Services that are not benefits specifically provided under the plan, are excluded by the plan, are provided by an ineligible provider, or are otherwise not eligible to be covered services, whether or not they are medically necessary.

Non-Preferred Brand Name Drug — A brand name drug that is not on the Performance Drug List. (Refer to the definition of *Preferred Brand Name Drug*.) You generally pay more for non-preferred brand name drugs than you pay for preferred brand name and generic drugs.

Nurse — A registered graduate nurse (RN), a licensed practical nurse (LPN) or a licensed vocational nurse (LVN).

Out-of-Network Care — Care from a provider, including but not limited to, a hospital, freestanding ambulatory facility (surgical center), physician, skilled nursing facility, hospice, home health care agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract for this product with the claims administrator to provide services to its plan participants at the time services are rendered.

Out-of-Pocket Maximum — The maximum amount of a member's coinsurance payments during a given calendar year. When the out-of-pocket maximum is reached, the level of benefits is increased to 100% of the maximum allowed amount for covered services.

Outpatient Services (Mental Health/Substance Abuse) — Services that are provided in an outpatient provider's office or center, where a member can seek brief periods of treatment but is not confined to a hospital bed or inpatient services.

Partial Hospitalization (Mental Health/Substance Abuse) — Intensive psychiatric care provided in an ambulatory setting, also called "day treatment." Typically, the patient receives services a minimum of four hours per day for a minimum of three days per week. Partial Hospitalization programs can be appropriately utilized as an alternative level of care in lieu of inpatient care or as a "step down" for those patients who have received treatment in an inpatient setting and are not yet able to function adequately without intensive support.

Pharmacy Step Therapy — Use of a lower-cost drug in select specialty medication categories before accessing a higher-cost medication that treats the same condition in substantially the same way.

Physician — A medical practitioner who is licensed to prescribe and administer drugs or perform surgery and who practices within the scope of their license. Any other licensed medical practitioner whose services are required to be covered by law in the locality where the services are rendered is also covered if that person is operating within the scope of their license and is performing a service for which benefits are provided under this plan when performed by a physician.

Preferred Brand Name Drug — A brand name drug that has been reviewed by the prescription drug plan administrator and approved for inclusion on its Performance Drug List (PDL). The PDL is determined

to be a clinically appropriate and economically advantageous subset of its clinical formulary, as revised from time to time. Through the use of lists of preferred drugs, health plans can maximize treatment quality while controlling prescription drug costs for the plan and its participants.

Preservice Medical Necessity Determination — Under medical and prescription drug plans, some treatments and medications may need preapproval (prior authorization) from the health plan's carrier in order to be covered. Prior authorization is usually required if you need a complex treatment or prescription. Typically, your service provide seeks preapproval, but it is ultimately your responsibility to ensure that preapproval has been received.

Preventive Care — Services, as defined by the Patient Protection and Affordable Care Act, and as amended by the Preventive Women's Health Care Amendment, intended to detect and, in many cases, prevent health problems for which you may be at risk. Examples of preventive care services include well-baby care, routine physical exams and immunizations, routine mammograms, prostate-specific antigen (PSA) tests and certain other routine screenings. There are age- and gender-specific guidelines for preventive care, and the provider must code the services as preventive. Certain medication or supplements are covered at 100%. Call the Member Services number on the back of your medical ID card for details.

Primary Care Physician (PCP) — A provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other provider as allowed by the plan. A PCP supervises, coordinates and provides initial care and basic medical services to a member and is responsible for ongoing patient care.

Prior Authorization — The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the pharmacy and therapeutics committee.

Rehabilitative Therapy — Includes cardiac and pulmonary rehabilitation, as well as physical, occupational, speech and chiropractic therapy that is provided on an inpatient or outpatient basis for rehabilitation following an injury or surgery, or for some chronic or acute medical conditions.

Residential Treatment Center/Facility — A provider licensed and operated as required by law that includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on site at least eight hours daily with 24 hours availability
- A staff with one or more Doctors available at all times
- Residential treatment takes place in a structured facility-based setting
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

- Nursing care
- Rest care

- Convalescent care
- Care of the aged
- Custodial care
- Educational care

Retail Health Clinic — A facility that provides limited basic medical care services on a walk-in basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physicians assistants and nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Semiprivate Room — A hospital room that contains two or more beds.

Skilled Nursing Facility — A licensed institution that specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis. The institution must maintain all facilities necessary for medical treatment, provide treatment for a fee under the supervision of physicians, and provide nursing services.

Specialist — A provider who is not specified as a PCP, but typically any person or organization appropriately licensed to provide medical care in any generally accepted medical specialty or subspecialty.

Specialty Drugs — Typically, high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty drugs often require special handling, such as temperature-controlled packaging and expedited delivery. Most specialty drugs require preauthorization to be considered medically necessary.

Surgical Facility (Freestanding) — A licensed institution that has a medical staff of physicians, nurses and anesthesiologists; at least two operating rooms and a recovery room; x-ray and lab facilities; equipment for emergency care; a blood supply; and an agreement with hospitals for immediate acceptance of a patient in need of inpatient care.

Transplant Providers

- **Network Transplant Provider** — A provider that has been designated as a “Center of Medical Excellence” for transplants by the claims administrator and/or a provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such providers have entered into a transplant provider agreement to render covered transplant procedures and certain administrative functions for the transplant network. A provider may be a network transplant provider with respect to:
  - Certain covered transplant procedures;
  - All covered transplant procedures.
- **Designated Transplant Provider** — A provider that has achieved designation as a Blue Distinction Center + (BDC+) or Blue Distinction Center for Transplant (BDCT) procedures.
- **PAR Transplant Provider** — Hospitals participating in the claims administrator’s network; also known as “Network” or “PAR” (are **not** designated as either Blue Distinction Center+ or Blue Distinction Center).
- **Non-PAR Transplant Provider** — Any provider that does not hold a contractual agreement with Blue Cross Blue Shield Plans to provide transplant services; also known as “out-of-network.”
- **Out-of-Network Transplant Provider** — Any provider that has **not** been designated as a “Center of Medical Excellence” for transplants by the claims administrator nor has not been selected to participate as a network transplant provider by the Blue Cross and Blue Shield Association.

Types of Claims

- **Preservice Claim** — A claim for benefits where preapproval for any part of the care is a condition to receiving the care. Preservice claims may involve urgent care, as described below.
- **Concurrent Care Claim** — A claim for benefits for an ongoing course of treatment to be provided for a period of time for treatment or for a number of treatments. Three situations may give rise to concurrent care claims:
  - A decision to reduce or end the period of time for treatment or number of treatments
  - Your request for an extension of the period of time for treatment or number of treatments
  - Your request for an extension of the period of time for treatment or number of treatments involving urgent care, as described below
- **Post-Service Claim:** A claim for benefits that have already been received and any claim for benefits for which preauthorization is not required.
- **Urgent Care Claim:** A preservice or concurrent care claim becomes a claim involving urgent care when the normal time frame for making a determination would:
  - Seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function (in the view of a prudent layperson acting on behalf of the medical plan who possesses an average knowledge of health and medicine, or a provider with knowledge of the claimant's medical condition); or
  - Subject a claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim (in the view of the provider with knowledge of the claimant's condition).

  Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care shall be treated as an urgent care claim.

Urgent Care — Care for an unforeseen condition that requires medical treatment in the outpatient department of a hospital, clinic or doctor's office for the treatment of acute pain, acute infection or protection of public health. These conditions are not life-threatening but may cause serious medical problems if not promptly treated.

Kaiser Permanente Gold HSA

Kaiser Permanente, a nonprofit health care organization (Kaiser Foundation Health Plan, Inc.), administers the Kaiser Gold with HSA plans. This plan is available in California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington and Washington D.C.

Note

If you are covered under a Kaiser Permanente plan, refer to the **Evidence of Coverage** document provided by your insurance carrier.

Kaiser Permanente provides services directly to plan participants through an integrated medical care program. As a Kaiser Permanente member, you select this medical care program to provide your health care. That means Kaiser Permanente plan providers inside the Kaiser Permanente service area provide the care you need, including:

- Routine care with your own personal plan physician

- Hospital care
- Laboratory and pharmacy services
- Urgent care and emergency services
- Other benefits as described in the Evidence of Coverage booklet

Kaiser Permanente also offers a variety of health education programs that provide ways to protect and improve your health.

For detailed information about the plan, refer to the Evidence of Coverage booklet, which describes covered services, any limitations and special programs, or call Member Services. To view the Evidence of Coverage booklet, go to my.kp.org/rtx (for a hard copy, please call Member Services). Note that in the case of any discrepancy between this document and the Evidence of Coverage, the Evidence of Coverage governs.

Note

By selecting Kaiser Permanente to provide your health care, **you must receive all covered care from Kaiser Permanente plan providers inside the Kaiser Permanente service area**. As described in the Evidence of Coverage booklet, the only exceptions include the following: Authorized referrals, emergency ambulance services, emergency services, post-stabilization care, out-of-area urgent care and hospice care.

Choosing a Primary Care Physician (PCP)

Whether you're new to Kaiser Permanente or a long-time member looking to make a change, it's easy to select a personal physician—called your primary care physician (PCP)—to coordinate your care. Remember that with the exception of certain services (authorized referrals, emergency ambulance services, emergency services, post-stabilization care, out-of-area urgent care and hospice care), your PCP must provide or coordinate all your care.

To find Kaiser Permanente providers and locations:

- Go to kp.org, click **Doctors & Locations** and then select your region
- Or, if you are a member, you may also call Member Services

You can change your PCP at any time and for any reason. If you make a change, your plan's Member Services representative will tell you when the change becomes effective.

Note

It's recommended that you elect a PCP for yourself and each family member when you first enroll in a Kaiser plan. You can elect your PCP online or by calling Kaiser Permanente Member Services. If you don't select a PCP, Kaiser Permanente can select one for you.

Services overview

At Kaiser Permanente, we believe that good health care begins with selecting a personal physician, one you choose and can change at any time. Kaiser Permanente's proactive approach to health also includes:

- Coverage for a range of preventive services
- Simple, no-paperwork referrals to Kaiser Permanente specialists
- Facilities that offer primary care, laboratory, x-ray and pharmacy services all under one roof — integrating your care and saving multiple trips
- Telehealth services, so you can connect to primary, specialty and urgent care providers with email, phone and video visits — from home or while you're traveling (see Reminder: Nonpreventive phone and video visits subject to the deductible for important information about scheduled nonpreventive phone and video visits)
- A secure, electronic medical record that goes wherever you go — giving Kaiser Permanente's doctors, nurses and other authorized health care staff important access to your medical history. (**Note:** Any telehealth visits become part of your electronic medical record.)

In addition, as a Kaiser Permanente member, you can go to kp.org or my.kp.org/rtx to access a variety of services, including emailing your doctor's office, requesting routine appointments, viewing certain lab results and ordering prescription refills. You can also download the KP mobile app, access online resources like health and drug encyclopedias or create a personalized action plan to help you lose weight, eat better or stop smoking. To learn more about available services, go to kp.org, or call Member Services.

How the plan works

Most covered expenses — including most prescription drugs — are subject to a calendar-year deductible, which resets each Jan. 1. There are two exceptions:

- **Routine in-network preventive care**, which is covered at 100% in-network (no deductible, no coinsurance, no out-of-pocket cost). In compliance with the Affordable Care Act (ACA), this coverage extends to include Women's Health Services, certain preventive supplements and tobacco-cessation prescriptions (as defined by Kaiser Permanente)
- **Preventive prescription drugs**, which are covered at 100% (no deductible, no coinsurance, no out-of-pocket cost)

The deductible can be satisfied by one family member or a combination of family members. If you have family coverage, you must satisfy the family deductible before benefits are payable.

After you meet the deductible, the plan pays a percentage of eligible expenses. You pay the remainder of the charges until you reach the calendar-year out-of-pocket maximum, which includes the deductible and coinsurance for all eligible services and supplies. If you reach the out-of-pocket maximum, the plan covers eligible expenses at 100% for the remainder of the calendar year.

Care obtained outside the Kaiser Permanente network is generally covered only in urgent and emergency situations, as defined by the plan.

The Kaiser Permanente plans require a referral for certain services. In certain circumstances, your PCP may refer you to an out-of-network specialist. Unless your PCP receives authorization from the plan, any care you receive outside the network will not be covered.

Prescription drug coverage is administered by Kaiser Permanente. Mail-order pharmacy benefits are available for all Kaiser plans in all regions. Contact the number on your plan ID card to obtain additional information.

For detailed information about the plan, refer to the Evidence of Coverage booklet — which describes covered services, any limitations and special programs that may be offered — or call Member Services.

Reminder: Nonpreventive phone and video visits are subject to the deductible

To comply with Internal Revenue Service (IRS) rules regarding HSA-qualified plans, scheduled nonpreventive phone and video visits are subject to the plan deductible. Your cost will depend on the service you receive and the length of your visit. Once you satisfy your deductible, these services will be provided at no out-of-pocket cost to you (coinsurance will not apply).

Generally speaking, scheduled phone and video visits cost less than in-person visits. To request an estimate for a scheduled nonpreventive phone or video visit, call Member Services.

After your visit, you'll receive a bill for any deductible amount you owe. For more information about phone and video visits, go to kp.org/getcare.

Note that this change does not affect emailing your doctor's office with non-urgent questions, or calling a licensed care provider for advice, referrals, prescriptions and more. These services are not subject to the deductible and continue to be provided at no cost to you.

About the Kaiser Permanente (KP) Evidence of Coverage booklet

This SPD section provides only a brief summary of the Kaiser Permanente Gold HSA. Refer to the Kaiser Permanente Evidence of Coverage booklet or call Member Services for additional information about the plan, including details about:

- Member services
- Emergency services and urgent care
- Maternity care
- Post-stabilization care
- Coordinated care delivery (including interactive video visits, second opinions and dispute resolution)
- Autism Spectrum Disorder (ASD) treatment, including Applied Behavior Analysis (ABA) therapy (see also the following inset box for a description of covered services)
- Transplant services
- Bariatric surgery
- Limitations and exclusions
- Post-service claims and appeals
- Coordination of benefits (COB) provisions
- Subrogation provisions

To view the Evidence of Coverage booklet, go to my.kp.org/rtx (for a hard copy, call Member Services). In the case of any discrepancy between this document and the Evidence of Coverage, the Evidence of Coverage governs.

Limitations, exclusions and administrative information

For a description of Kaiser Permanente's limitations, exclusions or administrative information, including post-service claims and appeals, coordination of benefits (COB) provisions and subrogation provisions refer to the Kaiser Permanente Evidence of Coverage booklet.

Kaiser Permanente Hawaii HMO

With the Kaiser Permanente HMO available in Hawaii, you are required to elect a PCP. You receive care from your PCP or a doctor to whom your PCP refers you. If you do not select a PCP when you first enroll, one will be selected for you. You can change your PCP at any time.

It's important to note that with the exception of emergency care or out-of-state urgent care, this plan does not offer coverage if you visit an out-of-network provider. If you enroll in this plan and choose to receive care from a non-participating provider, those services will not be covered, and you will be responsible for the entire cost.

With the Kaiser Permanente Hawaii HMO, your eligibility for wellness and preventive-care benefits may vary. Refer to the plan's Evidence of Coverage for more information.

- Preventive care is generally covered at 100% with no copay.
- General office visits are covered at 100% after you pay a copay.

To be eligible for coverage, all services and supplies must be medically necessary as defined by the plan.

For more information on the Kaiser Permanente Hawaii HMO, review the plans benefits summary located in the *Appendix* or refer to the plan's Evidence of Coverage. Details are also available on **Your Gateway**.

HMSA (Hawaii)

Like the Kaiser Permanente Hawaii HMO, the HMSA plan is also a health maintenance organization. You receive care from your PCP or a doctor to whom your PCP refers you. You must receive a referral from your PCP to see a specialist.

This plan does not have a deductible, but there is an out-of-pocket maximum for each coverage tier. It's important to note that with the exception of emergency care, this plan does not offer coverage if you visit an out-of-network provider. If you enroll in this plan and choose to receive care from a non-participating provider, those services will not be covered, and you will be responsible for the entire cost.

With the HMSA plan, your eligibility for wellness and preventive-care benefits may vary. Refer to the Plan Certificate for more information.

- Preventive care is covered at 100% with no copay or coinsurance.
- Other services are subject to either copays or coinsurance.

To be eligible for coverage, all services and supplies must be medically necessary as defined by the plan.

For more information on the HMSA plan, review the plans Benefits Summary located in the *Appendix* or refer to the Plan Certificate. Details are also available on **Your Gateway**.

Cigna Global

All eligible U.S. outbound (expatriate) employees on international assignments and their eligible dependents have access to medical and vision coverage through the Cigna Global Choice with HSA (a high deductible health plan) or the Cigna Global PPO. They're also eligible for dental coverage through

Cigna Global, which requires a separate election. (**Note:** Medical and vision coverage are bundled into one plan; you cannot elect only medical or only vision coverage without the other.) Both medical plan options offer comprehensive worldwide coverage and are administered by Cigna Global Health Benefits.

Predeparture medical assessment

It is likely that health care needs and services in your assignment country will vary from those in your home country. Cigna's Pre-Departure Medical Assessment Program is designed to identify any medical needs you and any family members may have while you are on assignment outside the U.S.

Before you leave, you will be asked to complete a 10–15 minute confidential and secure questionnaire through Cigna's member website cignaenvoy.com. It's in your best interest to complete this survey well in advance of your departure date so that Cigna can provide assistance and support before you arrive at your assignment. Log in to the assessment prior to obtaining your Cigna Global ID card using the following credentials:

Client ID: RAY09023A

Password: 09023ARAY

Depending on the medical information provided and your country of assignment, a Cigna medical representative may reach out to you to discuss managing your medical needs. In addition, Cigna will provide you with access to relevant information that you can download and review to help you prepare for your assignment.

When you enroll in a Cigna Global plan, you'll gain access to the Certificate of Coverage booklet on cignaenvoy.com, which describes the services that are covered, plan limitations, and any special programs that may be offered. For detailed information about your plan, refer to the Certificate of Coverage or call Cigna at **855-448-5733** (toll-free) or **302-797-3784** (collect calls accepted from outside the U.S.). Representatives are available 24 hours a day, seven days a week.

Cigna Envoy

The easiest way to manage your Cigna Global coverage is through Cigna Envoy,® your personalized online health resource. As soon as you receive your Cigna ID card, go to cignaenvoy.com and follow these steps:

1. Under the "Customers" section, select "Register."
2. Register using the information exactly as it appears on your Cigna ID card.
3. Follow the remaining prompts to fully register your account.

Once you have registered, you can:

- Print ID cards
- Find a nearby health care professional or facility
- Submit, review and track claims
- Access claim forms in multiple languages
- Send an email to the Cigna Global service center, available 24 hours a day, seven days a week
- Sign up for direct deposit for claims reimbursement

- Get country-specific information, everything from immunization requirements to electronic adapter needs

If you have questions about how to create your account or need help locating a provider, call Cigna at **855-448-5733** (toll-free) or **302-797-3784**. When calling from outside the U.S., collect calls are accepted. Representatives are available 24 hours a day, seven days a week.

Manage your health benefits anytime, anywhere!

The Cigna Envoy mobile app makes it easy to manage your health benefits anytime, from anywhere. You can use the app to:

- Locate nearby health care professionals and facilities
- Manage and track the status of pending claims
- Download or send an electronic version of your membership cards
- Contact Cigna with one tap of a finger

The app is free to Cigna Global Health Benefits plan participants and is available from the Apple App Store, Google Play or the Amazon Appstore. Download the app today.

Cigna Global medical coverage

You and your eligible dependents have access to a wide variety of health care professionals. How you access care depends on where you and your family members are when seeking care:

- **Outside the U.S.:** Routine care and doctor visits are always covered. Although there isn't a network of physicians, direct payment is available at more than 300,000 providers worldwide.
- **Within the U.S.:** You and your eligible dependents have access to a network of physicians and hospitals through the Cigna Open Access Plus (OAP) provider network. You are covered whether you visit an in-network or an out-of-network provider. To receive the highest level of benefits, it's your responsibility to confirm that a U.S. provider is a member of the Cigna OAP network.

No matter where you seek care, you will not be required to visit a primary care physician (PCP) first or get a PCP referral to visit a specialist. However, having a PCP to coordinate and manage your care is always recommended.

The amount you and the plan pays for covered services varies based on the plan you are enrolled in, the service provided and if you are outside or within the U.S. Refer to the Cigna Global Benefits Summaries in the *Appendix* for more information on cost sharing or contact Cigna.

Cigna Global plan ID cards

As a participant with Cigna Global, you will receive an ID card. Your ID card lists the information your health care provider will need when you receive care, as well as the numbers you can call when you have questions about the plan (collect calls are accepted). You should carry this card with you at all times and refer to it whenever you need medical and/or dental care.

How costs are calculated

Deductible calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the individual deductible –OR– • When the family deductible is satisfied regardless of whether or not the individual deductible is satisfied
Out-of-pocket calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the individual out-of-pocket maximum –OR– • When the family out-of-pocket maximum is satisfied regardless of whether or not the individual out-of-pocket maximum is satisfied. The out-of-pocket maximum includes deductible payments, coinsurance payments, copays, pharmacy copays and pharmacy coinsurance payments. Any pre-admission certification/continued stay review penalties are not included.
Network accumulation	Plan deductible, out-of-pocket maximums and service-specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

Coverage outside the U.S.

When you or your family is outside the U.S., you can see any physician you choose. However, through cignaenvoy.com, you can access a listing of recommended providers and facilities where the quality of care has been reviewed. (You can find hospitals online or by calling Cigna.) Since Cigna Global Health Benefits has established direct payment with these facilities, coordinating payment is easier when you use a recommended provider or facility.

Wellness and preventive care are covered at 100% — with no coinsurance for either plan. For other medical services — including office visits as well as inpatient and outpatient hospital care — each plan pays a set coinsurance and you pay the balance, up to the calendar-year out-of-pocket maximum. Once you reach the calendar-year out-of-pocket maximum, the plan pays 100%, up to reasonable and customary amounts, of the rest of your covered charges for care received outside the U.S. for the remainder of that calendar year.

Please note that the following do not count toward the out-of-pocket maximum:

- Charges for services that are not covered by the plan or exceed plan limitations
- Charges in excess of the reasonable and customary amount
- Penalties

Coverage within the U.S.

This section describes how the Cigna Global plans provide coverage for care received within the U.S. This applies to you when on home leave or a business trip to the U.S. as well as to dependents who remain at home in the U.S.

In-network care

Within the U.S., you receive the highest level of benefits when you use the nationwide Cigna OAP network. Participating providers and hospitals have contracted with Cigna to provide quality medical services at predetermined rates.

It's recommended, although not required, that you choose a PCP to coordinate your care received within the U.S. Whenever you use a provider that participates in the Cigna OAP network, benefits for eligible services are paid at a higher level, and you are not required to file any claim forms for in-network services.

Note

For care received within the U.S. with Cigna Global, the in-network and out-of-network deductibles and out-of-pocket maximums are combined. This means eligible expenses you incur in-network apply to the out-of-network deductible and out-of-pocket maximum. In addition, all copays apply to both the in-network deductible and the in-network out-of-pocket maximum.

When you receive in-network care, your provider is responsible for ensuring that any required notification (see Prior Authorization Requirements) is provided to Cigna.

Finding in-network health care providers

Using Cigna OAP network providers can help you save money on your health care expenses. To find providers in your area who participate in the network, go to cignaenvoy.com, click on Physician Directory and search for a provider within the U.S. Since providers may join or leave the network at any time, you should call Cigna to check if a specific provider still participates in the Cigna OAP network.

Once you have located a provider, you can learn their:

- Area(s) of specialty
- Address, including directions to the office
- Hospital affiliation(s)
- Board certification(s)
- Language abilities

If you don't have access to a computer, call Cigna.

Out-of-network care

You always have the option of seeing a provider or specialist who does not participate in the network. This is called out-of-network care.

When you seek care within the U.S. with a provider that does not participate in the Cigna OAP network, you pay a larger share of the costs.

With out-of-network care, the plan pays benefits for covered health services using the maximum reimbursable charge, which is determined based on the lesser of the provider's normal charge for a similar service or supply; or a percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the maximum reimbursable charge, then data in the database for similar services may be used.

Note

The provider may bill you for the difference between the provider's normal charge and the maximum reimbursable charge, in addition to applicable deductibles and Coinsurance.

Any amount you pay above the maximum reimbursable charge as well as the following do not count toward the deductible or the out-of-pocket maximum:

- Charges for services that are not covered by the plan or exceed plan limitations
- Prescription drug charges
- Penalties

The deductible does not apply to the out-of-pocket maximum. Once you reach the out-of-pocket maximum, the plan pays 100% of the rest of your covered out-of-network charges, up to maximum reimbursable charges, for care received in the U.S. for the remainder of that calendar year.

This is how the majority of out-of-network services — including wellness and preventive care, office visits and inpatient hospitalizations — are covered. An exception is emergency care, which may be covered at the in-network level if emergency procedures are followed; see the Emergency care section for more information.

Prior authorization requirements

If you receive care from a network provider, your provider is responsible for notifying Cigna.

If you receive care from an out-of-network provider, you are responsible for calling Cigna. It's recommended to have your ID card or ID number available when you call.

In either case, prior authorization is required for certain types of care received within the U.S. To find out if the care you need requires prior authorization, or to receive care coordination assistance, call Cigna.

If you seek care from an out-of-network provider within the U.S. for a service that requires prior authorization and you do not notify Cigna, no benefits will be payable. Note that any penalties you pay do not apply to the calendar year deductible or out-of-pocket maximum.

Certification requirements for services rendered within the U.S.

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number **800.441.2668** to precertify services.
- You or your dependents are responsible for ensuring that out-of-network providers precertify services.

Failure to obtain precertification may affect your out-of-pocket costs.

Covered services

This section highlights benefits that are available to U.S. outbound (expatriate) employees on international assignment and their covered dependents through the Cigna Global plans. For more information about how Cigna Global covers particular benefits outside or within the U.S., refer to the Cigna Global Benefit Summaries located in the *Appendix*.

Primary care

Although the Cigna Global plans do not require you to choose a PCP or obtain a PCP referral to see a specialist, it is always recommended that you choose a primary care doctor to coordinate your care. You and your PCP work as a team. Your PCP:

- Knows you and sees you for regular checkups when you're healthy
- Works with you when you're sick
- Is your partner in the health care system, referring you to specialists and arranging for hospitalization when necessary

If you are establishing yourself as a new patient with a PCP, it is a good idea to schedule an appointment for a new patient exam. This will help your provider get to know you when you are in good health and establish a baseline for treating you in the future.

Wellness and preventive-care benefits

Routine physical exams are covered at 100% with no cost sharing when performed outside the U.S. or by a Cigna OAP network physician within the U.S. If you or your covered dependent receives care within the U.S. and chooses to receive a routine physical exam out-of-network, it is covered at the out-of-network level. Physical exams required by a third party — such as a school, employer or camp — are not covered.

An exam is considered routine if you are presenting no unusual complaints to your physician. While annual routine physical exams are generally recommended, your physician will determine the frequency that is right for you based on your age, gender and medical history.

In addition, the plan covers related preventive-care services at 100% with no deductible, coinsurance or copay when received outside the U.S. or through a Cigna OAP network provider within the U.S.

Examples of services include:

- Related laboratory tests, chest x-rays and EKGs
- Annual screenings for diabetes, cholesterol, blood pressure and body mass index (BMI)
- Colorectal cancer screening
- Visual skin check
- For men, testicular exam and prostate exam
- For women, breast exam, mammogram (including 3-D mammogram), pap smear, family planning services and bone mass density exam (PCP referral not required to see a network OB/GYN for these services) and Women's Health Services as preventive care
- Well-baby and well-child visits, including age-appropriate immunizations

For more information, refer to the Cigna Global Benefit Summaries in the *Appendix*.

Specialty care

With Cigna Global, you always have direct access to specialty care. Specialists include:

- Cardiologists
- Chiropractors
- Dermatologists
- Ear/nose/throat doctors
- OB/GYNs

- Physical, speech, occupational, cardiac rehabilitation and pulmonary therapists
- Podiatrists

Benefits vary according to the type of specialist and where you seek care. For details, see the Cigna Global Benefit Summaries in the *Appendix*.

Emergency care

You are always covered for emergency care, no matter where you are when you need care. For purposes of the plan, an emergency is defined as a serious medical condition or symptom resulting from injury or sickness that arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally within 24 hours of onset, to avoid jeopardy to the life or health of a covered person.

If you need emergency care, you should go immediately to the nearest emergency room or international hospital. When you arrive, simply show your Cigna Global ID card to provide the facility with the contact details of the appropriate service center to be contacted.

If emergency procedures are followed, emergency room facility charges are covered based on the plan you enroll in (cost sharing is waived if admitted).

Ambulance services

The plan covers ground ambulance transportation in emergency cases no matter where you are. In addition, the plan covers emergency air-ambulance service in the U.S. if ground transportation is impossible or would cause your life or health serious jeopardy.

Family planning benefits

Family planning benefits (for example, Depo-Provera injections; diaphragms; IUDs; FDA-approved oral, injectable and emergency contraceptives) are covered at 100%. In order to receive 100% coverage for any prescription that qualifies as preventive care, you must use a generic equivalent, if available.

See the Prescription drug coverage section under the Cigna Global Benefit Summaries in the *Appendix* for pharmacy information.

Infertility treatment

Following a medically necessary diagnosis, the treatment of infertility, including Zygote Intrafallopian Transfer (ZIFT) and Gamete Intrafallopian Transfer (GIFT), is covered the same as any other illness (no dollar limits, no attempt limits).

Note that coverage does not extend to experimental fertility care services, monetary payments to gestational carriers or surrogates or the reversal of voluntary sterilization undergone after the covered individual successfully procreated with the covered individual's partner at the time the reversal is desired.

Maternity care benefits

Maternity care is covered the same as any other covered medical expense.

Short-term therapies

Benefits are provided based on the allowed charge for short-term rehabilitative therapy by a physical therapist; at a general, chronic disease or rehabilitative hospital or community health center; or in a doctor's office. Benefits include physical therapy, speech therapy, occupational therapy, pulmonary therapy, cardiac rehabilitation or an organized program of these combined services.

Mental health care

The plan provides benefits for medically necessary mental health and substance use disorder treatment. Benefits are coordinated to provide confidential counseling and referral services for mental and nervous disorders as well as for substance use disorders.

If you need mental health care outside the U.S., you can receive care from any qualified mental health and substance use disorder medical professional.

If you need care within the U.S., Cigna Global offers a network of providers who specialize in the treatment of mental health and substance use disorders. Every provider in the network has been carefully screened and selected for their experience and quality of care. By using network providers, you maximize the mental health and substance use disorder benefits available through the plan. No matter where you seek care, remember that inpatient care must be authorized in advance or benefits may be reduced.

Autism Spectrum Disorders (ASD) — Cigna Global provides coverage for Autism Spectrum Disorders (ASD) as mandated by the state of Delaware, where Cigna Global Health Benefits is based.

Covered services include those for the treatment of ASD that is diagnosed by a physician for behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive or advance these services, including those necessary for Applied Behavioral Analysis (ABA); and any care determined by the Secretary of the Department of Health and Social Services based upon that department's review of best practices and or evidence-based research to be medically necessary.

Services are covered the same as any other covered medical expense. There are no dollar, visit or age limits for ASD treatment.

Transplant coverage

You are covered for transplants received outside the U.S. Transplants received within the U.S. are covered when received at a Cigna LifeSOURCE Transplant Network® facility. The Cigna LifeSOURCE Transplant Network performs:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Small bowel transplants
- Liver/small bowel transplants
- Kidney transplants
- Pancreas transplants
- Kidney/pancreas transplants
- Bone marrow/stem cell transplants
- Other transplant procedures when the plan determines it is necessary to perform the procedure at a designated transplant facility

Procedures must be performed at a designated transplant facility — a facility designated by the plan to provide medically necessary covered health services and supplies for qualified procedures plan.

Services and supplies for necessary organ or tissue transplants are payable under this plan.

Gender dysphoria (transgender surgery and gender dysphoria treatments)

Cigna Global provides benefits for services related to gender dysphoria (transgender surgery and gender dysphoria treatments). Once a licensed provider makes a diagnosis, Cigna Global services are covered the same as any other covered medical expense.

For more details or if you have any questions, refer to the plan's Certificate of Coverage or call Cigna.

When you are away from your home or residence

You are always covered while you are away from home or your expatriate residence. If you need medical care, call Cigna for assistance.

If you are traveling and serious injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic.

Cigna Global prescription drug coverage

Prescription drug coverage for Cigna Global-enrolled U.S. outbound (expatriate) employees and their covered dependents filling a prescription inside or outside of the U.S. is administered by Cigna Global.

When you need to fill a prescription outside of the U.S., generic and brand name medicines are reimbursed at the same level—prescriptions filled outside the U.S. are not subject to a formulary.

There isn't a mail-order service for prescriptions filled outside the U.S. — you must use a local pharmacy.

Cigna Global Health Benefits will provide direct reimbursement to those pharmacies outside the U.S. that will accept it. If you must pay for your prescriptions out of pocket, submit a claim form for reimbursement (see Claims for benefits from Cigna Global located in the *Claims* chapter for more information).

Note

If you and/or a dependent who is accompanying you on your assignment takes prescription drugs, be sure to ask Cigna to confirm that those medications are allowed in the country of your international assignment before you are deployed. Depending on the medication, you may want to purchase a one-year supply in advance of your deployment.

Cigna Global telemedicine

Cigna Global provides telemedicine through Teladoc Health International. This service is available 24/7 via the Cigna Wellbeing App, Global Telehealth gives you access to licensed doctors around the world and provides:

- Video or phone consultations with licensed doctors when medically necessary
- Prescriptions for common health concerns when medically necessary and permitted
- Treating medical conditions like fever, rash, pain and more
- Assistance with preparations for an upcoming consultation
- Discussing medication plan and potential side effects
- Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions

Cigna Global dental coverage

Cigna Global dental coverage is offered separately from medical and vision coverage. Preventive and routine care is covered at 100% with no deductible. After you meet the individual or family deductible ($50/$100), the plan covers basic services (such as fillings, root canal therapy and oral surgery) at 80%, and major services (such as the installation of bridges and crowns) at 60%. The annual per person benefit maximum is $2,500 (separate lifetime maximums for orthodontia and implants apply).

Dental provider networks vary depending on if you seek care outside or within the U.S.:

- **Outside the U.S.:** Although there isn't a network of providers, similar to medical coverage, direct payment is available with more than 300,000 Cigna Global Health Benefits preferred providers worldwide.
- **Within the U.S.:** Similar to medical coverage, you and your eligible dependents have access to a network of providers, which for dental coverage is called the Cigna Dental PPO/EPO network. You are covered whether you visit an in-network or an out-of-network provider. To receive the highest level of benefits, it is your responsibility to confirm that a U.S. provider is a member of the Cigna Dental PPO/EPO network.

Note

Within the U.S., all coverage is based on the participating provider's fee if services are rendered by a dentist who participates in the Cigna Dental PPO/EPO network. With an out-of-network provider, coverage is based on the maximum allowable charge for a particular service or procedure; you may be responsible for paying the difference between the actual charge and the maximum allowable charge.

For more information about dental benefits, including a list of direct payment providers, go to cignaenvoy.com.

Dental benefit cost sharing

Deductibles and Maximums
(do not apply to preventive and routine care)

Individual deductible	$ 50
Family deductible	$ 100
Annual benefit maximum (per person)	$2,500
Orthodontia maximum (per person, lifetime)	$2,500

Dental benefit cost sharing	
Preventive and Routine Care (Type 1) • Oral exam and cleaning twice each calendar year (regardless of whether care is routine) • Bitewing x-ray, twice per calendar year • Full mouth x-ray, once every five years • Periodontal cleaning, once every three months following active periodontal treatment (not to be combined with preventive cleanings) • Space maintainers, fixed unilateral (limited to non-orthodontic treatment) • Topical application of sealant, per tooth, on a posterior tooth (only one treatment per tooth in any three years)	Plan pays 100%
Basic Services (Type 2) • Fillings • Root canal therapy • Oral surgery and extractions • Repair of bridgework and dentures • Periodontics	After you meet the deductible, plan pays 80%
Major Services (Type 3) • Installation of bridges and dentures • Crowns and gold restorations • Reconstructive dental surgery	After you meet the deductible, plan pays 60%
Implants	After you meet the deductible, plan pays 60%
Orthodontics (treatment for children and adults)	After you meet the deductible, plan pays 100%

Cigna Global vision coverage

Included with your medical enrollment is coverage for vision exams, frames and lenses or contacts. Benefits are identical under both plans and covered per the table below:

Vision benefit cost sharing	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Examinations One every 24 consecutive months	100%	100% not subject to deductible	
Lenses and Frames or Contacts One every 24 consecutive months	100%	100% not subject to deductible	
Hardware Maximum Benefit		$250	

International Employee Assistance Plan (IEAP)

For U.S. outbound (expatriate) employees on international assignment, call LifeResources collect from outside the U.S. at **+1-312-595-0074** or go to liferesourcesray.com (to register, the company's web ID is Raytheon).

Medical and dental exclusions and limitations

Coverage limitations determined by plan or provider type are shown in the Certificate of Coverage booklet. Payment for the following is specifically excluded from this plan:

- Aids or devices that assist with nonverbal communications, including but not limited to, communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books. Note that coverage is available for certain aids or devices used to treat Autism Spectrum Disorder (ASD)
- Artificial aids, including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs
- Charges for assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care
- Blood administration for the purpose of general improvement in physical condition
- Charges made by a hospital owned or operated by, or which provides care or performs services for, the U.S. government, if such charges are directly related to a military-service-connected injury or sickness
- Charges made by any covered provider who is a member of your family or your dependent's family
- Charges that would not have been made if the person had no insurance
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where, in the utilization review, the physician's opinion is that the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- Consumable medical supplies, other than ostomy supplies and urinary catheters, including but not limited to, bandages and other disposable medical supplies; skin preparations; and test strips, except as specified in the Home Health Services or Breast Reconstruction and Breast Prostheses sections of the Certificate of Coverage booklet
- Cosmetic surgery and therapies (**Note:** For purposes of the plan, cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. This includes — regardless of clinical indication for — macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy/movement therapy; applied kinesiology; Rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.)
- Cosmetics, dietary supplements as well as health and beauty aids
- Medical and hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under this plan
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in this plan
- Charges that exceed the reasonable and customary amount (applies to outside the U.S.) or the maximum reimbursable charge (applies within the U.S.)

- To the extent of the exclusions imposed by any certification requirement shown in this plan
- To the extent that you or any one of your dependents is in any way paid or entitled to payment for those expenses covered by or through a public program, other than Medicaid.
- For or in connection with experimental, investigational or unproven services (**Note:** For purposes of this plan, experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review physician to fall into at least one of the following categories:
  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the Clinical Trials section of the Certificate of Coverage booklet
  - The subject of an ongoing phase I, II or III clinical trial, except as provided in the Clinical Trials section of the Certificate of Coverage booklet.)
- Genetic screening or pre-implantations genetic screening (**Note:** For purposes of the plan, general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked, inheritable disease.)
- Cost of immunizations or medications to protect against occupational hazards and risks
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term or maintenance care that is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected
- Injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan
- For or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit
- Charges for or in connection with an injury or sickness that is due to war, declared or undeclared; riot; civil commotion; or police action that occurs in the employee's country of citizenship
- Massage therapy
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree or a retiree's dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider
- Membership costs or fees associated with health clubs, weight-loss programs and smoking cessation programs
- Non-medical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, as well as services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disability
- Expenses for supplies, care, treatment or surgery that are not medically necessary
- Charges for which you are not obligated to pay, for which you are not billed or for which you would not have been billed except that they were covered under this plan

- Nutritional supplements and formulae, except for infant formula needed for the treatment of inborn errors of metabolism
- Medical treatment when payment is denied by a primary plan because treatment was received from a nonparticipating provider
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- Charges for claim payments that are illegal under applicable law
- Personal or comfort items, such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles that are not for the specific treatment of an injury or sickness
- Private hospital rooms and/or private duty nursing, except as provided under the Home Health Services section of the Certificate of Coverage booklet
- Unless otherwise covered in this plan, charges for reports, evaluations, physical examinations or hospitalization are not required for health reasons (**Note:** This includes, but is not limited to, employment, insurance, government licenses as well as court-ordered, forensic or custodial evaluations.)
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails (**Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.)
- Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn

Upon your return to the U.S.

As you prepare to return to the U.S., it's important to note that your Cigna Global medical, dental and vision coverage will end on the date your international assignment ends.

To choose the medical and dental plans that are right for you after your international assignment ends, you must actively elect coverage from the company-sponsored medical and dental options that are available to employees in the U.S. within 30 days of your assignment end date.

Dental

Dental coverage is available to you and your eligible family members. It pays benefits for preventive care plus other services, like fillings, crowns and dentures.

In this chapter

Raytheon Technologies offers two dental plan options:

- **Delta Dental Plus** covers a broad range of dental services, including orthodontia for adults and children.
- **Delta Dental Basic** covers a broad range of services but does not cover orthodontia. For major care, you must use an in-network provider for the plan to pay benefits.

Note

Refer to the *Eligibility and enrollment* chapter for details about who you can cover and when you can enroll and make changes to your benefits.

Plan benefits

With both dental options, plan benefits for preventive care are paid before the deductible has been met. For all other types of care, you pay a deductible before the plan shares costs with you. If you reach the benefit maximum, you pay 100% of the cost for any dental services you receive for the rest of the calendar year.

		Delta Dental Plus	Delta Dental Basic
Deductible What you pay before the plan shares the cost of basic and major care	**You Only**	$50	$50
	You + Family	$100	$100
Covered services What the plan pays	**Diagnostic and Preventive Care** Such as cleanings, exams and X-rays	100%, no deductible	100%, no deductible
	Basic Care Such as fillings and root canals	80%	80%
	Major Care Such as crowns, bridgework and dentures	60%	40% (in-network only)
	Orthodontia Braces for adults and children	100%	Not covered
Benefit maximums Most the plan will pay in benefits per person	**Basic and Major Care**	$2,500 annually	$750
	Orthodontia	$2,500 lifetime	N/A

Note

If you receive care from an out-of-network provider, benefits are based on the maximum allowable charge for a particular service or procedure. This is the amount Delta Dental would pay to a network provider for that service or procedure. You are responsible for paying the difference between the actual charge and the maximum allowable charge.

Expanded network discounts

When dentists join the Delta Dental PPO and/or Delta Dental Premier network, they agree to accept lower negotiated fees for providing care. Delta Dental network providers also extend these same discounted rates for services that your plan would generally cover, but are not covered due to certain circumstances, such as when you:

- Exceed your visit limit for a certain service, including cleanings or x-rays;

- Exceed your annual benefit maximum; or
- Are over the age limit for a certain service, such as for fluoride varnish

Note that having access to discounted rates under certain circumstances does not mean you are eligible for additional benefits from the plan. For example:

- The Delta Dental Plus and Delta Dental Basic options cover two cleanings per calendar year and Susan likes to have three cleanings per year. While the plan will not cover the third cleaning, Susan will be charged the full, negotiated rate instead of the retail rate for the third cleaning.
- Mike is in the Delta Dental Basic plan and just learned he needs a root canal. While root canals are generally covered, he'll be responsible for 100% of the cost of the procedure since he has already hit the plan's $750 benefit maximum. Mike will be charged the full, negotiated rate for the procedure, not the retail rate.

Note that extended discounts apply only to services that are considered core benefits of your plan. Discounts do not apply to services your plan does not cover. In addition, certain services are excluded, including:

- General anesthesia and IV sedation that is not in conjunction with the surgical removal of impacted teeth
- Implants that are not received in lieu of a three-unit bridge
- Orthodontia, including Invisalign, medically necessary orthodontia and age-based restrictions for standard orthodontia care

For more information about what services are covered and not covered, call Delta Dental of Massachusetts at **877-335-8227**, Monday through Thursday from 8:30 a.m. to 8 p.m. ET, and Friday from 8:30 a.m. to 4:30 p.m. ET.

Enhanced benefits for chronic health conditions

For plan participants with certain health conditions maintaining proper dental health is critical to maintaining overall health. We include enhanced benefits for plan participants with certain medical conditions. The following are medical conditions that qualify for additional benefits:

Heart disease, stroke, or diabetes

- Periodontal treatment
- Periodontal maintenance

Maternity periodontal treatment

- Periodontal maintenance
- Oral evaluation
- Periodontal evaluation
- Cleaning
- Full mouth scaling (in presence of inflammation)
- Emergency palliative treatment

Chronic kidney disease, organ transplants, radiation for head or neck cancers, rheumatoid arthritis, Sjögren's syndrome, lupus, Parkinson's disease, ALS, or Huntington's disease

- Periodontal treatment
- Periodontal maintenance

Enhanced benefits for chronic health conditions

- Topical application of fluoride varnish
- Sealants and sealant repair
- Tooth decay/cavity prevention

Opioid misuse and addiction

- Periodontal treatment
- Periodontal maintenance
- Oral evaluation
- Topical application of fluoride varnish
- Sealants and sealant repair
- Tooth decay/cavity prevention

Plan maximums, limitations and exclusions apply.

The enrollment for this program is on a self-reported basis. To enroll for this enhanced benefit, a member will need to complete the Enhanced Benefit Enrollment form and submit it to Delta Dental of Massachusetts.

Covered services

Diagnostic and preventive care

Covered services include:

- Comprehensive oral evaluation for new and established patients, once every five years per dentist
- Cleaning of teeth (oral prophylaxis), twice per calendar year
- Fluoride treatments once per calendar year for plan participants under age 19
- Periodic evaluation twice per calendar year (benefits are paid even if the visit is for nonroutine care)
- Periodontal cleaning up to four times per calendar year (or up to two times per year when combined with routine teeth cleaning) following active periodontal treatment for participants with a history of osseous surgery and/or scaling and root planning
- Space maintainers for plan participants through age 18
- Sealants on unrestored permanent molars:
  - Once per tooth every 36 months for plan participants under age 19
  - For plan participants age 16 up to age 19 for those who had a recent cavity and are at risk for decay
- X-rays:
  - Bitewing x-rays, twice per calendar year for plan participants under age 19 and once per calendar year for plan participants age 19 and over
  - Single tooth x-rays, four times per calendar year
  - Full mouth or panoramic x-rays once every 60 months (with a shared combined frequency limit)

Basic care

Covered services include:

- Apicoectomy, once per tooth
- Bone graft/guided tissue regeneration on natural teeth only for periodontal conditions:
  - Not covered with an implant or extraction
  - No more than two teeth per quadrant every 36 months
- Emergency/palliative and minor treatment for pain relief
- Extractions (once per tooth)
- Fillings — amalgam or composite (once every 24 months per surface, per tooth)
- General anesthesia/IV sedation administration
  - Covered with surgical extractions, osseous surgery (D4260 and D4261) and implants (D6010 and D6013)
  - Up to one hour
  - Only when administered by a licensed dentist
- Occlusal guards, one appliance every 36 months
- Frenectomy (frenulectomy) for plan participants over age six
  - Buccal or labial two per lifetime
  - Lingual once per lifetime
- Periodontal scaling and root planing, once every two years per quadrant and no more than two quadrants on the same date of service
- Periodontal surgery, once every 36 months per quadrant and no more than two quadrants on the same date of service on natural teeth
- Prosthetic maintenance as follows:
  - Bridge or denture repairs once per calendar year
  - Crowns or onlay repairs two per calendar year, per tooth
- Recementing of crowns, inlays, onlays or bridges, two per calendar year per tooth
- Root canal treatment, once per tooth
- Root canal retreatment, once per tooth, after six months of original root canal
- Rebase or reline of existing removable dentures, once every 36 months
- Vital pulpotomy, limited to primary teeth only, once per tooth

Major care

Note

For major care to be covered under the Delta Dental Basic option, you must receive care from an in-network provider.

Covered services include:

- Adding teeth to an existing partial removable denture, once per tooth every 12 months
- Bridges, once per 84 months for plan participants age 16 or older

- Cone beam x-ray, two per calendar year
- Crowns, onlays, inlays, build-ups and post and cores for plan participants age 12 or older, when a tooth is damaged by decay or fracture to the point that it cannot be restored by a regular filling (once every 84 months per tooth)
- Dentures, once per arch per 84 months for plan participants age 16 or older
- Implants, once per tooth per 84 months for plan participants age 16 or older
- Implant abutments, once every 84 months for plan participants age 16 or older
- Labial veneers, once every 84 months per tooth
- Temporomandibular joint (TMJ) appliance, once every 60 months (surgery is generally covered under the plan participant's medical plan.)

Orthodontia

Note

Orthodontia is not covered under the Delta Dental Basic option. Reimbursement under the Delta Dental Plus option is based on 24 months of active treatment and is handled as follows:

- The lifetime maximum is paid out over a 12-month period or until the lifetime maximum has been reached
- The first payment is based on the banding date (the date the braces are put on)
- Monthly payments are automatically issued assuming the plan participant remains eligible for orthodontia benefits

- Orthodontia, including appliance therapy or harmful-habit appliances, as well as surgical access of an unerupted tooth and placement of device to facilitate eruption of impacted tooth, for all plan participants enrolled in the Delta Dental Plus option
  - Treatment must be administered/supervised by a licensed dentist
  - Mail-order kits are not covered

Services not covered

There are some services that are not covered by the dental plan options, even if your dentist approves or recommends them. Services not covered by the dental plan options include the following:

- Services or supplies received before your coverage becomes effective
- Bleaching
- Bone grafts and guided tissue regeneration in conjunction with surgical implant placement and endodontic procedures, such as apicoectomy (a surgical procedure to remove the end of a tooth root), root amputations, soft tissue grafts and extractions
- Charges for broken appointments
- Caries susceptibility tests
- Charges by the dentist for completing dental forms
- Corticotomy
- Cosmetic services, meaning those that are meant to change or improve appearances
- Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn covered child

- Adjustment of a denture or bridgework that is made within six months after installation
- Any duplicate appliance or prosthetic device
- Services or supplies that are covered by any employers' liability laws
- Services or supplies that are deemed experimental in terms of generally accepted dental standards
- Services or supplies furnished by a family member
- Gingivectomy to aid the placement of a restoration
- Home health aids used to prevent decay, such as toothpaste and fluoride gels
- Surgical or nonsurgical procedures around dental implants
- Injections of antibiotic drugs
- Instruction for oral care, such as hygiene or diet
- Replacement of a lost, missing or stolen crown, bridge or denture
- Services or supplies received through a medical department or similar facility that is maintained by the covered person's employer
- Myofunctional therapy
- Nitrous oxide
- Pulp caps
- Replacement of teeth beyond the normal complement of teeth
- Services or supplies received by a covered person for which no charge would have been made in the absence of dental coverage for the covered person
- Services or procedures that Delta Dental determines are not generally acceptable, e.g., laser-assisted new attachment protocol (LANAP)
- Services not performed by a dentist, except for the services of a licensed hygienist whose services are supervised and billed by a dentist and that are for:
  - Cleaning and scaling of teeth, or
  - Fluoride treatments
- Services or supplies for which a covered person is not required to pay
- Office visits after regular office hours
- Repair of an orthodontic appliance
- Orthodontic treatment that is not administered and directly supervised by a licensed dentist, and mail-order orthodontic kits
- Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan sponsored or contributed to by the company
- Periodontal splinting
- Photographs, such as any "before and after" pictures
- Prescription drugs
- Services or supplies that any employer is required by law to furnish in whole or in part
- Restorations for reasons other than decay or fracture, such as to increase the height of teeth
- Ridge augmentation or preservation
- Silver fluoride
- Sinus lifts
- Sterilization supplies

- Surgical access of an unerupted tooth and placement of device to facilitate eruption of impacted tooth (unless related to orthodontia, which is covered only by the Delta Dental Plus option)
- Teledentistry
- Temporary crowns, fixed bridges and dentures that are placed as part of the procedure to place a permanent appliance
- Therapeutic drug injections
- Transitional implants
- Treatment of failed dental implants, including surgical debridement (removal of dead tissue) and bone graft placement
- Services or supplies received as the result of dental disease, defect or injury due to an act of war or warlike act in time of peace, which occurs while coverage is in effect
- Services or supplies that are covered by any workers' compensation law or occupational disease law

Network providers

Note

Both dental plan options — Delta Dental Plus and Delta Dental Basic — use the Delta Dental PPO Plus Premier dental network, offering you a choice of two networks: Delta Dental PPO and Delta Dental Premier.

With the Delta Dental Plus option, you have the flexibility to use the dentist of your choice for all dental care. With the Delta Dental Basic option, you must use a network dentist for the plan to pay benefits for major services. For preventive care and basic services, you may use the dentist of your choice.

Although your deductible and coinsurance are the same whether you use in-network or out-of-network providers, there are advantages to staying in network.

When you use in-network providers	When you use out-of-network providers
You generally pay less each time you receive eligible services, since your share of the cost is based on rates that Delta Dental negotiated with participating providers. There is no balance billing. In other words, you're not billed for charges in excess of the maximum allowable charge for an eligible service.	Because these providers haven't agreed to negotiated rates, the plan pays benefits based on the maximum allowable charge for a particular service. If the provider charges more, you'll be responsible for paying the amount that exceeds the maximum allowable charge plus the applicable coinsurance and deductible.
You don't have to file claims; your network dentist takes care of all the paperwork.	You may be asked to pay for your care up front and submit a claim for reimbursement. Delta Dental will reimburse you for payment to the dental provider.

Finding network dentists

To take advantage of all that Delta Dental has to offer, check that your dentist participates in the Delta Dental PPO Plus Premier network before receiving care. Here's how to look up network dentists:

- Go to deltadentalma.com/raytheon and select **Find a dentist**.
- Select **Dentist specialty**, if interested.
- Select the network for **Delta Dental PPO Plus Premier**.
- Select **Yes** to search by your device's current location or **No** to search by ZIP code, city or address.
- Select **Find dentists**.

Pretreatment estimates

Before undergoing any dental treatment that will cost more than $300, you should request a pretreatment estimate to find out what the plan will cover for the proposed treatment. You are encouraged to request a pretreatment estimate before beginning any costly or extensive dental treatment (for example, a root canal or bridgework). To request a pretreatment estimate, ask your dentist to complete the regular dental claim form, indicating the type of work planned and the estimated cost. Delta Dental will provide you and your dentist with a statement showing the estimate of benefits payable under your plan.

Alternative treatments

For many dental conditions, there may be more than one acceptable course of treatment. When you request a pretreatment estimate, Delta Dental may suggest one or more alternative treatment methods that meet professional dental standards. In this case, you may still choose the original treatment proposed by your dentist. However, the plan will only pay benefits equal to the less expensive treatment. You are responsible for paying any difference *in addition to* any deductible or coinsurance.

How to file a claim

When you receive care from a network dentist, your dentist will file claims directly with Delta Dental. If you use a non-network dentist, you may have to pay the dentist up front for your care and file a claim for reimbursement by following these steps:

1. Before your appointment, go to deltadentalma.com/raytheon to download a dental claim form. (You may also use a standard American Dental Association (ADA) claim form)
2. Complete and sign the following sections of the form:
    - Insurance company/dental benefit plan information
    - Policyholder/subscriber information
    - Other coverage
    - Patient information
    - Authorizations
3. Give the form to your dentist to complete and sign the remaining sections
4. Submit the completed form, together with your original itemized dental bill(s), plan group number and subscriber ID number to:

    Delta Dental of Massachusetts
    P.O. Box 2907
    Milwaukee, WI 53201-2907

If your claim for benefits is denied in whole or in part, you have the right to an appeal, as described in the *Claims* chapter. All claims must be submitted within one year from the date of service.

Note

Delta Dental makes the final decision as to whether or not a particular service is covered. To determine what is and is not covered under your plan, see your plan's summary of benefits chart as well as the list of limitations and exclusions, or contact Delta Dental at **877-335-8227**.

For information about how to appeal a denied claim, see the *Claims* chapter.

Vision

Vision coverage is available to you and your eligible family members. It pays benefits each year for an eye exam plus other services, like eyeglasses or contacts.

In this chapter

Raytheon Technologies offers a vision plan option through VSP Vision Care (VSP). With the vision plan, you can make all decisions regarding where, when and how you receive vision care.

You may choose to receive care from either a VSP doctor or a non-VSP provider. Generally, your cost is lower when you use a doctor in the VSP network.

Note

Refer to the *Eligibility and enrollment* chapter for details about who you can cover and when you can enroll and make changes to your benefits.

Plan benefits

For most eligible vision care services, the plan pays benefits for in-network care after you pay a copay. Some benefits are paid up to a benefit maximum based on the service.

Plan benefits with VSP doctors and affiliate providers

Covered care[1]	In-network care
Eye exam (every calendar year)	
WellVision exam®	Plan pays 100% after $10 copay
Prescription glasses (every calendar year)	
Frames	
• Featured brands	Plan pays up to $225 after $10 copay + 20% discount on any remaining amount
• Other brands	Plan pays up to $175 after $10 copay + 20% discount on any remaining amount
• Costco, Walmart, Sam's Club	Plan pays up to $175 after $10 copay
Lenses • Single vision, lined bifocal, lined trifocal and standard progressive lenses • Impact-resistant lenses for enrolled children	Plan pays 100% after $10 copay
Lens enhancements	
• Premium progressive lenses	Plan pays 100% after the $10 lens copay and the $95–$105 copay
• Custom progressive lenses	Plan pays 100% after the $10 lens copay and the $150–$175 copay
• Other lens enhancements	Average savings of 30%
Contacts — instead of eyeglasses (every calendar year)	
• Medically necessary	Plan pays 100% after $10 copay for exam and contacts
• Elective	Plan pays 100% up to $175 for contact lens exams (fitting and evaluation) and lenses + 15% discount for exam
Essential medical eye care (as needed)[2]	
• Retinal screening for plan participants with diabetes	Plan pays 100% (copay does not apply)

[1]Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change.

[2]Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.

Covered care[1]	In-network care
• Additional exams and services for plan participants with diabetes, or age-related macular degeneration or glaucoma • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all plan participants	Plan pays 100% after $20 copay (per exam)
Extra savings and discounts	
Glasses and sunglasses	Extra $50 to spend on featured frame brands 20% off additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam
Routine retinal screening (optional service provided during a WellVision Exam)	Up to a $39 copay
Laser vision correction (provided at contracted VSP facilities)	• Average 15% off the regular price or 5% off the promotional price; discounts are only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Plan benefits with non-VSP providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call VSP Member Services at **888-426-3937** for out-of-network plan details.

Using a VSP doctor

The nationwide VSP network includes doctors and participating retail chains, including Visionworks, Costco, Cohen's Fashion Optical, Wisconsin Vision, Walmart, Sam's Club and Rx Optical. You can choose from more than 38,000 providers in 98,000 locations. To find participating doctors and retail chain partners in your area, confirm eligibility or verify benefits, visit vsp.com or call VSP Member Services at **888-426-3937**.

Using a VSP doctor can help you save money on routine vision expenses. To make the most of your benefits, simply follow these steps:

1. Choose a VSP doctor.
2. Make an appointment, identifying yourself as a VSP Vision Care-covered individual through Raytheon Technologies. Your doctor will confirm your eligibility and coverage with VSP Vision Care.
3. Pay only your copay for care when you receive it. You will also be responsible for any charges that your plan does not cover.

When you follow these steps, VSP will pay the balance directly to your doctor. You do not need to complete any claim forms.

Note

If you go to a VSP doctor or participating retail chain partner, tell your provider your coverage is with VSP. There are no claim forms when receiving services from a VSP provider.

ID cards are not issued for vision coverage. If needed, you may obtain an ID card by logging into your VSP account at VSP.com.

Filing a claim if you use a non-VSP provider

If you choose to receive routine vision care from a non-VSP provider, you may ask the provider to contact VSP directly to confirm your eligibility before your appointment. Once confirmed, your provider may submit your claim to VSP. In this case, VSP will directly reimburse your provider the allowed amount, which can then be deducted from your bill. Note that VSP will ask for your permission before discussing allowed reimbursement amounts with your non-VSP provider.

If your provider does not contact VSP to confirm your eligibility, you must pay the full cost of your care when you receive it. To receive reimbursement, you can upload receipts and submit your request online at vsp.com (link to the Benefits & Claims section), or submit a VSP Member Reimbursement Form along with a copy of your itemized receipt (keep your original receipt for your records) to:

VSP Vision Care
Attn: Out-of-Network Claims
P.O. Box 385018
Birmingham, AL 35238-5018

VSP will reimburse either a provider or you for the covered amount. If your provider charges more than the covered amount, you are responsible for paying the difference. Your claim must be submitted within one year of the date you receive the vision services or supplies.

If your claim for benefits is denied in whole or in part, you have the right to an appeal, as described in the *Claims* chapter.

Extra-cost items

Vision coverage is designed to cover your vision needs rather than cosmetic materials. If you select certain optional items, you will have to pay an additional amount. However, the cost of optional items is generally less if you purchase them from a VSP doctor. For some items, such as frames that cost more than the plan allowance, discounts are available when you use a VSP doctor.

Examples of optional items include:

- Blended or progressive multifocal lenses
- Contact lenses, in excess of the plan allowance
- Cosmetic lenses
- Frames that are valued at more than the plan allowance
- Optional cosmetic processes
- Oversized lenses
- UV-protected lenses

Safety eyeglasses as required by OSHA

If you work in an area or on a job that requires eye protection, you are eligible to receive prescription safety eyeglasses with permanently affixed or attachable side shields from a VSP doctor every two calendar years (not through participating retail chains). This benefit includes one repair every two years, based on the date of the first repair. You are eligible for the safety eyeglasses benefit even if you do not enroll in a vision plan. There are no copays for safety glasses. However, you will be responsible for the cost of any lens options not covered under the plan and/or frame costs that exceed the plan allowance.

You must obtain authorization for safety eyeglasses from your manager or supervisor. The authorization must be presented to the VSP doctor at the time of your appointment. You can receive your safety eyeglasses from your network provider at the same time you receive your examination and regular eyewear. However, if you receive an eye exam for regular eyewear and safety eyewear at the same time, you will be responsible for paying the eye exam copay.

For more information on how the safety eyeglasses program works, call VSP Customer Care; search on empowerU or visit the Other Benefits section on **Your Gateway**.

Services not covered

There are some vision services that are not covered, including, but not limited to:

- Any eye examination or corrective eyewear that is required as a condition of employment
- Corrective vision services, treatments and materials of an experimental nature
- Services or materials otherwise covered, at no cost, under any type of governmental contract or another insurance contract
- Lenses and frames furnished under this plan that are lost, broken or scratched, except at the normal intervals when services are otherwise available
- Medical or surgical eye treatment
- Benefits payable under a company-sponsored medical plan or other medical program
- Nonprescription lenses when the refractive error is less than a +/–.50 diopter power
- Nonprescription sunglasses when the refractive error is less than a +/–.50 diopter power
- Orthoptics or vision training and any supplemental testing
- Expenses paid by an employer, whether under workers' compensation law or otherwise
- Two pairs of glasses in lieu of bifocals

Note

VSP makes the final decision as to whether or not a particular service is covered. To determine what is and is not covered, see your plan's summary of benefits chart as well as the list of limitations and exclusions, or contact the plan administrator.

For information about how to appeal a denied claim, see the *Claims* chapter.

Health Savings Account

A Health Savings Account (HSA) helps you save for future health care expenses using pre-tax dollars. You can also use the money now for eligible out-of-pocket health care expenses, if needed.

In this chapter

HSAs feature a triple-tax advantage:

1. Money goes into your account before taxes[1], so you pay less in taxes and save money.
2. The money in your account grows tax free until you need it.
3. Withdrawals you make to pay eligible health care expenses are tax free.

To have an HSA, you need to be enrolled in one of the company's HSA-qualified medical plans and not have any other medical coverage, including Medicare.

Fidelity Investments is the HSA recordkeeper for Raytheon Technologies.

[1] Note that state income tax laws in Alabama, California, New Hampshire, New Jersey and Tennessee differ from the federal income tax treatment of HSA contributions and earnings.

Account highlights

Here are other things to know about the HSA in addition to the triple-tax advantage.

The company helps fund your HSA	If you enroll in the Anthem Gold, Anthem Silver, Kaiser Gold or Cigna Global Choice HSA medical plan, the company makes a lump-sum contribution to your HSA if you have an account open with Fidelity, the HSA recordkeeper for Raytheon Technologies. The amount of the company's contribution depends on your medical coverage tier. **Note:** Allow a minimum of two weeks for your Fidelity HSA account to open following your acceptance of the Fidelity Terms & Conditions on **Your Gateway**. If there are issues opening your account, you will be contacted directly by Fidelity. The company contribution will generally be deposited the month after your Fidelity account is successfully opened.
The money in your HSA is yours to keep	You always own the money in your HSA, including the company's contributions. There is no vesting rule. Your HSA balance rolls over year after year; there are no "use-it-or-lose-it" provisions. The money in your HSA is yours to keep until you spend it, even if you leave the company or retire. If you carry your account balance forward into the next calendar year, you can invest the money in your HSA. For details, see the Investing Your HSA section.
It's flexible and easy to use	You can access and manage your HSA online and use an HSA debit card to pay eligible expenses. Plus, you don't have to submit receipts to be reimbursed for eligible expenses (but keep your receipts for tax purposes).

Account contributions

Your HSA is funded by contributions from you and the company. The total annual contributions to your HSA (your contributions plus company contributions) are subject to annual limits determined by the IRS each year. If you are age 55 or older, you may make an additional $1,000 catch-up contribution to your HSA — over and above the regular contribution limits.

2023 HSA contribution limits

Medical coverage tier	2023 total maximum contribution	Company contribution	Your maximum contribution
You only	$3,850	$750	$3,100
You + Spouse/Partner	$7,750	$1,125	$6,625
You + Child(ren)	$7,750	$1,125	$6,625
You + Family	$7,750	$1,500	$6,250

Note

It's your responsibility to keep track of the total contributions to your HSA for the year. The company doesn't have any details about HSA contributions you may have made beyond what's deducted from your pay or contributed by the company.

Your contributions

If you choose to contribute to your HSA, you elect a goal amount on **Your Gateway** when you first open your HSA with Fidelity Investments (Fidelity), the HSA recordkeeper for Raytheon Technologies. The goal amount is divided by the number of pay periods in the year or the number of pay periods remaining in the year (if you elect or modify your election after the beginning of the year) to determine how much will be deducted from each paycheck on a pre-tax basis. For example, if elect to contribute $5,000 to an HSA with a Dec. 1 effective date, a $2,500 deduction will be processed against each of your remaining two paychecks.

The amount you elect to contribute via payroll deduction remains on record until you make a different election. You may decrease or increase the amount of your HSA contribution (up to the annual limit) at any time via **Your Gateway**. Any change you request, including stopping or starting contributions, becomes effective with the next available pay period.

Company contribution

Note

To receive the company contribution, you must meet the following criteria:

- Have an HSA open with Fidelity (see the Setting up your HSA section)
- Be of active status with the organization at the time the contribution is funded into your account (employees on Leave of Absence are eligible for the company contribution when they return to active status)

If you become benefits-eligible by Oct.15 and enroll in an HSA-qualified medical plan, you will receive a company contribution for the current year provided you have opened an HSA with Fidelity.

If you become benefits-eligible after Oct. 15, you will not receive a contribution for the current year. You will be eligible for the company contribution the following year as provided you're enrolled in an HSA-qualified medical plan and have an HSA open with Fidelity.

If you're enrolled in an HSA-qualified medical plan and have an HSA open with Fidelity, the company will make a lump-sum contribution to your account. The contribution amount depends on your medical coverage tier, and it's made in January if you enroll during Annual Enrollment or as soon as administratively possible for new hires or those enrolling during the year as a result of a qualified change in status. You will receive this contribution even if you don't make contributions to your HSA.

Note

The contribution amount is based on your coverage tier in place at the time you first become eligible for the company contribution during the plan year. If your coverage tier changes to cover additional family members, you will not be eligible to receive additional company contribution during the plan year. For example:

- You are enrolled in You Only coverage as of Jan. 1 and are eligible for the $750 company contribution.

On March 1, you enroll your spouse and change to You + Spouse coverage. You are not eligible to receive the additional $375 to get you to the $1,125 company contribution for You + Spouse coverage tier.

Account contributions and coordination with other types of medical coverage

To be eligible to make and receive contributions to an HSA, the only medical coverage you (the employee) can have is through an HSA-qualified high-deductible health plan. (Note that federal regulations allow anyone who is making or receiving contributions to an HSA to carry coverage for a specific disease or illness, such as cancer coverage. If you have questions about critical illness coverage, call Mercer at **800-557-5091**.)

This regulation means you (the employee) cannot be covered by and/or receive benefits from[1]:

- Your spouse's non-high-deductible medical plan or health care FSA, such as may be offered through their employer
- Medicare Part A, Part B and/or Part D
- TRICARE
- Medicaid
- A health plan made available to retired federal employees
- The U.S. Department of Veterans Affairs (VA) or Indian Health Services (IHS) during the three months prior to you making or receiving contributions to an HSA.[2] Note that this is an Internal Revenue Service (IRS) exclusion and does not apply to employees who received VA or IHS preventive care, vision and/or dental services.

You also cannot be claimed as a dependent on a tax return. In addition, note that children are not eligible to establish their own HSAs.

[1]If you're enrolled in Medicare or TRICARE (meaning you are not eligible to make or receive contributions to an HSA), you may enroll in an HSA-qualified plan and elect to participate in a HCSA, if eligible. In this case, you may use your pre-tax HCSA contributions to pay for eligible medical, dental and vision expenses that other benefit plans do not cover or cover only in part, including an HSA-qualified medical plan's deductible and coinsurance, as well as those listed in *IRS Publication 502, Medical and Dental Expenses*, available at irs.gov.

[2]If you receive hospital and/or medical services from the VA for a service-related disability, you're continuously eligible to make and/or receive contributions to an HSA and the three-month period described above does not apply. In addition, as described in the above footnote, if you use the VA for non-service-related disability care, you may enroll in an HSA-qualified medical plan and elect to participate in a HCSA, if applicable.

Setting up your HSA

The process to open your HSA with Fidelity begins when you enroll in an HSA-qualified medical plan. That's what makes you eligible to open an HSA on **Your Gateway** and elect how much you want to contribute to it. You can open your HSA when you first enroll for benefits as a new hire, during Annual Enrollment or at any time during the year.

You will also be required to review and agree to Fidelity's Terms & Conditions, which you can review on **Your Gateway**. To accept the Terms & Conditions, simply click **Yes** in the dropdown menu. By doing so, you provide electronic consent and agree to the stated terms that will open your HSA.

Once Fidelity receives notification that you have enrolled (generally within one week), you can log on to NetBenefits at netbenefits.com/raytheon and click on **Activate HSA**. From there, simply follow the instructions to activate the features of your account, including making your beneficiary election(s) and requesting additional Fidelity HSA® debit cards. A Fidelity HSA debit card will be mailed to you after you open your account.

Keep in mind that the USA Patriot Act requires financial institutions, in this case Fidelity, to acquire and maintain a physical address for all account holders. If your address on file is a PO box, you must provide Fidelity with a physical address in order to open your HSA. To do so, go to NetBenefits, click **Activate HSA** and enter your legal/residential address and the other required information under Personal Information. Your HSA cannot be opened until you provide Fidelity with your legal/residential address.

Once everything is in order, Fidelity will mail you a welcome kit verifying that your HSA is open. This kit will contain your account number, customer service and website information, bank disclosures, a schedule of fees and other important information.

Naming your beneficiary

Because you always own the money in your HSA, you should elect a beneficiary(ies) when you activate the features of your HSA through NetBenefits (click on **Activate HSA**). You can also update your beneficiaries at any time through NetBenefits by clicking Update Beneficiaries on the HSA page. If there is no beneficiary(ies) designation on record at the time of your death, your account balance will be transferred to your legal spouse, or if you are not married, to your estate. For more information about what happens to your HSA in the event of your death, see the *Custodial and Deposit Agreement* in the welcome kit you will receive when your account is first opened.

Eligible expenses

You can use your HSA to pay health care expenses that the IRS considers deductible for federal income tax purposes. The expenses you pay with money from your account can't be deducted on your federal income tax return that year. Any portion of a health care expense that is paid by other insurance is not eligible for reimbursement. An expense is incurred when you receive a service or make a purchase, not when you receive or pay a bill.

Eligible expenses include most out-of-pocket health care expenses that aren't covered by your medical, dental or vision plans, such as:

- Deductibles
- Coinsurance
- Copays that you pay under your medical, dental and vision plans
- Prescription drugs

- Dental care, including orthodontia
- Vision and hearing care
- Smoking cessation programs
- LASIK eye surgery
- Weight-loss programs and/or drugs
- Infertility treatment
- You may use your available HSA funds to pay for eligible expenses incurred by those dependents you claim on your federal tax return, even if they are not covered by your medical plan. Note that if you use HSA funds for non-qualified expenses, the money used is included in your annual income and becomes taxable. In addition, the money is subject to a 20% penalty. This penalty is waived if you are older than age 65, if you become disabled or if you die. See the Taxes section for more details.

Because your balance rolls over from year to year (there are no “use it or lose it” rules) — and can grow tax-free — funds in your HSA can be used to help pay for health care costs incurred in retirement, including Medicare premiums, expenses not covered by Medicare, as well as long-term care insurance premiums and eligible dental and vision expenses. For a full list of eligible expenses, refer to *IRS Publication 502, Medical and Dental Expenses*.

Ineligible expenses

The following is a partial list of ineligible expenses:

- Insurance premiums
- Health club memberships
- Hair loss treatments or transplants
- Funeral or burial expenses
- Cosmetic procedures and medications
- Vitamins and dietary supplements
- Payment of services not yet provided

Accessing the funds in your HSA

When you incur an eligible expense, you can use your HSA to pay for it by:

- Using your HSA debit card
- Writing a check from your HSA
- Using the online bill payment feature available via NetBenefits (at netbenefits.com/raytheon)

You can only use the funds that are in your HSA at the time you pay your bill. If an eligible expense exceeds your current HSA balance, you cannot pay for it using your HSA until your HSA contributions exceed the amount owed.

If you pay for an expense out of pocket, you can reimburse yourself from your HSA by transferring money online from your HSA to your bank account or by writing a check to yourself using your HSA checkbook. Learn more on NetBenefits (at netbenefits.com/raytheon).

Investing your HSA

When you open an HSA, which is a brokerage account, your contributions are initially invested in a “core account,” Fidelity Cash Reserves, which unlike other investment options is insured by the Federal Deposit

Insurance Corporation (FDIC). This conservative money market fund holds both the company's and your contributions until you invest or withdraw them.

As described in the welcome kit you will receive from Fidelity, you can choose to invest the money in your HSA in a variety of investment options — including more than 5,000 mutual funds, individual stocks and bonds, treasuries and certificates of deposit (CDs). After your account is open and funded, you can invest the money in your account using NetBenefits.

Transferring an existing HSA account to Fidelity

If you have an existing HSA account with another bank, you can transfer the funds to your Fidelity HSA. Contact Fidelity for more information.

Taxes

Federal taxes are not applied to:

- Your contributions (both pre-tax contributions made through payroll deduction and any lump-sum contributions), any catch-up contributions, the company's contributions and any investment earnings on any contributions to your account while the money remains in an HSA
- Payments made from an HSA for qualified health-care-related expenses

Although most states comply with federal regulations regarding HSA taxation, state income tax laws in Alabama, California, New Hampshire, New Jersey and Tennessee differ from the federal income tax treatment of HSA contributions and earnings. You are encouraged to consult a tax advisor for the applicable state tax information where you live.

Taxes and penalties will apply if you use HSA funds for non-qualified expenses. You are also subject to tax penalties if you and/or the company contributes to your HSA once your participation in Medicare Part A, B and/or D begins. Each year, Fidelity is required to provide you with a:

- Form 1099-SA, which shows all distributions
- Form 5498-SA, which shows all contributions and your year-end account value

HSA participants are required to file a Form 8889 with their annual tax returns, showing their total distributions for qualified health care expenses.

If you made HSA contributions in excess of the amount that you're permitted to make or you receive or make contributions when you are not eligible (such as if you enroll in Medicare Part A and/or Part B), you will be subject to taxes and penalties on the excess or ineligible amount. In some specific situations, you may be able to avoid the penalties if you arrange to have the excess amount distributed to you before your tax-filing deadline. A refund of excess contributions can be processed through NetBenefits. For assistance, call Fidelity.

Fees

Fidelity does not charge account fees. Commissions and other expenses associated with transacting or holding specific investments (e.g., mutual funds) may apply. The welcome kit you will receive shortly after you activate your HSA will include a complete list of any fees, including those charged by the investment fund manager, as detailed in each available fund's prospectus.

Filing an HSA claim

Raytheon Technologies provides access to the HSA but it is an individual account with Fidelity, and it is up to the participant to file claims and follow IRS guidance.

You can use your Health Savings Account Visa debit card to pay for eligible expenses within the same plan year, or you can pay for eligible expenses and then submit a claim for reimbursement. There isn't a deadline for filing an HSA claim. To file an HSA claim, contact Fidelity Investments at:

Fidelity Institutional Retirement Services Company
Raytheon Claims & Appeals Unit
P.O. Box 770003
Cincinnati, OH 45277-1060

800-544-3716

Spending accounts

Spending accounts offer you a convenient way to pay for certain health and dependent care expenses and to save on taxes at the same time. When you direct part of your pre-tax pay to a spending account, you lower your taxable income for the year. This means you pay less in taxes and have more take-home pay.

In this chapter

Two types of spending accounts are available to you:

- **Health Care Spending Account (HCSA):** You can use this account to pay for eligible out-of-pocket health care expenses. The types of eligible expenses you can use this account for depend on whether you're enrolled in an HSA-qualified medical plan and eligible to contribute to a Health Savings Account (HSA). See How the spending accounts work for details.

  You may contribute from $120 to $2,850 — before taxes — to an HCSA.

- **Dependent Care Spending Account (DCSA):** You can use this account to reimburse yourself for eligible child care and adult care expenses while you (and your spouse, if you're married) work, look for work or attend school full time.

  You may contribute from $120 to $5,000 each year — before taxes — to a DCSA. If you are married and file a single tax return, you can each contribute $2,500

You may participate in one or both each year. Both spending accounts are administered by Smart-Choice Accounts. If you want to participate in a spending account, you must make an active election.

Note

Refer to the *Eligibility and enrollment* chapter for details about when you can enroll and make changes to your benefits.

How the spending accounts work

Here's an overview of how the spending accounts work:

1. Estimate your eligible health care and/or dependent care expenses for the upcoming year. What you can use money in an HCSA for depends on if you're enrolled in an HSA-qualified medical plan and are eligible to contribute to an HSA. See below for details.
2. Enroll in the spending account(s) you want to participate in during initial benefits enrollment (for employees who are newly eligible for benefits) or during Annual Enrollment (for current employees) by selecting a separate contribution amount.
3. Your spending account(s) will be set up with Smart-Choice Accounts. To use your spending account(s) to pay for out-of-pocket eligible expenses:
   - For the **HCSA**, you may be able to use the Smart-Choice Card to pay for certain eligible health care expenses. Refer to the Smart-Choice Card for the HCSA section for details. For other expenses, you can pay out of pocket and submit claims to be reimbursed from your HCSA. Remember to keep your receipt(s) for reimbursement. Refer to the Submitting claims section of this chapter for details on how to file a claim.
   - For the **DCSA**, you pay for eligible expenses out of pocket and submit reimbursement claims throughout the year as services are provided and as you incur expenses. Refer to the Filing a DCSA claim section of this chapter for details on how to file a claim.
4. Your contribution election will carry forward each year after you enroll. To no longer participate in a spending account, you will need to opt out during Annual Enrollment or if you have a qualified change in status.

Types of expenses you can use an HCSA for

If you're enrolled in an HSA-qualified medical plan and are eligible to contribute to an HSA, you can participate in the HCSA but can only use it for a limited purpose: to pay for eligible dental and vision expenses (but not medical expenses).

If you're not enrolled in an HSA-qualified medical plan or you're not eligible to contribute to an HSA, you can participate in the HCSA and use it to pay for eligible medical, dental and vision expenses.

Spending account contributions

You will be asked to complete your enrollment either online via **Your Gateway** or by calling the Raytheon Technologies Benefits Center. When you enroll, you must indicate the contribution amount you wish to have deducted from your paycheck for each spending account for the year.

You can enroll in both the Health Care and Dependent Care Spending Accounts. However, you'll need to allocate your annual contributions for each account separately and cannot combine or transfer funds from one account to the other to pay for eligible expenses.

If you process a qualified change in status, you can only be reimbursed for expenses incurred on or after the coverage effective date (expenses incurred prior to the change in coverage are not eligible for reimbursement.

The amount you choose to contribute is deducted from your paycheck in equal installments throughout the year. If you enroll in the middle of the year (for example, you are newly eligible or you have a qualified change in status), you may still contribute the annual maximum to your account for that year. In that case, the amount you elect to contribute will be divided by the number of pay periods remaining in the year.

Account access

When you enroll in a spending account, you will be set up on Smart-Choice Accounts. You can log on to Smart-Choice Accounts for detailed, personalized information about your spending account — you can review claim status, verify account activity and monitor your account balance(s). You can access Smart-Choice Accounts from the **Your Gateway** home page. To log on to **Your Gateway**:

- From work, visit **Your Gateway** through the empowerU portal on your business unit's intranet page.
- From home (or from any other computer with internet access), go to yourtotalrewards.com/rtx. You'll be asked to enter your User ID and Password. If you don't have a User ID, **Register as a New User.** If you don't know your User ID and/or Password, follow the prompts to reset your User ID and/or Password.

You can also access Smart-Choice Accounts via the Smart-Choice Mobile app. This app is available for iPhone and Android smartphone users.

The Raytheon Technologies Benefits Center via Access Direct provides participant support for all your employee benefits and services. Representatives are available at **800-243-8135** from 8 a.m. to 8 p.m., ET, Monday through Friday. You will need the last four digits of your Social Security number and your date of birth to speak to a representative.

Spending accounts and Social Security

If your annual salary is less than the Social Security maximum taxable wage (as determined by the IRS), you'll see a decrease in the amount of Social Security taxes taken from your paycheck when you contribute to a spending account. That's because when you contribute pre-tax dollars to a spending account, you reduce the amount of federal income taxes deducted from your Social Security benefit. You may want to consider this when you're deciding whether to participate in a spending account.

Using an HCSA

Key deadlines

Date	Why it matters
Dec. 31 of the current plan year	Date eligible medical expenses must be incurred for them to be payable from your HCSA
March 15 of the following calendar year	Date eligible **dental** and **vision** expenses may be incurred to be payable from your HCSA **Example:** If you have $50 left in your HCSA at the end of the year, you can use that money for eligible dental and vision expenses incurred Jan. 1 through March 15 of the following year, before any remaining balance is forfeited.

Date	Why it matters
April 30 of the following calendar year	Date all claims for reimbursement from your HCSA must be submitted

Smart-Choice Card for the HCSA

If you've enrolled in the Health Care Spending Account, you can use the Smart-Choice Card to pay for certain eligible health care expenses. Dependent care expenses aren't eligible for reimbursement through the Smart-Choice Card program. As you use your card, eligible health care expenses will be automatically deducted from your account.

How the Smart-Choice Card program works

You'll receive a package containing one Smart-Choice Card issued in your name, activation instructions, a Cardholder Agreement and information explaining approved use of the Smart-Choice Card. You may request free additional cards for your spouse and/or dependent child(ren) through the Smart-Choice Accounts website, which you can access through **Your Gateway**.

The Smart-Choice Card remains active as long as you have a positive account balance, continue to participate in the Health Care Spending Account during the current calendar year and remain employed by Raytheon Technologies. Your Smart-Choice Card will be canceled upon termination of employment. By signing and using the Smart-Choice Card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your eligible dependents,
- Any expense paid with the card has not been, or will not be, reimbursed by another source,
- Your expenses were incurred on or after the date your HCSA took effect, *and*
- Your expenses don't include any amounts that are otherwise payable from the plan for which you or your dependents are eligible.

The Smart-Choice Card has been designed for use at merchants and providers that primarily provide health services and prescriptions (for example, pharmacies, physician's offices, hospitals and dentist's offices). For a detailed list of eligible merchants and providers, visit the Smart-Choice Accounts website. The Smart-Choice Card is a signature-based card. Each time you use the Smart-Choice Card at an approved merchant location for an eligible health care expense, you'll need to choose the "credit" option and will be required to provide your signature. If you choose the "debit" option, your transaction will not be processed. With each Smart-Choice Card purchase, your HCSA goal amount is reduced by the purchase amount. Other expenses, such as cosmetics or food items, must be paid for separately.

Save your receipts

Because the IRS requires that all Smart-Choice Card transactions be verified as eligible health care expenses, you may be required to provide Smart-Choice Accounts with supporting documentation to validate your expenses. Make sure that you save all of your itemized receipts (indicating the date of service, name of the service provider, name of the product or service, and any amount paid by other coverage). Refer to the Cardholder Agreement for more information.

If you are currently contributing to an HCSA, the Smart-Choice Card has a three-year expiration. You may use the card for eligible expenses in the following situations:

- Current plan year dollars used to pay for current plan year expenses.

- Prior plan year dollars used to pay for eligible **dental** and **vision** expenses incurred in the current plan year between Jan. 1 and March 15. Once Smart-Choice Accounts validates the expense, it will be applied to your prior plan year account. This process may take up to 30 days.
- Prior plan year dollars used to pay for eligible expenses incurred in the prior plan year but paid for in the current plan year. In this case, you must contact Smart-Choice Accounts to request that the funds be applied to the prior year plan. (**Note:** You may be asked to submit documentation to validate the claim.)

Lost or stolen cards

If your Smart-Choice Card is lost or stolen — or you believe that there has been any unauthorized use of your card — you must contact the Raytheon Technologies Benefits Center via **Access Direct** immediately at **800-243-8135** from 8 a.m. to 8 p.m., ET, Monday through Friday (excluding holidays). Outside normal business hours, you may call **866-438-5797** to report a lost or stolen Smart-Choice Card.

In case of errors relating to your Smart-Choice card

Call Smart-Choice Accounts at the number provided on the back of your card as soon as possible if you think a Smart-Choice Card transaction in the statement or receipt is wrong or if you need more information about a transaction listed in the statement or receipt. Smart-Choice Accounts must receive notification of any errors no later than 60 days after you received the first statement (either via the Smart-Choice Accounts website or by mail) in which the problem or error appeared. When you contact Smart-Choice Accounts, be prepared to:

- Provide your name, Social Security number (when applicable), and Smart-Choice Card number
- Describe the error or the Smart-Choice Card transaction that you're unsure about, and explain the reason you believe there's an error or why you need more information
- Provide the dollar amount of the suspected error. If you call Smart-Choice Accounts, you may be required to send your complaint or question in writing within 10 business days

Within 10 business days of receiving notification of an error from you, Smart-Choice Accounts will coordinate with the Smart-Choice Card issuer to determine whether an error occurred and will correct any error promptly. If more time is needed to correct the error, however, Smart-Choice Accounts may take up to 45 days to investigate your complaint or question. If this additional time is necessary, Smart-Choice Accounts will credit the monies held by Raytheon Technologies for the amount that you think is in error, so you will have use of the total amount during the investigation. If Smart-Choice Accounts requests that you put your complaint or question in writing and it doesn't receive the information within 10 business days, Smart-Choice Accounts may not provide this credit. Smart-Choice Accounts will inform you of the results within three business days after completing the investigation. If Smart-Choice Accounts decides that there was no error, a written explanation will be mailed to you. You may ask for copies of the documents that were used in the investigation.

Validation of Smart-Choice Card transactions

As required by the IRS, all transactions must be validated as eligible health care expenses at the point of sale or by submitting paper documentation. This process involves requesting receipts or other supporting documentation from you to verify that the card transaction has been approved as an eligible health care expense. All card transactions will be validated either electronically at point-of-sale, electronically by matching against a specific copay amount, electronically by matching against certain health vendor claims, or via paper documentation afterward. You should retain your receipts for all transactions, as they may be required for substantiation purposes.

Automatic validation for medical providers

Your Smart-Choice Card can be used for other types of health care transactions without the need for submission of receipts or further review.

Your Smart-Choice Card transactions will also be compared electronically against certain health vendor claims if you have your medical, dental or prescription drug coverage through Raytheon Technologies. Expenses that match the amounts received from these health vendors will be approved without any additional validation requirement.

Recurring transactions

If you purchase an eligible health care item or service using your Smart-Choice Card, that same item or service will be validated automatically the next time you purchase it with your card at the same provider for the same dollar amount. In addition, any recurring Smart-Choice Card transactions will carry over to the new plan year for participants who re-enroll in a flexible spending account. This means you'll be able to continue purchasing the same health care item or service (provided that the dollar amount does not change) without having to submit supporting documentation to Smart-Choice Accounts again the following plan year.

Paper validation

Paper substantiation and a manual claim filing process are required for the purchase of any health care service that isn't automatically or electronically substantiated. These types of purchases are treated as conditional, pending substantiation of the expenses.

The process for paper validation is outlined below:

1. The merchant is reimbursed the amount of the charge, and your available HCSA balance is reduced.
2. If the expense cannot be automatically or electronically substantiated within 30 days, you'll be sent a letter or email instructing you that your itemized receipts are required to validate the transaction.
3. If the documentation you provide is insufficient, you'll be sent a letter or email instructing you to provide more documentation.

Expenses for which you don't provide adequate documentation are considered ineligible and treated as overpayments. Refer to the Overpayment process section below for more information.

Overpayment process

If you purchase products or services with your Smart-Choice Card that aren't eligible for reimbursement through your HCSA, you'll receive notification from Smart-Choice Accounts that your transaction has been deemed an overpayment.

Outstanding balances generally occur when:

- Your failure to respond to substantiation requests for Smart-Choice Card transactions one month after the initial request was sent by Smart-Choice Accounts.
- Your Smart-Choice Card transactions were authorized at the point-of-sale, and then later deemed ineligible after the substantiation process was completed.
- Claim adjustments were made because of contribution amount changes, ineligible expenses or improper processing of the claim.

Once overpayments totaling more than $100 have been identified, the following actions will be taken immediately:

- Your Smart-Choice Card will be suspended and will remain suspended until the overpayments are reduced below $100.
- You'll be notified, via an Explanation of Benefits (EOB) statement, that you must refund the overpayment by mailing a check to Smart-Choice Accounts.
- Future paper claims will be processed, and eligible amounts will be applied to the outstanding overpayment. Payment will not be made on any claim until the overpayment has been fully recouped.
- If you provide the required substantiation documentation, recovery of overpayments that were caused by an unsubstantiated Smart-Choice Card transaction will be canceled.

Smart-Choice Accounts will take the following correction procedures to recover overpayments:

- You'll be given the option to write a personal check to Smart-Choice Accounts to refund the overpayment.
- Claims offset and recovery by personal check will run concurrently.

To repay your overpayment, you can pay online via electronic check through the Smart-Choice website, the Smart-Choice mobile app or by mailing a check to:

Smart-Choice Accounts
P.O. Box 660114
Dallas, Texas 77387-4030

The overpayment will remain active on the account until all amounts are recovered. Smart-Choice Accounts will provide Raytheon Technologies with a monthly report of outstanding overpayments.

Employer options for overpayment recovery

If the overpayment amount isn't recovered through the options above, Raytheon Technologies will determine if further action should be taken:

- Raytheon Technologies may choose to withhold the overpayment amount from your wages or other compensation to the extent consistent with applicable law.
- Raytheon Technologies may choose to report the overpayment as taxable income on your Form W-2 only after all other options have been exhausted.
- If Raytheon Technologies isn't able or doesn't choose to recover the overpayment through wage withholding, Raytheon Technologies may treat the overpayment as any other business indebtedness (for example, formal collection activity, write-off).

Note

If you enrolled in a plan that has coinsurance and you visit your doctor, wait until after your doctor submits a claim to your health plan to pay for any coinsurance using your Smart-Choice card. Doctors often have negotiated reduced rates, so using your Smart-Choice Card at the time of service may result in an overpayment. Once your health plan pays its portion of the claim, your doctor will bill you for your responsibility. At that time, you may use your Smart-Choice Card to pay your portion of the bill.

Important information regarding errors, liability and related disclosures

The following disclosures relate to issues concerning the Smart-Choice Card and certain matters pertaining to it. Any other issues that relate to your spending account (such as benefit eligibility, participation, enrollment, claims or substantiation) that are governed under the terms of your spending account and the Employee Retirement Income Security Act of 1974 (ERISA) will be subject to the dispute procedures available under the plan offered by or through Raytheon Technologies.

Documentation

Information regarding Smart-Choice Card transactions under the plan will either be made available on the Smart-Choice Accounts website or will be mailed to you upon request.

Smart-Choice Accounts liability

If Smart-Choice Accounts doesn't complete a transaction on time or in the correct amount, according to the Cardholder Agreement, it will be liable for your losses or damages. However, some exceptions apply. Smart-Choice Accounts will not be liable if, for example:

- You don't have enough available funds under the plan (through no fault of Smart-Choice Accounts) to make the transaction,
- Smart-Choice Accounts' system wasn't working properly, and you knew about the breakdown before you started the transaction,
- Circumstances beyond Smart-Choice Accounts' control (such as fire or flood) prevented the completion of the transaction, despite reasonable precautions that have been taken, *or*
- Any other exceptions stated in the Cardholder Agreement apply

Confidentiality

Smart-Choice Accounts may disclose information to third parties about your Smart-Choice Card account or the transactions that you make using the Smart-Choice Card under the following circumstances:

- Where it's necessary for completing transactions,
- To verify the existence and condition of your Smart-Choice Card account for a third party, such as a merchant,
- To comply with a government agency or court order,
- As provided in the Cardholder Agreement or in the plan, *or*
- If you give Smart-Choice Accounts your written permission.

In case of errors relating to your Smart-Choice Card

Call Smart-Choice Accounts at the number provided on the back of your Smart-Choice Card as soon as possible if you think a card transaction in the statement or receipt is wrong, or if you need more information about a transaction listed in the statement or receipt. Smart-Choice Accounts must receive notification of any errors no later than **60** days after you received the first statement (either via the Smart-Choice Accounts website or by mail) in which the problem or error appeared. When you contact Smart-Choice Accounts, be prepared to:

- Provide your name and Social Security number and Smart-Choice Card number
- Describe the error or the Smart-Choice Card transaction that you're unsure about, and explain the reason you believe there's an error or why you need more information

- Provide the dollar amount of the suspected error. If you call Smart-Choice Accounts, you may be required to send your complaint or question in writing within **10** business days

Smart-Choice Accounts will determine whether an error occurred within **10** business days after it receives notification from you and will correct any error promptly. If more time is needed to correct the error, however, Smart-Choice Accounts may take up to **45** days to investigate your complaint or question. If this additional time is necessary, Smart-Choice Accounts will credit the monies held by your employer for the amount that you think is in error, so that you will have use of the total amount during the investigation. If Smart-Choice Accounts requests that you put your complaint or question in writing and it doesn't receive the information within **10** business days, Smart-Choice Accounts may not provide this credit.

Smart-Choice Accounts will inform you of the results within **three** business days after completing the investigation. If Smart-Choice Accounts decides that there was no error, a written explanation will be mailed to you, and you will be required to pay back the monies that were credited to your account. You may ask for copies of the documents that were used in the investigation.

Important information regarding electronic delivery of statements and notices

The following paragraph applies to you only if you agree to accept electronic delivery of statements and notices via the Smart-Choice Accounts website.

At your request, Smart-Choice Accounts agrees to provide you with a paper copy of any statement or notice at no additional charge. You can make the request by calling Customer Service between 8 a.m. and 8 p.m., ET, Monday through Friday (excluding applicable holidays), by phone at the telephone number listed on the back of your Smart-Choice Card. You also have the right to withdraw your consent to the electronic delivery of statements and notices at any time by calling Customer Service.

Eligible and ineligible expenses for individuals who are not participating in an HSA-qualified medical plan or are not eligible to contribute to an HSA

If you are not participating in an HSA-qualified medical plan, you may participate in the HCSA and use it to pay for a wide variety of health care expenses that are either not covered or covered only in part under your medical, vision or dental coverage. See below for examples of expenses that are eligible and ineligible to be paid by your HCSA. In some cases, you may be required to complete a letter of medical necessity.

For a full list of eligible expenses, refer to *IRS Publication 502, Medical and Dental Expenses*.

Examples of eligible expenses

- Acupuncture
- Ambulance
- Braille books and magazines, limited to the difference between the cost of the Braille items and the cost for regular items
- Special car controls for those living with a handicap (a letter of medical necessity must be provided)
- Charges in excess of reasonable and customary limits set by your health plan
- Chiropractic, medical or podiatric expenses in excess of medical plan limits
- Copays
- Cost for medical services by Christian Science practitioners
- Contact lenses and supplies, such as saline and cleaning solutions
- Crutches

- Plan deductible and coinsurance amounts
- Deductibles
- Dental examinations, if not reimbursed under a dental plan
- Treatment for drug abuse or alcoholism, including meals and lodging, if they are necessary for the treatment
- Eye surgery
- Prescription eyeglasses, including lenses, frames and exams
- Purchase of a guide dog for a blind or deaf individual
- Health club fees (a letter of medical necessity must be provided)
- Hearing expenses, including examinations, hearing aids and batteries required to operate a hearing aid
- Hospitalization charges in excess of the usual and customary fees, including private room coverage
- Laboratory fees
- Costs for medical services provided by physicians, surgeons, specialists or other medical practitioners
- Medicine or other drugs that require a prescription and are prescribed by a doctor, including birth control pills (**Note:** To comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your pharmacy may not include the prescription drug's name on the prescription label. Since Smart-Choice Accounts needs the name of the drug to ensure it meets IRS eligibility rules, you must include the name of the drug when you submit your claim. If you do not provide the drug's name, your claim will be denied.)
- Mileage to and from medical visits, based on the IRS reimbursement schedule, provided you have a medical receipt
- Expenses for medical care of a dependent in a nursing home
- Nursing services when provided by a registered nurse or licensed practical nurse for medical care
- Services by an optometrist
- Orthodontia
- Orthopedic shoes, orthotics and braces
- Over-the-counter (OTC) health care items that are not medications such as bandages, contact lens solutions, menstrual products, first-aid supplies and thermometers. Expenses for products that are merely beneficial to general health, such as vitamins, toiletries, cosmetics and sundry items, are not eligible for reimbursement
- OTC medications, such as pain relievers, cough suppressants, antihistamines and insulin (a prescription is not required)
- Oxygen or oxygen equipment to relieve breathing problems caused by a medical condition
- Medically necessary psychiatrist/psychologist fees
- Smoking cessation programs
- Purchase or rental of special medical equipment, such as wheelchairs, crutches and orthopedic shoes, if the primary purpose is medical care
- Medical expenses paid to a special school if the main reason for using the school is relieving the medical or physical disability
- Tuition fees for a special school for a learning-disabled child who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders, when recommended by a doctor. Tutoring fees for a teacher specially trained and qualified to work with children with severe learning disabilities are also eligible when recommended by a doctor

- On the recommendation of a psychiatrist, medical expenses paid to a special school for an intellectually and developmentally disabled person to help the person adjust from life in a mental hospital to community living (must be a special school, not the home of a relative)
- Sterilization fees
- Surgery, including experimental procedures
- Special telephone for the deaf, limited to the difference between the cost of the special telephone and the cost for a regular telephone
- Audio display television for the deaf, limited to the difference between the cost of the audio display television and the cost for a regular television
- Medical expenses for therapy received as medical treatment, such as speech, occupational, physical or cardiac therapy
- Weight-loss programs and weight loss medications (a letter of medical necessity must be provided)
- Vaccinations

Examples of ineligible expenses

- Premiums for continued coverage through COBRA
- Cosmetic surgery, except to correct congenital abnormality, bodily injury or disfiguring disease
- Cosmetics, such as toiletries and toothpaste
- Any expense covered by a health plan
- Custodial care in an institution
- Dancing or swimming lessons, even when recommended by a qualified physician to improve health
- Expenses that are filed on a federal tax return for a tax credit or for which a deduction is taken
- Funeral and burial expenses
- Expenditures for the general health of an individual, including expenses related to exercise, fitness, nutrition, recreation, vacation or membership in a spa or health club
- Hair removal (electrolysis)
- Hair transplants
- Health club dues, YMCA dues, steam bath, etc. (unless a letter of medical necessity is provided)
- Household and domestic help, even if recommended by a qualified physician due to an
- individual’s inability to perform physical housework
- Any expenses incurred in connection with an illegal operation or treatment
- Insurance premiums, including premiums for employer-provided medical, dental or vision coverage and for contact lens insurance
- Life insurance premiums or premiums for policies taken to provide repayment for loss of earnings or accidental loss of life, limb, sight, etc.
- Maternity clothes, diaper service, etc.
- Charges by a nurse (RN or LPN) who cares for your normal healthy newborn child
- Costs for sending a child with behavioral or disciplinary problems to a special school for benefits the child may receive from the course of study and disciplinary methods
- Student health fees
- Teeth whitening products or services
- Transportation expenses to and from work, even if a physical condition requires a special means of transportation

- Vacation or travel, when taken for general health purposes, improvement of morale or to relieve physical or mental discomfort
- Vitamins, when taken for general health purposes
- Weight-loss programs and weight loss medications (**Note:** These products are eligible if a letter of medical necessity is provided.)

Eligible and ineligible expenses for individuals who are participating in an HSA-qualified medical plan and eligible to contribute to an HSA

If you are participating in an HSA-qualified medical plan and are eligible to contribute to an HSA, you may still enroll in the HCSA, but are limited to using it for a limited purpose — to pay for dental and vision expenses. See the following list for examples of expenses that are eligible and ineligible to be paid by your HCSA. In some cases, you may be required to complete a letter of medical necessity.

Examples of eligible expenses

- Contact lenses and supplies, such as saline and cleaning solutions
- Dental examinations, if not reimbursed under a dental plan
- Dental or vision plan deductible and coinsurance amounts
- Eye surgery
- Prescription eyeglasses, including lenses, frames and exams
- Services by an optometrist
- Orthodontia

Examples of ineligible expenses

- Any expenses paid through your HSA
- Insurance premiums for continued coverage through COBRA
- Cosmetic surgery, except to correct congenital abnormality, bodily injury or disfiguring disease
- Cosmetics, such as toiletries and toothpaste
- Any expense covered by a health plan
- Expenses that are filed on a federal tax return for a tax credit or for which a deduction is taken
- Expenditures for the general health of an individual, including expenses related to exercise, fitness, nutrition, recreation, vacation or membership in a spa or health club
- Any expenses incurred in connection with an illegal operation or treatment
- Insurance premiums, including premiums for employer-provided dental and vision coverage and for contact lens insurance
- Teeth whitening products or services
- Transportation expenses to and from work, even if a physical condition requires a special means of transportation; and
- Vitamins, when taken for general health purposes

Tax implications

Employee contributions to a spending account are deducted from your pay and are generally excluded from federal income, Social Security, and most states' income taxes.

Under current IRS regulations, you can only deduct from your income tax any eligible health care expenses exceeding 7.5% of your adjusted gross income, provided you're itemizing deductions. However, when you receive reimbursement from the HCSA for these expenses, you give up the opportunity to take a tax deduction on your federal income tax return. Therefore, you must choose whether you want to take the tax deduction or receive reimbursement through the HCSA.

If you don't itemize your tax deductions or if your health care expenses are less than 7.5% of your adjusted gross income, it may be more beneficial to participate in the HCSA. Consult a tax advisor to determine what is best for your situation.

Submitting a claim

If you are notified that you're required to send receipts or other documentation to meet IRS audit requirements, or if you did not use your Smart-Choice Card to pay for an eligible health care expense and would like reimbursement, the Smart-Choice Accounts website offers you the convenience of creating a claim form and submitting documentation online.

Upload, fax or mail

If you need to submit a claim form and/or documentation for reimbursement or validation of an expense on your Smart-Choice Card, you can choose to upload, fax or mail it by following these steps:

- Log on to the Smart-Choice Accounts website which you can access through **Your Gateway**.
- Select Submit Claim, then choose Health Care.
- Select Upload or Send by Fax or Mail.
- Enter the required claim information and review it (you can submit for multiple claims/expenses).
- If you select Send by Fax or Mail, print the claim form and sign and date the printed page. Refer to the section below for more information.
- If you select Upload, follow the on-screen steps to upload the required documentation and submit. To upload, you can either scan the documents or take a picture with your smartphone.

You may also use the Smart-Choice mobile application to:

- Submit health care claims for reimbursement
- Submit documentation by snapping a photo of your receipt(s)
- Gain immediate access to account information
- Get "alerts" about any actions needed

If you don't have internet access, you can obtain a paper claim form by calling Smart-Choice Accounts and then fax or mail the completed claim form with the required documentation of your expenses to Smart-Choice Accounts.

Fax your claim to:
855-673-6719

Mail your claim to:
Smart-Choice Accounts
P.O. Box 64009
The Woodlands, TX 77387-4009

Smart-Choice Accounts will not accept handwritten or verbal information directly from participants. Whether you upload a claim through the website or submit a claim by fax/mail, you must provide itemized receipts or other required documentation for products purchased or services rendered. If a claim is

submitted without itemized documentation, you will be required to provide alternative information that supplies the missing information. If a claim is submitted with illegible documentation, you will have to resubmit the claim with clear, supporting documentation. Information cannot be accepted over the phone. In certain cases, you may have to provide this documentation for verification purposes when using your Smart-Choice Card. If you don't provide this supporting documentation, your claim may not be processed, and you won't be reimbursed.

The following are examples of documents that you may be required to provide for HCSA claim processing:

- EOB from your health plan(s) if the plan(s) partially reimbursed you for an eligible expense
- Itemized bills or receipts for eligible expenses that aren't covered by your health plan(s) (**Note:** Bills should include date of service, description of service or product, provider of service, amount paid, and the recipient of the service.)
- Proof of medical necessity for certain types of expenses

Canceled checks and online bank statements will not be accepted.

Your claim should be processed as soon as administratively possible, and no later than 30 days after Smart-Choice Accounts receives your paperwork. For faster processing, upload your claim form and supporting documentation to Smart-Choice Accounts.

Note

Smart-Choice Accounts makes the final decision as to whether or not a particular service is covered. To determine what is and is not covered under your plan, visit the Smart-Choice Accounts website.

For information about how to appeal a denied claim, see the *Claims* chapter.

Using a DCSA

Key deadline

Date	Why it matters
Dec. 31 of the current plan year	Date eligible child care and adult care expenses must be incurred for them to be payable from your DCSA
April 30 of the following calendar year	Date all claims for reimbursement from your DCSA must be submitted

The IRS "use it or lose it" rule requires you to use all the money in your account(s) to pay for eligible expenses during the plan year. If you don't incur enough eligible expenses to deplete your account by the end of the plan year, you'll forfeit any balance that remains in your account.

Eligible expenses

To be eligible for reimbursement from your DCSA, dependent day care expenses must meet the following criteria:

- They must be employment related. This means the expenses must be incurred in order for you (or you and your spouse if you are married) to work.
- They must be for the care of a dependent either in or outside of your home. Expenses may be for babysitters, companions, eligible day care centers, nursery schools and daytime summer camps. (The expense is not eligible if the person providing the care is someone you claim as a dependent on your income tax return or if the care is provided by your child or stepchild who is under age 19. To be eligible, the dependent, other than children under age 13, must spend at least eight hours a day in your home.)
- An eligible day care center must be properly licensed under all applicable state and local laws, care for six or more individuals and receive a fee for the services.
- If you are married, your spouse must have earned income for the year in which the dependent care expense is incurred, unless your spouse is disabled or a full-time student for at least five months of the year.

Eligible expenses also include FICA and other taxes you pay on behalf of a day care provider or any other expenses that qualify as dependent care under IRS regulations. For a full list of eligible expenses, refer to *IRS Publication 503, Child and Dependent Care Expenses*.

Examples of eligible expenses

- Expenses for an after-school program
- Amounts paid for care performed outside the home for the care of your dependent or disabled spouse. To be reimbursed for expenses incurred by a dependent who is not a qualifying child, the dependent must regularly spend at least eight hours a day in your household
- Amounts paid to a dependent care center, babysitter or nurse who cares for fewer than six individuals
- Expenses for a licensed day care center that cares for six or more unrelated individuals
- Amounts paid to a maid or cook if part of the services are provided to a person who qualifies for dependent care
- The full amount paid to a nursery school (pre-kindergarten), even when the school provides lunch and educational services as long as these services are not itemized on the bill
- Amounts paid to a relative who provides dependent care services, provided the individual is not a dependent for whom a personal exemption deduction is allowed for federal income tax purposes or a child or stepchild who is under age 19 at the end of the calendar year
- Expenses for a summer day camp

Examples of ineligible expenses

- Babysitting expenses, when for non-work or non-school activities
- Care in a convalescent nursing home
- Custodial care for a dependent who resides outside your home
- The cost of food, clothing and education
- Expenses for any kindergarten program
- Overnight camp
- Expenses for any K-12 private schools
- Services provided by one dependent to care for another
- Expenses for which a dependent care tax credit is taken or that are reimbursed under a health care FSA

- Transportation expenses furnished by anyone other than the provider
- Tuition for schooling for the first grade or higher
- Dependent care that allows you or your spouse to do volunteer work

Filing a DCSA claim

After you pay for an eligible dependent care service, and the service has been rendered, you can submit claims to Smart-Choice Accounts for reimbursement. If a claim includes future dates of service, the claim will be denied unless the claim documentation is itemized, in which case the claim will be partially approved up to the date it is being processed. To submit a claim, you must complete a claim form and include acceptable documentation of your eligible expenses. Claims for the current plan year must be submitted by April 15 of the following year.

You can only be reimbursed up to the amount that's available in your account. If you incur expenses that exceed your available funds, future claims will be reimbursed as additional funds accumulate in your account.

The following are examples of documents that you may be required to provide for DCSA claim processing:

- Bills for eligible day care expenses or other proof of payment for services rendered
- Receipts for your payment to a preschool for admission of an eligible dependent

You will have to report the Social Security Number of an individual caregiver or the taxpayer ID of a day care center on your federal income tax returns. The amount you contribute to this account will appear on your Form W-2.

Canceled checks and online bank statements will not be accepted.

There are several ways to submit your claim for reimbursement. The Smart-Choice Accounts website offers you the convenience of creating a claim form and submitting documentation online.

Upload, fax or mail

To get reimbursed for your DCSA claims, you need to send your itemized receipts or other documentation to Smart-Choice Accounts with a completed claim form. You can upload the required documentation on the Smart-Choice Accounts website, or fax or mail it in by following these steps:

- Log on to the Smart-Choice Accounts website which you can access through **Your Gateway**.
- Select Submit Claim, then choose Dependent Care.
- Select Upload or Send by Fax or Mail.
- Enter the required claim information and review it (you can submit for multiple claims).
- If you select Send by Fax or Mail, print the claim form and sign and date the printed page. Refer to the section below for more information.
- If you select Upload, follow the on-screen steps to upload the required documentation and submit. To upload, you can either scan the documents or take a picture with your smartphone.

You may also use the Smart-Choice mobile application to:

- Submit dependent care claims for reimbursement
- Submit documentation by snapping a photo of your receipt(s)
- Gain immediate access to account information
- Get "alerts" about any actions needed

If you don't have internet access, you can obtain a paper claim form by calling Smart-Choice Accounts and then fax or mail the completed claim form with the required documentation of your expenses to Smart-Choice Accounts.

Fax your claim to:
855-673-6719

Mail your claim to:
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The Woodlands, TX 77387-4009

Smart-Choice Accounts will not accept handwritten or verbal information directly from participants. Whether you upload a claim through the website or submit a claim by fax/mail, you must provide itemized receipts or other required documentation for products purchased or services rendered. If a claim is submitted without itemized documentation, you will be required to provide alternative information that supplies the missing information. If a claim is submitted with illegible documentation, you will have to resubmit the claim with clear, supporting documentation. Information cannot be accepted over the phone. In certain cases, you may have to provide this documentation for verification purposes when using your Smart-Choice Card. If you don't provide this supporting documentation, your claim may not be processed, and you won't be reimbursed.

Your claim should be processed as soon as administratively possible, and no later than 30 days after Smart-Choice Accounts receives your paperwork. For faster processing, upload your claim form and supporting documentation to Smart-Choice Accounts.

Note

Expense reimbursement eligibility is based on IRS guidelines. Smart-Choice Accounts follows those guidelines. To determine if an expense is eligible, visit **Your Gateway**.

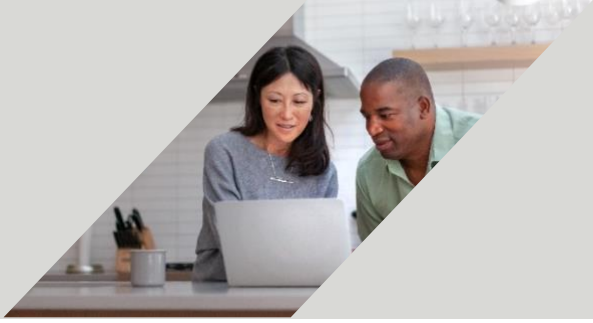
For information about how to appeal a denied claim, see the *Claims* chapter.

Tax implications

The IRS also has tax deduction regulations for eligible dependent care expenses. A portion of these expenses can be claimed as a tax credit on your federal income tax return, whether you itemize your deductions.

However, you can't use eligible expenses that you claim for reimbursement through your DCSA when you calculate the dependent care tax credit on your federal income tax return. This means that your annual contribution to your DCSA must be subtracted from your total dependent care expenses before you can calculate the tax credit. Visit the IRS website at irs.gov for specific information about the tax credit or consult a tax advisor to determine what is best for your situation.

LifeResources



LifeResources, powered by ComPysch, is a work/life support program offered at no cost to you.

In this chapter

All members of your household can access consultations, referrals and free information to help balance all areas of life. LifeResources includes up to 10 counseling sessions per issue per year, at no separate cost to you.

Available support

You and your household members can get support in a variety of areas:

- **Confidential counseling**

  Life can be stressful. That's why LifeResources provides confidential, short-term counseling services, available 24/7 every day of the year. Whether you need guidance mentoring a staff member, help handling a troubled teen or if you're experiencing a stressful work situation, highly trained clinicians will listen to your concerns and provide referrals for face-to-face or virtual services. Clinicians can provide assistance with a variety of issues, including anxiety, depression, stress, grief, loss, life adjustments and relationship/marital concerns. There is no separate cost to you for using this service.

- **Adult and eldercare services**

  To help support adult and elderly dependents, LifeResources includes a wide range of information and resources about caregiving and housing options, chronic illness support, transportation and meal services as well as senior activity groups. If your family member needs more personalized assistance, a LifeResources elder care consultant will work with you to locate a resource that meets your specifications.

- **Child and family care services**

  Services include information, consultation and online resources for adoption, summer camps, daycare, parenting and more. If you need a new or different childcare service — even on short notice — a LifeResources child care consultant will work with you to find options that meet your requirements. The FamilySource program can help parents navigate care for children with special needs.

- **Convenience services**

  Too much to do and too little time to get it all done? The work/life specialists at ComPsych can do the research for you and provide qualified referrals and customized resources for child and elder care, moving, pet care, college planning, home repair, buying a car, planning an event, selling a house and more.

- **Financial services**

  If you have financial questions, you can get answers about budgeting, debt management, tax issues and other money concerns from on-staff certified public accountants (CPAs), Certified Financial Planners® and other financial experts. LifeResources provides tax and investment advice via unlimited, free phone consultations with credentialed financial professionals.

- **Legal support**

  In the event you need legal assistance, you can call LifeResources and speak with an expert about family law matters, including divorce, custody, child support and adoption; bankruptcy and credit issues; landlord/tenant issues, including eviction and lease questions; civil and criminal actions; immigration concerns; wills and living wills. If you need legal representation, the program can refer you to a qualified attorney for a free 30-minute consultation and a 25% reduction in customary legal fees thereafter.

- **GuidanceResources®**

  When you go to liferesourcesray.com, you have access to timely, expert information on thousands of topics, including relationships, work, school, children, wellness, legal, financial and free time. You can

search for qualified child and elder care, attorneys and financial planners, as well as ask questions, take self-assessments, view on-demand trainings and more.

Dedicated support for Raytheon Technologies employees

LifeResources has 15 Consultants supporting 20 Raytheon Technologies sites. These consultants are available to provide counseling for any Raytheon Technologies employee and their immediate family members. In addition, there are two Virtual Consultants for employees who may not have a Virtual Consultant representing their worksite. All Virtual Consultants are licensed counselors. Like with any LifeResources support, all consultations are strictly confidential.

Contact ComPsych to find out if your location has an onsite EAP or how to gain access to the Virtual Consultants.

Using LifeResources

To learn more or to access the services offered through LifeResources, call **866-640-7008** (TTY: **800-697-0353**), toll free, or go to liferesourcesray.com (to register, the company's web ID is **Raytheon**).

When you call, a GuidanceConsultant℠, a master's level counselor, will work with you to answer your questions or help you find solutions to a wide variety of issues. As always, services are confidential and available 24/7. Appointments are offered in-person and virtually.

For expatriate employees on international assignment, call LifeResources collect from outside the U.S. at **+1-312-595-0074** or go to liferesourcesray.com.

Interactive digital tools

LifeResources partners with myStrength® to offer an interactive Computerized Cognitive Behavioral Therapy (CCBT) program, which is designed to help you tackle common challenges, including stress, depression, anxiety and insomnia.

Available anywhere, anytime, this user-friendly digital program is quick, easy and effective. Log on to liferesourcesray.com (to register, the company's web ID is **Raytheon**) and click on the Digital Self-Care Tools box on the homepage for informative interactive programs, in-the-moment coping tools, and inspirational resources on anxiety, chronic pain, depression, mindfulness, sleep, stress and substance-related and addictive disorders.

Note

If you or a covered dependent needs care beyond the 10 free sessions offered by LifeResources can provide, your company-sponsored medical plan provides comprehensive coverage for treatment of mental health and substance-related and addictive disorders. You will be responsible for any applicable costs for care. See the *Medical* chapter for details.

Healthy You Incentives

Being a Healthy You is easy — and rewarding — with Healthy You Incentives! Whether you want to lose weight, stress less, save more or sleep better, reward yourself as you work toward your well-being goals.

In this chapter

Raytheon Technologies provides most U.S.-based employees[1] with access to Healthy You Incentives, even if they're not enrolled in a company medical plan. Spouses/domestic partners, however, must be enrolled in a company medical plan to participate in the program.

Participation in the program is voluntary. You (and your spouse, if applicable) choose from a variety of available activities to earn Healthy You rewards.

[1]Healthy You Incentives is available to active U.S.-based employees. Employees in Puerto Rico, heritage Raytheon Company rehired retirees or employees covered by a collective bargaining agreement at Collins Aerospace Cedar Rapids Union 1362, Coralville Union 1634 or IMS Teamsters Union are not eligible at this time. If you are a union-represented employee, aspects of your benefits are covered by your union contract. Any terms and conditions of employment subject to your union contract will remain in effect through the duration of the contract.

About Healthy You

Healthy You goes beyond the basics of health insurance. Healthy You can help you be the best you can be by offering a wide range of resources to help you achieve a healthy mind, body, wallet and family.

Here are some of the things your Healthy You resources can help you achieve:

- Addressing anxiety, stress and burnout
- Getting better sleep
- Taking time away from work
- Body health (e.g., fitness centers, exercise programs and expert medical opinions)
- Engaging in your well-being
- Finding back-up care (child and adult)
- Growing your family (e.g., adoption, fertility, pregnancy and parenting)
- Mind health (e.g., digital coaching, video visits and live counseling)
- Showing thanks and appreciation
- Wallet health (e.g., savings vehicles, discount programs and financial security)
- And more!

Note

You can listen to podcasts, share and connect with coworkers on the Social page, and more on the Healthy You hub: RTXHealthyYou.com. It's your go-to place to learn about tools and resources to help you achieve a Healthy You.

Healthy You helps you experience the benefits of leading a healthier lifestyle while providing extra motivation and support to maintain those healthy habits. After you set up your Healthy You Incentives account, you can choose the activities that are right for you — and get rewarded for doing them.

Getting started

You will need to create an account on the Healthy You Incentives platform in order to set your login credentials. If you're eligible for Healthy You Incentives, you can:

- Go to **Your Gateway** >Healthy You tab (employees only)
- Visit RTXHealthyYou.com and click the Incentives button on the top right.

Your eligible spouse/domestic partner will need to set up their own account to participate. You can send them an invitation once you've registered and signed in, or they can go to RTXHealthyYou.com.

Take a health assessment

Once you're registered, take your health assessment to create your personalized Healthy You program. The health assessment is a short, confidential[1] questionnaire that covers topics like your nutrition, exercise and sleep habits.

[1]Your individual health information will not be shared with the company. For more information, review privacy notices under Help Center within the Healthy You Incentives platform.

After you complete your health assessment, click on Rewards to see the activities and reward opportunities to choose from to work on a Healthy You. Your program results are based on areas of need as identified through your health assessment.

The amount you are eligible to earn and actually earn during the year depends on your engagement with Healthy You and your activity level on the platform. To earn the maximum rewards, you'll need to complete all Healthy You activities by the end of the year.

Using your rewards

You can redeem rewards as you complete activities, or you can let them accumulate and redeem them later — it's up to you.

You can choose whether you'd like to redeem your rewards as a contribution to your Fidelity HSA, eGift card or charitable donation.

Using rewards to fund your HSA

If you're enrolled in an HSA-qualified medical plan and you've opened your Fidelity HSA, you can use your rewards to fund your HSA. HSA contributions earned through Healthy You Incentives will generally be deposited into your account the month after you select to redeem your rewards as HSA contributions.

Any HSA contributions that your spouse/partner earns through Healthy You Incentives will be deposited into your (the employee's) Fidelity HSA.

Redeeming rewards for gift cards and charitable contributions

Rewards redeemed as gift cards or charitable donations are subject to taxes. The taxes for these rewards will appear on your paycheck as a TFB (i.e., Taxable Fringe Benefit) after you redeem your reward. For example, if you redeem $100 in rewards in May, you will be taxed on the $100 in your June paycheck.

If your spouse/domestic partner also participates in Healthy You Incentives and they redeem rewards as gift cards or charitable donations, the taxes for their rewards will also appear as a TFB on your paycheck.

Note

If you have redeemable rewards in your account at the end of the year, these rewards will remain in your account and will be redeemable the following year.

Life insurance

Life insurance is designed to protect the future of those who depend on your income for support. It provides benefits if you or a covered dependent dies.

In this chapter

Raytheon Technologies offers the following group life insurance plans to benefits-eligible full-time and part-time employees:

- Employee Basic Life Insurance
- Employee Supplemental Life Insurance
- Spouse/Partner Life Insurance
- Child Life Insurance

You are eligible if you are a full-time, active, salaried employee based in the U.S. or serving as a U.S. outbound (expatriate) employee. Certain hourly management-represented and part-time employees are also eligible.

Please refer to the **Group Life Insurance Certificate** from New York Life Insurance Company, our national insurance carrier, for more detailed coverage information about life insurance.

Note

Refer to the *Eligibility and enrollment* chapter for details about who you can cover and when you can enroll and make changes to your benefits.

Generally, you must be actively at work on the day coverage, or an increase in coverage, becomes effective. **Actively at work** means you're performing all material duties of your job in the location where these duties are normally carried out. If you're not actively at work on the date coverage would become effective, it becomes effective on the date you return to active work.

Available coverage

Employee Basic Life Insurance

Raytheon Technologies provides Employee Basic Life Insurance at no cost to you. You may choose from two options.

1. Coverage equal to **one times your annual base pay** (rounded up to the next $1,000). If your annual base pay changes during the year, your Employee Basic Life Insurance coverage amount will be adjusted accordingly. Your annual base pay is defined in the *Eligibility and enrollment* chapter.
2. **Fixed coverage of $50,000** to avoid imputed income. No credit is provided for this level of coverage.

Imputed income

You're required to pay imputed income tax on the cost of any company-paid life insurance in excess of $50,000. See Imputed income in the *Eligibility and enrollment* chapter for more information. If your annual base pay exceeds $50,000, you'll have the option to limit your Employee Basic Life Insurance coverage to $50,000. (Please note that the imputed income is a much lower amount than your actual coverage. It's based on the cost — not the value — of company-provided coverage over $50,000.)

Employee Supplemental Life Insurance

You can increase your life insurance coverage by buying supplemental coverage on an after-tax basis. You can add coverage that's a multiple of your annual base pay, from one times this amount to nine times this amount (rounded up to the next $1,000), up to a maximum of $15 million (including your Employee Basic Life Insurance).

Example

Total combined employee life insurance benefit

If you earn $99,400 in annual base pay, here's how much life insurance coverage you'd have if you elect basic coverage of one times your pay and supplemental coverage of two times your pay:

Employee Basic Life Insurance (company pays for your coverage)	**$100,000**
Employee Supplemental Life Insurance (you pay for your coverage)	**$199,000**
Total employee life insurance benefit	**$299,000**

If your annual base pay changes during the year, your Employee Supplemental Life Insurance coverage amount (and the paycheck premium charged) will be adjusted accordingly.

Your paycheck premium depends on the amount of coverage you choose, your age as of Jan. 1 of the coverage year and your tobacco user status. If you don't use tobacco products, your premium will be lower.

Spouse/Partner Life Insurance

Spouse/Partner Life Insurance assists you with the additional expenses you may have if your spouse or partner dies. You need to decide whether you want this coverage and, if you do, which coverage level is right for you. Spouse/Partner Life Insurance paycheck premiums are paid on an after-tax basis.

The following coverage options are available:

- $10,000
- $25,000
- $50,000
- $100,000
- $150,000
- $200,000
- $250,000

Your paycheck premium depends on the amount of coverage you elect, your spouse's or partner's age as of Jan. 1 of the coverage year and their tobacco user status. If they don't use tobacco products, your premium will be lower.

For details about spouse/partner eligibility, see Dependent eligibility in the *Eligibility and enrollment* chapter.

Child Life Insurance

You may purchase life insurance for your eligible dependent children. The following coverage options are available (amounts are per child):

- $2,500
- $5,000
- $10,000
- $15,000
- $20,000
- $25,000

Your paycheck premium depends on the amount of coverage you elect. The premium is a group rate that covers all eligible children, regardless of the number of children in your family. For details about child eligibility, including when coverage starts and ends, see Dependent eligibility in the *Eligibility and enrollment* chapter.

Evidence of Insurability (EOI)

Employee Supplemental Life Insurance EOI

When you first become eligible to enroll in Employee Supplemental Life Insurance (for example, when you're hired, during Annual Enrollment, when you have a qualified change in status or if you switch from part-time working fewer than 20 hours to full- or part-time status), you can enroll in supplemental coverage for the first time or increase your current coverage by one level without providing EOI as long as your total election doesn't exceed $1.5 million in total supplemental coverage. You must enroll within 31 days of becoming eligible.

If you initially elect supplemental coverage that's greater than one times your annual base pay, or if you elect coverage that is greater than $1.5 million, you must provide EOI that's satisfactory to New York Life.

During future Annual Enrollment periods or when you have a qualified change in status (as summarized in the *Eligibility and enrollment* chapter), you can enroll in supplemental coverage for the first time or increase your current coverage without EOI as long as your total election doesn't exceed one times your annual base pay, up to a maximum of $1.5 million in total supplemental coverage.

You'll need to provide EOI if you elect or increase your supplemental coverage to more than one times your annual base pay or more than $1.5 million in total supplemental coverage.

If EOI is required, the increased coverage won't begin until the medical information has been approved by New York Life. If you don't provide EOI when required, you'll be assigned the highest coverage available

without EOI. Once the medical information is approved, coverage is effective the first of the month following the date the EOI was approved.

Spouse/Partner Life Insurance EOI

EOI will be required if you elect spouse or partner life insurance coverage of $25,000 or more when you're first eligible to enroll. If you wait to elect coverage during Annual Enrollment or when you have a qualified change in status (as summarized in the *Eligibility and enrollment* chapter), you can add or increase coverage for your spouse or partner to $25,000 without EOI.

You'll need to provide EOI for coverage elections or increases above $25,000. If EOI is required, the increased coverage begins the first of the month following the date your spouse's/partner's medical information is approved by New York Life. Until EOI is approved, or if your spouse/partner fails to provide the medical information when required, coverage defaults to the highest level of coverage that does not require EOI.

Child Life Insurance EOI

No EOI is required for child life insurance coverage.

Beneficiaries

Employee Basic and Supplemental Life Insurance beneficiaries

Any life insurance amount payable as a result of your death is payable to the beneficiaries you designate. You can have different beneficiaries for Employee Basic Life Insurance and Employee Supplemental Life Insurance. Your beneficiary may be any person, a trust, an estate, a charity or other legal entity.

In most cases, you may, without the consent of your beneficiaries, change your designations at any time by filing a new beneficiary form online via **Your Gateway**. The change will be effective on the date you change your beneficiary online via **Your Gateway**.

If, at the time of your death, there is no designated beneficiary on file for all or any part of your coverage, or if there is no named beneficiary living at the time of your death, the insurance will be paid, at the option of New York Life, in the following order:

- Surviving lawful spouse
- Surviving child(ren)
- Surviving parent(s)
- Surviving sibling(s)
- Employee's estate

Spouse/Partner and Child Life Insurance beneficiaries

You are automatically the beneficiary for Spouse/Partner and Child Life Insurance. However, you may name another beneficiary if you choose.

Submitting life insurance claims

If you die, your beneficiary may request benefits by notifying the Human Resources Department and by calling the Advocacy Support Center at **800-828-8100**. The Advocacy Support Center will assist your beneficiary with all required steps to receive any benefits that may be due to them.

If your spouse, partner or child dies and is covered under life insurance through Raytheon Technologies, you may contact the New York Life Counseling and Administration Service Center at **800-858-9203**. New York Life provides benefit counseling, completes claim paperwork and coordinates the life insurance claim on your behalf.

See the *Claims* chapter for more information on submitting claims, as well as the process for appealing denied claims.

Accelerated death benefits option

If you or your spouse or partner become terminally ill — as diagnosed by two unaffiliated physicians — with 12 months or less to live, you may apply to receive accelerated death benefits.

You may be eligible for:

- Up to 80% of your Employee Basic Life Insurance to maximum of $500,000, and
- Up to 80% of your Employee Supplemental Life Insurance to a maximum of $500,000

Your spouse or partner may be eligible to receive up to 80% of their life insurance.

When an accelerated benefit payment is made, life insurance coverage is reduced by that amount and your beneficiaries will receive the remaining balance upon the death of the insured.

How benefits are paid

When New York Life receives a certified copy of your death certificate (or your dependent's death certificate, as appropriate) and any other information or forms it may request in connection with the claim, the amount of life insurance designated to each beneficiary is generally paid out in a lump sum. However, another payout option may be available through the New York Life GBS Assurance Program.

Note

In the event of your death or a dependent's death while wearing a seat belt or wearing a motorcycle or bicycle helmet, an additional life insurance benefit equal to 10% of the coverage amount will be paid to the designated beneficiary.

New York Life GBS Assurance Program

If you choose — and wherever permitted by state law — life insurance proceeds of $5,000 or more may be deposited into a personalized checking account so that you or your beneficiary can write checks from $250 up to the full amount of the life insurance proceeds.

The New York Life GBS Assurance Program is an optional program that provides all the features, benefits and materials necessary to guide beneficiaries in the management of their accounts. Other important benefits include:

- One-on-one bereavement counseling
- Legal assistance
- Financial planning advice

This program allows the beneficiary to defer important decisions at a difficult time, while still providing security and immediate access to funds.

The New York Life Assurance accounts offer a competitive money market rate guaranteed to equal or exceed the previous week's Bank Rate Monitor (BRM) Index.

Beneficiaries receive monthly statements for their New York Life Assurance accounts showing the balance, any withdrawals and the interest earned. On a yearly basis, beneficiaries receive 1099 income tax forms showing the interest earned on the account that has been reported to the IRS.

Checking privileges are cost-free, with no maintenance charges, per-check fees or penalties for withdrawal. However, there are nominal charges for checks returned unpaid, stop payments and extra copies of a check or monthly statement.

Beneficiaries may maintain a balance in their accounts for as long as they want. However, if an account balance falls below $250, the remaining balance will automatically be sent to the beneficiary in the form of a check, and the account will be closed.

Waiver of premium

If you become totally and permanently disabled for six months or more and are unable to work, your Employee Supplemental Life Insurance, Spouse/Partner Life Insurance and Child Life Insurance will be continued at no cost to you until age 65 — for as long as you remain totally disabled and continue to provide proof of disability to New York Life.

Totally and permanently disabled means you are completely unable to engage in any occupation for wage or profit because of injury or sickness that is expected to last for the rest of your life.

Once you have been totally and permanently disabled for at least six months, the Counseling and Administration Service Center will send you a *Waiver of Premium* claim form. You must mail the form to New York Life, who must approve you for this benefit, and you must continue to pay your paycheck premiums until you are approved. Contact the Counseling and Admin Service Center at **800-858-9203** with questions.

Note

If you are disabled, on a MetLife-approved waiver of premium and terminate your employment prior to age 65, the amount of your active employee optional life insurance coverage will continue under the provisions of the waiver of premium until your waiver ends. The date your waiver ends varies depending on your disability status, your coverage when you were an active employee and plan provisions.

When your waiver of premium ends, you are eligible to convert or port your active employee optional life insurance coverage.

For questions related to a waiver of premium, call MetLife at **877-ASKMET7** (**877-275-6387**).

Assignment of insurance

You may make an irrevocable assignment of your Employee Basic Life Insurance and Employee Supplemental Life Insurance. This means that you may name someone else as the owner of the policy on your life. Spouse/Partner Life Insurance and Child Life Insurance are not assignable.

If you make an assignment, you may not change or cancel it. The person you assign your insurance to has the absolute and continuing right to name beneficiaries and to exercise any other privileges that would otherwise have been available to you.

Because of the various legal and tax implications involved, you should consult both your lawyer and tax advisor before taking this action to help you determine the consequences of assigning your coverage. If you wish to make an assignment, you must speak with a Benefits Advocate by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**. Raytheon Technologies and New York Life do not accept any responsibility for any assignment.

When coverage ends

Employee Basic Life Insurance and Employee Supplemental Life Insurance will end on the earliest of the following dates:

- The last day of the payroll period in which your employment ends for any reason, unless you are totally disabled (on severance in the case of Employee Basic Life Insurance)
- The last day of the payroll period in which a qualified change in status results in the cancellation of coverage
- December 31 of the current year, in the case of cancellation during Annual Enrollment for the next plan year
- When you are no longer an eligible employee
- The date the group contract is discontinued
- You die

Spouse/Partner Life insurance and Child Life Insurance will end on the earliest of the following dates:

- The date your life insurance coverage ends
- The last day of the payroll period in which you made the required contribution
- The last day of the payroll period in which your spouse/partner and/or child ceases to meet the eligibility requirements of the plan
- The last day of a payroll period in which a qualified change in status results in the loss of a covered dependent

Life insurance portability

The life insurance portability feature is available to you if your employment ends or you are no longer an eligible employee. This feature offers you the convenience and security of continuing your life insurance coverage for yourself and your covered dependents at group rates on a direct bill basis, regardless of your health condition.

Employee Basic Life Insurance, Employee Supplemental Life Insurance, Spouse/Partner Life Insurance and Child Life Insurance are portable. This means that if you leave Raytheon Technologies for any reason, you can continue coverage until you or your spouse/partner reach age 80 or your child reaches age 70.

You will be required to pay the appropriate premiums to ensure continuation of coverage. The premium rates for continuing coverage are higher than what you pay as an active employee. However, they are significantly lower than what you would pay to convert to an individual policy (see Conversion to an individual policy below).

You do not have to provide Evidence of Insurability (EOI) to continue coverage. However, you have only 62 days from the date your coverage ends to apply for coverage under the portability provision.

To port, you should complete the life insurance portability form — called the *Application for Continuation of Insurance* — and send it to the address on the form. This form is sent to you by the Raytheon Technologies Benefits Center when your coverage terminates.

Conversion to an individual policy

If your coverage ends, you may convert all or part of your life insurance to any type of individual coverage offered by New York Life. Your cost will depend on the type and amount of insurance you choose and its rate for your age when you make the conversion. Evidence of Insurability (EOI) will not be required.

To convert, you must complete the conversion form within 62 days after your life insurance coverage ends. Several provisions apply:

- If you become eligible for coverage under any group life policy during the 62-day period, you may only convert the difference between your current coverage and your new group coverage.
- If you die during this 62-day period, your life insurance amount in effect on your last day of work will be paid to your beneficiary.
- If your coverage ends because the group contract is discontinued, the amount you may convert will be limited by the terms of the group contract.

If your group coverage ends, you will pay more to continue Employee Basic Life Insurance, Employee Supplemental Life Insurance, Spouse/Partner Life Insurance or Child Life Insurance under an individual converted policy than to continue coverage under the life insurance portability provision (refer to Life insurance portability above).

Here's a comparison between the portability feature and the conversion option.

	Portability	Conversion
Cost	Portable pool (group) rates based on age	Individual rates based on age
Coverage	Term Life policy	Permanent Life
Continuation period	Employee or spouse/partner: To age 80 Child(ren): To age 70	Varies based on converted policy provisions
EOI	None	None

Note

This summary and the **Life Insurance Company of North America Life Insurance Policy** and **Group Life Insurance Certificate** comprise the summary plan description for the Raytheon Technologies Employee Basic, Employee Supplemental, Spouse/Partner and Child Life Insurance plans as of Jan. 1, 2023.

Accidental Death and Dismemberment (AD&D) insurance

In the event of serious accidental injury or death, Accidental Death and Dismemberment (AD&D) coverage provides insurance protection — 24 hours a day, whether at work, at home or while traveling.

In this chapter

Raytheon Technologies offers the following group AD&D insurance plans to benefits-eligible full-time and part-time employees:

- Employee Basic AD&D Insurance
- Employee Voluntary AD&D Insurance
- Spouse/Partner AD&D Insurance
- Child AD&D Insurance

You are eligible if you are a full-time, active, salaried employee based in the U.S. or serving as a U.S. outbound (expatriate) employee. Certain hourly management-represented and part-time employees are also eligible.

Please refer to the **Certificate of Insurance** from National Union Fire Insurance Company of Pittsburgh, Pa., an AIG company, for more detailed coverage information.

Note

Refer to the *Eligibility and enrollment* chapter for details about who you can cover and when you can enroll and make changes to your benefits.

Generally, you must be actively at work on the day coverage, or an increase in coverage, becomes effective. "**Actively at work**" means you're performing all material duties of your job in the location where these duties are normally carried out. If you're not actively at work on the date coverage would become effective, it becomes effective on the date you return to active work.

Available coverage

Employee Basic AD&D Insurance

Raytheon Technologies provides Employee Basic AD&D Insurance at no cost to you. Coverage is equal to **one times your annual salary** (rounded up to the next $1,000), up to a combined maximum of $15 million for Employee Basic AD&D and Employee Voluntary AD&D Insurance.

If your annual salary changes during the year, your Employee Basic AD&D Insurance coverage amount will be adjusted accordingly. Your annual salary is defined in the *Eligibility and enrollment* chapter.

Employee Supplemental (Voluntary) AD&D Insurance

Employee Supplemental AD&D refers to the Voluntary AD&D policy offered through AIG. You can increase your AD&D coverage by buying voluntary coverage on a pre-tax basis. Evidence of Insurability (EOI) is not required, even if you change your coverage during future Annual Enrollment periods or have a qualified change in status (as summarized in the *Eligibility and enrollment* chapter).

For Employee Voluntary AD&D Insurance, you may elect a coverage amount of **one to five times your annual salary** (rounded up to the next $1,000), up to a combined maximum of $15 million for Employee Basic AD&D and Employee Voluntary AD&D Insurance.

If your annual salary changes during the year, your Employee Voluntary AD&D Insurance coverage amount (and the paycheck premium charged) will be adjusted accordingly.

Note

You must elect Employee Voluntary AD&D Insurance to purchase voluntary AD&D coverage for your spouse/partner or children.

Spouse/Partner AD&D Insurance

If you choose Spouse/Partner AD&D Insurance, their coverage is equal to **60%** of your Employee Voluntary AD&D Insurance coverage amount, up to a maximum of $250,000.

For details about spouse/partner eligibility, see Dependent eligibility in the *Eligibility and enrollment* chapter.

Child AD&D Insurance

If you choose Child AD&D Insurance, their coverage is equal to **20%** of your Employee Voluntary AD&D Insurance coverage amount, up to a maximum of $25,000.

Your paycheck premium is a group rate that covers all eligible children, regardless of the number of children in your family. For details about child eligibility, including when coverage starts and ends, see Dependent eligibility in the *Eligibility and enrollment* chapter.

Example

If your Employee Voluntary AD&D Insurance coverage amount is $500,000, your spouse/partner coverage is 60% of that amount, or $300,000 ($500,000 x .60 = $300,000).

Child coverage would be 20%, or $100,000 ($500,000 x .20 = $100,000).

Your cost of coverage

There is a flat rate for each thousand dollars of coverage. For specific rates, visit **Your Gateway**.

Your annual cost for coverage is determined using the following calculation:

Your annual salary	**Multiplied by**	The amount of coverage you elect	**Rounded up to**	The next highest $1,000	**Divided by**	1,000	**Multiplied by**	The rate for your coverage

Example

You elect Employee Voluntary AD&D Insurance coverage of three times your annual base pay of $54,400:

Annual salary x elected coverage amount	**$54,400 x 3 = $163,200**
Rounded up to the next highest $1,000	**$164,000**
Divided by 1,000	**164**
Multiplied by your coverage rate (the rate applies per $1,000 of coverage)	**164 x $0.264 per $1,000 of coverage and assuming you also elected Spouse/Partner AD&D insurance) = $43.30 per year**

How benefits are paid

AD&D provides benefits if you or your insured dependents die; lose a limb, sight, speech or hearing; suffer severe burns; or become paralyzed as a result of a covered accidental injury.

Separate payouts

Employee Basic AD&D Life Insurance is *paid out separately* from any voluntary coverage you purchase. Your total coverage (one times your annual salary) is your **Principal Sum**.

Additionally, if you elect Voluntary AD&D Insurance:

- For yourself, the total amount of **Employee Voluntary AD&D Insurance** you elect (one to five times your annual salary) is your **Principal Sum**.
- For your dependents, benefits for serious accidental injuries or death are a percentage of your Employee Voluntary AD&D Insurance Principal Sum — 60% for Spouse/Partner AD&D Insurance and 20% for Child AD&D Insurance. Any benefits paid to your insured dependents, including additional

benefits listed later in this document, are based on your Employee Voluntary AD&D Insurance Principal Sum amount.

The following table shows the benefits payable under AD&D coverage. Remember, payout for any voluntary AD&D coverage you elect is in addition to, and separate from, your payout for Employee Basic AD&D Insurance.

If due to a covered accident:	Principal Sum paid*
Death	**100%**
If due to a covered accident, loss of:	**Principal Sum paid***
Both hands or both feet	**100%**
Sight of both eyes	**100%**
One hand and one foot	**100%**
One hand and the sight of one eye	**100%**
One foot and the sight of one eye	**100%**
Speech and hearing in both ears	**100%**
Permanent total loss of use of both arms and both legs	**100%**
Permanent total loss of use of both arms or both legs	**75%**
Permanent total loss of use of one arm and one leg	**75%**
One hand, one foot or sight in one eye	**50%**
Speech	**50%**
Hearing in both ears	**50%**
Permanent total loss of use of one arm or one leg	**50%**
Thumb and index finger of one hand	**25%**
Hearing in one ear	**25%**

*Benefits for covered dependents are a percentage of the Principal Sum listed — 60% for spouse, 20% for children.

AD&D also pays benefits if you, your insured spouse/partner or child suffer a severe burn, as shown in the table below:

Specified body area	Principal Sum[1] paid
Face, neck and head	**99%**
Hand and forearm, below elbow joint (right or left)	**22.5%**
Upper arm, below shoulder joint to elbow joint (right or left)	**13.5%**
Torso, below neck to shoulder joints and hip joints (front or back)	**36%**
Thigh, below hip joint to knee joint (right or left)	**9%**
Foot and lower leg, below knee joint (right or left)	**27%**

[1]Benefits for covered dependents are a percentage of the Principal Sum listed — 60% for spouse, 20% for children.

Note

Any loss or injury must occur within one year of the accident. If you suffer more than one loss in any one accident, only the largest eligible percentage for any one injury will be paid.

Definitions

Loss means:

- **For a hand or a foot:** Complete severance through or above the wrist or ankle joint
- **For sight of an eye:** Total and irrecoverable loss of the entire sight of that eye
- **For hearing in an ear:** Total and irrecoverable loss of the entire ability to hear in that ear
- **For speech:** Total and irrecoverable loss of the entire ability to speak
- **For thumb and index finger:** Complete severance through or above the metacarpophalangeal joint of both digits
- **For loss of use of an arm:** Loss of use of the entire arm from the shoulder joint, including the attached hand
- **For loss of use of a leg:** Loss of use of the entire leg from the hip joint, including the attached foot
- **For permanent total loss of use:** In this case, loss means complete and irreversible loss of functional, normal or characteristic use of the entire arm or leg due to:
  - Complete and irreversible paralysis;
  - Atrophy; or
  - An arthritic condition
- The injury resulting in permanent total loss of use must occur within 365 days of the accident that caused the injury (**Note:** The loss must continue for 12 consecutive months before payment can be made, except in the case of complete and irreversible paralysis, where there is no 12-consecutive-month waiting period.)

Additional AD&D benefits

Bereavement and Trauma Counseling

AD&D insurance provides benefits for counseling if you or an insured dependent suffer death, dismemberment, coma or loss of use as the result of a covered accident. AD&D insurance will pay up to $150 per counseling session for a maximum of 10 sessions for you and/or your insured dependents **combined** with respect to all losses caused by the same accident. Counseling expenses must be incurred within one year of the date of the covered accident.

Bereavement and trauma counseling expenses related to or resulting from any condition for which you are paid benefits under the Workers' Compensation Act or similar law are not covered.

Carjacking Benefit

If you or an insured dependent experience a covered loss as a result of a carjacking, AD&D insurance pays an **additional** benefit of 10% of the largest Principal Sum under the accidental death, accidental dismemberment, coma or loss of use benefit, up to a maximum of $50,000. Only one benefit per insured person is payable for all losses as a result of the carjacking.

Children's Additional Indemnity for Dismemberment and Loss of Use Benefit

When an insured dependent child suffers a covered accidental dismemberment or loss of use, Voluntary AD&D insurance pays an **additional** benefit equal to the amount payable under the accidental dismemberment or loss of use benefit.

Coma Benefit

If you or an insured dependent become comatose within 90 days of the date of a covered accident that caused the injury — and if the coma continues for a period of 30 consecutive days — AD&D insurance pays a monthly benefit of 1% of your Principal Sum (or the applicable percentage of the Principal Sum for insured dependents) for up to 100 months. No benefit is provided for the first 30 days of the coma.

Benefits end on the earliest of the following dates:

- The date the person is no longer comatose due to that injury,
- The date the insured person dies. or
- The date the total amount of monthly coma benefits paid for all injuries caused by the same accident equals 100% of your Principal Sum (or the applicable percentage of the Principal Sum for your insured dependents).

Common Disaster Benefit

If you and your insured spouse both die within 90 days of the same accident — and a Voluntary AD&D benefit is payable for both of you — your spouse's benefit amount is increased to equal 100% of your Principal Sum.

Day Care Benefit

If you die in a covered accident, Voluntary AD&D insurance pays benefits for day care expenses for your insured dependent children under age 13 who are enrolled in a day care facility or who enroll within 90 days of your death. The maximum benefit payable for each eligible child is the lesser of the actual cost the day care center charges that year for your dependent child's care — 5% of your Voluntary AD&D Principal Sum or $7,500 per year for a maximum of four years.

Elder Survivor Benefit

If you die in a covered accident, Voluntary AD&D insurance pays a benefit equal to 10% of your Voluntary AD&D Principal Sum, up to a maximum of $50,000, to or on behalf of any surviving elder dependent. **Elder dependent** means your parent, parent-in-law, grandparent, grandparent-in-law, great-grandparent or great-grandparent-in-law (whether natural, step or adoptive) who is primarily dependent upon you for support and maintenance.

Family Extension Benefit

If you die in a covered accident, any voluntary AD&D coverage for your dependents who remained insured from the date of the accident to your date of death will continue at no cost until the earliest of:

- Twelve months from your date of death
- The date your insured spouse remarries or the date your insured domestic partner enters into another domestic partnership or remarries
- The date your insured dependent child is no longer a dependent
- The date the policy ends

Group Medical/Dental Premium Continuation Reimbursement Benefit

If you elected Voluntary AD&D insurance for your dependents and die in a covered accident, your insured spouse/ partner and/or insured children are eligible to receive an amount equal to the lesser of the cost of the COBRA premium for continued coverage or 10% of your Voluntary AD&D Principal Sum. The maximum benefit is $10,000 per year, for up to three consecutive years, to pay for premiums to continue group medical and/or dental coverage provided by Raytheon Technologies.

Home Alteration and Vehicle Modification Benefit

AD&D insurance pays a one-time benefit for covered home alteration and vehicle modification required if you or an insured dependent require use of a wheelchair due to dismemberment or loss of use from a covered accident, provided use of a wheelchair was not required prior to the accident.

The maximum benefit under this provision is $25,000 for all losses caused by the same accident and incurred within one year of the covered accident.

Covered home alteration and vehicle modification expenses do not include any expenses for or resulting from any condition for which the insured person is paid benefits under the Workers' Compensation Act or similar law.

Permanent Total Disability

If you or an insured dependent are under age 70 and suffer a covered permanent total disability within a year of the covered accident, AD&D insurance pays a monthly benefit equal to 1% of your Principal Sum (or the applicable percentage of the Principal Sum for your insured dependent) starting with the 13th consecutive month of the covered permanent total disability.

Permanent total disability means that the insured person is permanently unable to perform the material and substantial duties of any occupation for which the person is qualified by reason of education, experience or training.

Benefits are payable after the insured person has remained permanently totally disabled for at least 12 consecutive months. The permanent total disability benefit continues until the earliest of the date the insured person:

- Is no longer permanently totally disabled;
- Dies; or
- Receives the permanent total disability benefit maximum — an amount equal to 100% of your Principal Sum (or the applicable percentage of the Principal Sum for your insured dependent).

Rehabilitation Benefit

AD&D insurance pays benefits for medically necessary rehabilitation expenses required if you or an insured dependent suffer a dismemberment or loss of use due to a covered accident. Expenses must be incurred within two years of the covered accident. The maximum benefit under this provision is $25,000 for all injuries caused by the same accident.

Rehabilitative expenses related to or resulting from an injury for which the insured person is paid benefits under the Workers' Compensation Act or similar law are not covered.

Seat Belt and Air Bag Benefit

AD&D insurance pays an additional seat belt and/or air bag benefit if you or an insured dependent suffer a covered accidental death while operating or riding in a private passenger automobile.

The **seat belt benefit** is payable if the death occurs while wearing a properly fastened, original, factory-installed seat belt. Children must be in a properly installed and fastened child-restraint device as defined by state law. If proper seat belt use is verified, AD&D insurance pays an additional benefit equal to 25%, up to a maximum of $100,000, of your Principal Sum (or the applicable percentage of the Principal Sum for your insured dependent).

The **air bag benefit** is payable if the death occurs while in a seat protected by a properly functioning, original, factory-installed air bag that inflated upon impact in the same accident. In this case, AD&D insurance pays an additional benefit equal to 10%, up to a maximum of $50,000, of your Principal Sum (or the applicable percentage of the Principal Sum for your insured dependent).

Travel Benefits

You, as well as any dependents insured in voluntary AD&D coverage, have access to AIG Accident and Health travel benefits while **more than 100 miles** from either your home or place of employment.

Emergency Evacuation Benefit

AD&D insurance will pay benefits for covered emergency evacuation expenses for a medically necessary evacuation if you or an insured dependent suffer an injury or emergency sickness more than 100 miles from home or workplace.

A **medically necessary evacuation** is one ordered by a physician due to the severity of the accident or emergency sickness.

AD&D insurance will also pay benefits equal to the cost of an economy-class airfare ticket to:

- Return your dependent children, who were traveling with you, to your home (in this case, a one-way economy airfare may apply)
- Bring one person to and from the hospital or other medical facility where the insured person is confined (in this case, a single round-trip economy airfare may apply)
- Bring one non-medical person from the place of the medical emergency to the place where the insured person is evacuated (not to exceed the cost of an economy-class round-trip airfare ticket)

Note

Travel benefits also include emergency travel assistance, VIP concierge services, worldwide travel assistance, travel medical assistance and security assistance (including if you or your insured dependent are a victim of identity theft). **For covered expenses to be paid, all arrangements must be made by AIG Travel.** Travel Guard® provides details, including how to register for AIG Travel Service benefits.

Repatriation of remains benefit

If you or an insured dependent die in a covered accident or due to an emergency sickness while more than 100 miles from home or workplace, AD&D insurance pays benefits for covered expenses to return the body home. Covered expenses include:

- Embalming or cremation
- The most economical coffin or receptacle adequate for transportation of the remains
- Transportation of the remains by the most direct and economical method of transportation and route possible

Tuition benefit

If you have Voluntary AD&D coverage for your family and die in a covered accident, your insured spouse and insured dependent children through the age of 26 are eligible to receive an additional benefit so they can enroll or continue their education in an institution of higher learning. To receive this benefit, your dependent(s) must have been covered by the plan at the time of your death. An **institution of higher learning** means any accredited institution that provides education or training beyond the twelfth-grade level, including but not limited to, any state university, private college or trade school.

The maximum benefit is equal to the lesser of:

- The actual tuition (excluding room and board);
- 5% of your Principal Sum; or
- $7,500 per year for dependent children and $5,000 per year for your spouse.

Benefits are payable for up to four consecutive years. Proof of enrollment in an institution of higher learning is required.

Exclusions

Benefits **are not paid** for death or injury caused by or resulting from:

- Full-time **active duty in the armed forces**, National Guard or organized reserve corps of any country or international authority (**Note:** Any unearned premium for a period the insured person is not covered due to their active-duty status will be refunded.)
- Commission of or attempt to commit a **felony**
- **Sickness, disease or infections** of any kind (**Note:** Exceptions include bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning.)
- **Suicide** or **intentionally self-inflicted injury**, or attempted suicide or intentionally self-inflicted injury

Beneficiaries

Any AD&D insurance amount payable as a result of your death is payable to the beneficiaries you designate. You can have different beneficiaries for Employee Basic AD&D Insurance and Employee Voluntary AD&D Insurance. Your beneficiary may be any person, a trust, an estate, a charity or other legal entity.

You are automatically the beneficiary for Spouse and Child AD&D Insurance in the event of their death. However, you may name another beneficiary if you choose.

Benefit payments for all other losses are paid to the person who suffered the loss. If that person is a minor child or not competent to give a valid release for payment, the payment is made to the individual's legal guardian.

In most cases, you may, without the consent of your beneficiaries, change your designations at any time by filing a new beneficiary form online via **Your Gateway**. The change will be effective on the date you change your beneficiary online via **Your Gateway**.

Submitting AD&D claims

You or your beneficiary may request benefits by notifying the Human Resources Department and by calling the Advocacy Support Center at **800-828-8100**. The Advocacy Support Center will assist you or your beneficiary with all required steps to receive any benefits that may be due.

See the *Claims* chapter for more information on submitting claims, as well as the process for appealing denied claims.

When AD&D coverage ends

AD&D coverage for you and your insured dependents will end when you:

- Terminate employment or retire
- Retire (coverage generally ends at the end of the month that your last day of employment occurs)
- No longer meet the plan's eligibility requirements
- Fail to pay the required paycheck premiums for voluntary AD&D coverage

Coverage also will end if the AD&D plan is terminated for all employees.

Conversion to an individual policy

You may convert your coverage to an individual policy if you are on a medical or workers' compensation leave of absence for 12 or more months or if you leave the company prior to age 79 for any reason (including retirement).

To apply for conversion, you must speak to a Benefits Advocate by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135** to request a conversion application within 31 days from the date your coverage will end. For your application to be considered, it must be completed and returned to the address on the form within 31 days of the date your coverage ends.

Note

This summary and the **Certificate of Insurance** from National Union Fire Insurance Company of Pittsburgh, Pa., an AIG company, comprise the summary plan description for the Raytheon Technologies Accidental Death and Dismemberment Plan as of Jan. 1, 2023.

IMPORTANT: This program provides accident insurance only. It does not provide comprehensive/major medical coverage and does not satisfy the minimum essential coverage requirements of the Patient Protection Affordable Care Act.

This is a brief description of the coverage(s) available under policy series C11656(REV 3-99) DBG-MA and C11656(REV 3-99) DBG-MA (905931A). The Policy contains reductions, limitations, exclusions, definitions and termination provisions. Full details of the coverage are contained in the Policy. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance underwritten by National Union Fire Insurance Company of Pittsburgh, Pa., a Pennsylvania insurance company, with its principal place of business at 1271 Ave of the Americas, 41st Floor, New York, NY 10020. It is currently authorized to transact business in all states and the District of Columbia. NAIC No. 19445. Travel Assist services are provided by Travel Guard Group, Inc., an AIG company.

Business Travel Accident insurance

All employees are automatically enrolled in Business Travel Accident (BTA) Insurance on their first day of work. The cost is paid entirely by Raytheon Technologies, and there are no enrollment forms to complete.

In this chapter

BTA Insurance provides benefits if you are injured or die as a result of a covered accident while traveling on company business, including travel between company facilities.

Your company-provided coverage

Your coverage

Your coverage is equal to **four times your annual salary** (rounded to the next highest $1,000), with a minimum of $50,000 and a maximum of $5 million. (Benefits may vary depending on your position or location.) This amount is called your **Principal Sum**.

Note

There is a $15 million combined maximum for Basic AD&D and BTA coverage.

Dependent coverage

Benefits are payable if your spouse and/or dependent children experience accidental death or dismemberment in a covered accident while traveling with you on company business, while on their way to join you or while relocating. These benefits are based on the amount of your BTA coverage.

- **Spouse** coverage is equal to **50%** of your Principal Sum, up to a maximum of $250,000.
- **Dependent children** coverage is equal to **10%** of your Principal Sum, up to a maximum of $50,000.

Additional Principal Sum for injuries sustained from a test aircraft

An additional Principal Sum amount of $500,000 applies if a covered injury is sustained while boarding, operating, riding or alighting from any aircraft being used for test-flight purposes or any aircraft considered experimental. For benefits to be paid, the aircraft and the pilot must meet Federal Aviation Administration requirements or the requirements of a similar governing authority, where applicable.

How benefits are paid

BTA insurance benefits are paid in a lump sum and are in addition to any other life or AD&D insurance benefits. This table shows the benefits payable under BTA coverage.

If due to a covered accident:	Principal Sum paid[1]
Death	100%
If due to a covered accident, loss of:	**Principal Sum paid***
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the sight of one eye	100%
Speech and hearing in both ears	100%
Use of all four limbs	100%
Use of any two limbs	75%
One hand or one foot	50%

[1]Benefits for covered dependents are a percentage of the Principal Sum listed — 60% for spouse/partner, 20% for children.

If due to a covered accident:	Principal Sum paid[1]
Sight of one eye	50%
Speech or hearing in both ears	50%
Use of one limb	50%
Loss of hearing in one ear	25%
Loss of the thumb and index finger of the same hand	25%

BTA also pays benefits if you, your eligible spouse or child suffer a severe burn while traveling on company business, as shown in the table below.

Specified body area	Principle Sum paid[1]
Face, neck and head	99%
Hand and forearm, below elbow joint (right or left)	22.5%
Upper arm, below shoulder joint to elbow joint (right or left)	13.5%
Torso, below neck to shoulder joints and hip joints (front or back)	36%
Thigh, below hip joint to knee joint (right or left)	9%
Foot and lower leg, below knee joint (right or left)	27%

Note

Any loss or injury must occur within one year of the accident. If you have more than one covered injury as a result of one accident, the plan will pay only one benefit equal to the largest eligible percentage for any one injury. Also, if more than one insured person should sustain a loss as the result of the same air travel accident, no more than a total of $25 million will be payable for losses due to that accident.

Definitions

Loss means:

- **For a hand or a foot:** Complete severance through or above the wrist or ankle joint
- **For thumb and index finger:** Complete severance through or above the metacarpophalangeal joint of both digits
- **For sight of an eye:** Total and irrecoverable loss of the entire sight of that eye
- **For speech:** Total and irrecoverable loss of the entire ability to speak
- **For hearing in an ear:** Total and irrecoverable loss of the entire ability to hear in that ear
- **For loss of use of an arm***:* Loss of use of the entire arm from the shoulder joint, including the attached hand
- **For loss of use of a leg:** Loss of use of the entire leg from the hip joint, including the attached foot
- **For permanent total loss of use:** In this case, loss means complete and irreversible loss of functional, normal or characteristic use of the entire arm or leg due to:
  - Complete and irreversible paralysis

- Atrophy or
- An arthritic condition

Additional BTA benefits

Accident Medical Expense Benefit

If you incur eligible medical expenses as the result of a covered accident within 180 days of the date of the accident that caused the injury, BTA insurance will pay benefits that are in excess of benefits payable for medical expenses under a:

- Valid and collectible Workers' Compensation claim, including Canadian Workers' Compensation and California Unemployment Compensation Disability Benefits, etc.
- Group hospital, surgical or major medical plan sponsored by the company

A list of eligible medical expenses follows:

- Hospital semi-private room and board (or, when medically necessary, room and board in an intensive care or cardiac care unit); hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an ambulatory medical center
- Services of a physician or a registered nurse (R.N.)
- Ambulance service to or from a hospital
- Laboratory tests
- Radiological procedures
- Anesthetics and the administration of anesthetics
- Blood, blood products and artificial blood products, and the transfusion thereof
- Physical therapy and occupational therapy
- Rental of durable medical equipment
- Artificial limbs, artificial eyes or other prosthetic appliances
- Medicines or drugs administered by a physician or that can be obtained only with a physician's written prescription

Benefits payable under this plan provision are *in addition* to any other benefits you may be eligible to receive from the plan for any loss you experience as a result of the same accident. In other words, your benefit due to a loss from the same covered accident will not be reduced by benefits payable under this provision of the plan.

The maximum benefit payable is $5,000 for any one covered accident. Expenses must be incurred within 26 weeks of the date of the covered accident.

Carjacking Benefit

If you or an eligible dependent experience a covered loss as a result of a carjacking, BTA insurance pays an additional benefit of 10% of the largest Principal Sum under the accidental death, accidental dismemberment, or loss of use benefit, up to a maximum of $50,000. Only one benefit is payable for all losses from the same carjacking.

Permanent Total Disability Benefit

You are eligible for a BTA insurance benefit if you become permanently and totally disabled within a year of a covered injury, provided you are under age 75 at the time you become disabled. **Permanently and totally disabled** means that you are permanently unable to perform the material and substantial duties of any occupation for which you are qualified by reason of education, experience or training.

If you are disabled for 12 consecutive months, during the 13th consecutive month, you will be paid the Principal Sum of your BTA coverage, less any other benefit that has been paid or is payable under other coverage that you qualify for as a result of the same accident.

Return of Pet

If your pet is traveling with you and is left unattended following your death in an area that is more than 100 miles from your place of primary residence, BTA insurance pays the reasonable cost, to a maximum of $1,000, to transfer your pet to your home (as defined by the plan). Reasonably incurred costs are for **transportation expenses only**. Expenses to kennel the pet are not reimbursable.

Return of Vehicle

In the event of your death in an area that is more than 100 miles from your place of primary residence or place of vehicle rental, BTA insurance pays the reasonable cost, to a maximum of $2,000, to transfer your motor vehicle to your home (as defined by the plan).

Seat Belt and Air Bag Benefit

BTA insurance pays an additional seat belt and/or air bag benefit if you or an eligible dependent suffer a covered accidental death while operating or riding in a private passenger automobile.

The **seat belt benefit** is payable if the death occurs while wearing a properly fastened, original, factory-installed seat belt. Children must be in a properly installed and fastened child-restraint device as defined by state law. If proper seat belt use is verified, BTA insurance pays an additional benefit equal to 25%, to a maximum of $100,000, of your Principal Sum (or the applicable percentage of the Principal Sum for your insured dependent).

The **air bag benefit** is payable if the death occurs while in a seat protected by a properly functioning, original, factory-installed air bag that inflated upon impact in the same accident. In this case, BTA insurance pays an additional benefit equal to 10%, up to a maximum of $50,000, of your Principal Sum (or the applicable percentage of the Principal Sum for your insured dependent).

Travel Benefits

AIG Health and Accident also provides travel benefits and travel-related services when you and any eligible dependents are traveling on company business **more than 100 miles** from either your home or place of regular employment or permanent assignment.

Bedside Visitor Benefit

If you or an eligible dependent are confined to a hospital or other medical facility for seven days or more due to a covered illness or injury, BTA insurance pays for one person to visit. This benefit covers the cost of one round-trip economy airfare ticket and the visitor's lodging and meals for up to five days (but only while the ill or injured person is in the facility), with a daily maximum of $200 for lodging and $50 for meals.

Emergency Evacuation Benefit

BTA insurance will pay benefits for covered evacuation expenses for a medically necessary evacuation if you or an eligible dependent suffer an injury or emergency sickness while traveling (as defined by the plan). A **medically necessary evacuation** is one ordered by a physician due to the severity of the accident or emergency sickness.

The plan will also pay benefits equal to the cost of an economy-class airfare ticket to:

- Return your dependent children, who were traveling with you, to your home (in this case, a one-way economy airfare may apply)
- Bring one person to and from the hospital or other medical facility where the insured person is confined (in this case, a single round-trip economy airfare may apply)
- Bring one non-medical person from the place of the medical emergency to the place where the insured person is evacuated (not to exceed the cost of an economy-class round-trip airfare ticket)

Repatriation of Remains Benefit

If you or an eligible dependent die in a covered accident or due to an emergency sickness while traveling (as defined by the plan), BTA insurance pays benefits for covered expenses to return the body home. Covered expenses include:

- Embalming or cremation
- The most economical coffin or receptacle adequate for transportation of the remains
- Transportation of the remains by the most direct and economical method of transportation and route possible

Note

Travel benefits also include emergency travel assistance, VIP concierge services, worldwide travel assistance, travel medical assistance and security assistance (including if you or your insured dependent are a victim of identity theft). **For covered expenses to be paid, all arrangements must be made by AIG Travel.** Travel Guard, the AIG Travel assistance services document provides details, including how to register for AIG Travel Service benefits.

Attendor Benefit

If you or an eligible dependent die outside your home country, BTA insurance pays for one person (referred to as the attendor) to accompany the remains while they're returned to your place of primary residence. This benefit covers the cost of one round-trip economy airfare ticket and the attendor's lodging and meals for up to seven days, up to a daily maximum of $300. The plan does not cover any expenses incurred in the attendor's place of primary residence.

For covered expenses to be paid, all arrangements must be made by AIG Travel, as described on Travel Guard information page located in the Appendix.

Weekly Accident Disability Benefit

You are eligible for a weekly disability benefit of 70% of your annual salary for up to one year if you become disabled within 180 days of a covered accident. **Totally disabled** means that you are unable to perform each and every duty of your occupation.

The maximum benefit payable is $500 per week, less any disability benefits you receive or are eligible to receive from any other company-sponsored plan or other sources, such as state-mandated plans or Social Security disability benefits. Benefits are payable for a maximum of 52 weeks for any disability caused by the same accident.

Weekly benefits will continue until the earliest of the date that:

- The benefit is paid for the maximum number of weeks allowed under the plan

- You no longer qualify as disabled, as defined by the plan
- You fail to provide proof of your disability when requested by AIG Health and Accident
- You return to work
- You die

You may be required to periodically provide AIG with proof of your continued disability. Failure to provide proof may result in suspension or termination of your benefits.

Exclusions

BTA insurance benefits are **not** paid for death or injury caused by or resulting from:

- Any loss related to an accident that occurs while you are on **vacation, commuting between home and work, on a leave of absence or not actively employed**
- Full-time **active duty in the armed forces**, National Guard or organized reserve corps of any country or international authority
- **Infections** of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent of and in the absence of any underlying sickness, disease or condition (including but not limited to diabetes)
- **Sickness, disease, mental incapacity or bodily infirmity,** whether the loss results directly or indirectly from any of these
- **Suicide** or **intentionally self-inflicted injury**, or attempted suicide or attempted intentionally self-inflicted injury
- **Travel or flight** in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a passenger, pilot, operator or crew member, unless specifically provided by the policy

Beneficiaries

Any BTA insurance amount payable as a result of your death is payable to the beneficiaries you designate. If that person is a minor child or not competent to give a valid release for payment, the payment is made to the individual's legal guardian.

You are automatically the beneficiary for all other losses.

In most cases, you may, without the consent of your beneficiaries, change your designations at any time by filing a new beneficiary form online via **Your Gateway**. The change will be effective on the date you change your beneficiary online via **Your Gateway**.

Submitting BTA claims

You or your beneficiary may request benefits by notifying the Human Resources Department and by calling the Advocacy Support Center at **800-828-8100**. The Advocacy Support Center will assist you or your beneficiary with all required steps to receive any benefits that may be due. See the *Claims* chapter for more information on submitting claims, as well as the process for appealing denied claims.

Assignment of insurance

With the consent of National Union Fire Insurance Company of Pittsburgh, Pa., an AIG company, you may make an irrevocable assignment of your BTA insurance. This means that you may name someone else as owner of the policy.

If you make an assignment, you may not change or cancel it. The person you assign your insurance to has the absolute and continuing right to name beneficiaries and to exercise any other privileges that would otherwise have been available to you.

Because of the various legal and tax implications involved, you should consult both your lawyer and tax advisor before taking this action to help you determine the consequences of assigning your coverage. If you wish to make an assignment, you must speak with a Benefits Advocate by calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**. Raytheon Technologies and National Union Fire Insurance Company of Pittsburgh, Pa. do not accept any responsibility for any assignment.

When BTA coverage ends

BTA insurance ends on your last day last day worked or on the date you are no longer eligible. Conversion options aren't available for this insurance.

IMPORTANT: This program provides accident insurance only. It does not provide comprehensive/major medical coverage and does not satisfy the minimum essential coverage requirements of the Patient Protection Affordable Care Act.

This is a brief description of the coverage(s) available under policy series C11860DBG-MA (9051307A). The Policy contains reductions, limitations, exclusions, definitions and termination provisions. Full details of the coverage are contained in the Policy. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance underwritten by National Union Fire Insurance Company of Pittsburgh, Pa., a Pennsylvania insurance company, with its principal place of business at 1271 Ave of the Americas, 41st Floor, New York, NY 10020. It is currently authorized to transact business in all states and the District of Columbia. NAIC No. 19445. Travel Assist services are provided by Travel Guard Group, Inc., an AIG company.

Other important information

Here's helpful information about your benefits, including some of your benefit participant rights.

In this chapter

Raytheon Technologies' medical plans provide benefits for certain health situations. In addition, in some situations, you or your covered dependents may continue your health care coverage, including Health Care Spending Account (HCSA) participation, after it ends under COBRA.

While you won't need the information in this chapter very often, it's good to know that it's here.

Newborns' and Mothers' Health Protection Act

By federal law, group health plans and health insurance issuers generally must provide minimum coverage levels to a mother and newborn child for a hospital stay in connection with childbirth. The minimum covered length of stay must be at least 48 hours following a vaginal delivery and 96 hours following a cesarean section. Federal law generally doesn't prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn in fewer than 48 (or 96) hours.

Plans and issuers may not, by federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay less than 48 (or 96) hours. A plan may not provide impermissible penalties and/or incentives with respect to mothers or attending providers to discourage 48- (or 96-) hour stays or encourage early discharges. In addition, benefits and cost-sharing may not be less favorable for the latter portion of a 48- (or 96-) hour stay.

Women's Health and Cancer Rights Act

The company-sponsored medical plans provide benefits related to breast reconstruction in compliance with the requirements of the Women's Health and Cancer Rights Act of 1998.

Under this federal law, group health plans and health insurance issuers that provide medical and surgical benefits for mastectomy must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the company-sponsored medical plans will provide coverage in a manner determined in consultation with the attending provider and the patient for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complication of the mastectomy, including lymphedema

Please see the plan summaries in the *Appendix* for out-of-pocket cost information for the Raytheon Technologies medical plans. These documents are available by visiting **Your Gateway** or upon request by calling the Raytheon Technologies Benefit Center via **Access Direct** at **800-243-8135** from 8 a.m. to 8 p.m. ET, Monday through Friday.

Qualified medical child support order

If you're ordered by a court to provide health care coverage for your child who is currently not covered by you as a dependent and you're enrolled in a health plan, you can add him or her as your dependent outside Annual Enrollment within 30 days of when the court order is issued via **Your Gateway** or by contacting the Raytheon Technologies Benefits Center via Access Direct at **800-243-8135**. You may also change to a plan that would provide benefits to your child if they live outside the service area of the plan in which you're currently enrolled.

If you aren't enrolled in a health plan, you can elect coverage for yourself and your dependent child by contacting the Raytheon Technologies Benefits Center. You can't enroll only your dependent child in a company-sponsored health care plan; you must enroll yourself in order to enroll your dependent child.

Also, if you're issued a QMSCO and you don't comply with it, the company may be obligated to enroll you as well as your child as your dependent. The added cost of your dependent's coverage will be deducted from your pay. You can obtain a free copy of the plan's QMCSO procedures via **Your Gateway**, by

contacting the Raytheon Technologies Benefits Center via Access Direct at **800-243-8135** or by writing to the Benefits Center at:

Raytheon Technologies Benefits Center QMCSO
Dept 01638
P.O. Box 1590
Lincolnshire, IL 60069-1590

Any QMCSO issued for your child must satisfy all of the following:

- The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible
- The order specifies the employee's name and last known address, except that the name and address of an official of a State or political subdivision may be substituted for the child's mailing address
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined
- The order states the period to which it applies and each plan to which the order applies
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above

Any payment of benefits in reimbursement for covered expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or to a state official whose name and address have been substituted for the name and address of the child.

No Surprises Act

The **No Surprises Act** provides patients with certain rights and protections against surprise medical bills.

Note

When you receive emergency care or are treated by an out-of-network provider in an in-network facility, you are protected from balance billings (surprise billings).

What is balance billing (sometimes called surprise billing)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copay, coinsurance and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Out-of-network providers and facilities haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- **Emergency services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copays and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless

you give written consent and give up your protections not to be balance billed for these post-stabilization services.

- **Certain services at an in-network hospital or ambulatory surgical center:** When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

  If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

Note

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copays, coinsurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization)
  - Cover emergency services by out-of-network providers
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit

If you believe you've been wrongly billed, you may contact plan administrator.

Continuation and conversion coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered family members may extend your participation in the following benefits if coverage ends because of a qualified change in status (described in the *Eligibility and enrollment* chapter):

- Medical
- Dental
- Vision
- LifeResources
- Health Care Spending Account

Continued health care coverage is offered to eligible employees and their eligible dependents who otherwise would lose coverage in a company-sponsored health plan because of death, termination of employment, conversion from full-time to part-time regularly scheduled to work fewer than 20 hours status, divorce, legal separation or a child's loss of dependent status.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you're eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

If you participate in the HCSA and then experience a COBRA-qualifying event, such as terminating employment with the company, you can maintain access to any remaining balance if you elect COBRA continuation coverage for the HCSA and pay the required COBRA premium. The premium amount is determined based on your HCSA contribution amount for the year plus a 2% administrative fee.

COBRA-qualifying events

COBRA continuation coverage is available to certain individuals who lose group health plan coverage due to the occurrence of a COBRA-qualifying event as described in the following table. If one of these events happens and coverage under the plan ends, you and/or your eligible dependents will be eligible to elect COBRA continuation coverage.

Qualifying event	You	Your spouse/partner	Your child(ren)
Your employment ends at Raytheon Technologies for reasons other than gross misconduct	✓	✓	✓
You lose your coverage because of a reduction in hours	✓	✓	✓
You and your spouse divorce or legally separate		✓	✓
Your domestic partnership ends		✓	✓
Your dependent child is no longer considered a dependent child under the terms and conditions of the health care plan			✓
You die		✓	✓
You become entitled to Medicare benefits		✓	✓

Note: Your eligible children include a child born to you, adopted or placed for adoption with you during your COBRA continuation coverage.

Note

Failure to pay for group health plan coverage in a timely manner during a leave of absence is not a COBRA-qualifying event. COBRA continuation coverage will not be available if you lose group health plan coverage for failure to pay any premiums on time.

COBRA continuation coverage notification requirements

There are certain events that have an impact on your dependent's COBRA eligibility:

- Your divorce or legal separation
- Your dependent child no longer meets the requirements for a dependent child
- A second qualifying event occurs during COBRA continuation coverage
- A determination is made that a qualified beneficiary was disabled during the first 60 days of COBRA continuation coverage
- A determination is made that a qualified beneficiary is no longer disabled
- Coverage under another group health plan

Note

If you fail to notify the Raytheon Technologies Benefits Center of a dependent's ineligibility for coverage within 60 days of the event or 60 days of the date coverage would otherwise end, that dependent will not be offered COBRA continuation coverage and no refund will be issued for any premiums paid for the ineligible dependent's coverage.

Notification period

If there is a dependent qualifying event (such as divorce, legal separation or loss of dependent status), you or your eligible family members must notify the Raytheon Technologies Benefits Center within the later of 60 days of the event or 60 days of the date coverage would otherwise end. You will receive a *COBRA Continuation Coverage Election Notice* and full details about continuing your coverage. If you do not notify the Raytheon Technologies Benefits Center within this 60-day time period, your eligible family members will not be allowed to elect COBRA.

Terms of continuation coverage

If you or an eligible family member chooses continuation coverage, Raytheon Technologies provides coverage that's identical to the coverage being provided to similarly situated active employees.

If a family member has elected continuation coverage individually, that person also has the same coverage options as stated above.

If your employment ends after Annual Enrollment but before Jan. 1, any elections you made to change your current coverage will be canceled. You'll be mailed a special enrollment package for COBRA continuation coverage that allows you to elect continuation of your current health plan coverage through COBRA until the end of the current plan year and then to change your current enrollment in a health plan for the next plan year. In this situation, if you're not enrolled in a health plan when your employment ends, you won't be able to elect COBRA continuation coverage.

If you're eligible for Medicare

If you are eligible for Medicare, contact the Raytheon Technologies Benefits Center to determine whether you're also eligible for COBRA.

If you are eligible for both Medicare and COBRA and you elect COBRA, Medicare will pay benefits for the covered service first, and after Medicare has paid its share, your company-sponsored COBRA continuation coverage will pay according to that plan's applicable provisions. You must notify the Raytheon Technologies Benefits Center that you are enrolled in Medicare so that your COBRA continuation coverage can coordinate correctly with your Medicare Part A and Part B coverage.

If you or your covered dependent(s) are eligible for Medicare and do not enroll in Medicare, or do not use providers who accept Medicare, you'll be responsible for paying the portion of medical expenses Medicare otherwise would have paid. Therefore, you should enroll in both Medicare Part A and Part B and use providers who accept Medicare.

If you or your covered dependent(s) become eligible for Medicare after enrolling in COBRA, you must notify the Raytheon Technologies Benefits Center immediately.

Note

Once your employment with the company ends through termination or retirement and you become entitled to Medicare, you may no longer be eligible for COBRA continuation coverage under a company medical plan. In this case, your spouse or dependent child(ren) may be eligible to continue medical coverage under COBRA after you become entitled to Medicare.

Cost

If you or an enrolled dependent elects continuation coverage, 102% of the group cost must be paid for each month of coverage, including the time between the date your active group coverage ends and the date you elect continuation coverage.

You have 45 days from the date of your election to pay past-due premiums. All past-due and current premiums must be paid for coverage to become effective.

Maximum period of COBRA continuation coverage

The maximum length of COBRA continuation coverage is either 18 months, 29 months or 36 months, depending on the qualifying event.

Length of COBRA continuation coverage	Eligibility	Qualifying events
18 months	You and your covered spouse and other covered dependents	• Your employment ends at Raytheon Technologies for reasons other than gross misconduct. • You lose your coverage because of a reduction in hours.
Up to 29 months	You and your covered spouse and other covered dependents	• You or an eligible dependent are deemed "disabled" for Social Security purposes prior to the qualifying event or at any time during the first 60 days of COBRA continuation coverage. **Note:** The initial qualifying event must have been your termination of employment or reduction in hours.

Length of COBRA continuation coverage	Eligibility	Qualifying events
Up to 36 months	Your covered spouse and other covered dependents	• You and your spouse divorce or legally separate. • Your dependent is no longer eligible for coverage under the terms and conditions of the health care plan. • You become entitled to Medicare. • You die. **Note:** The COBRA administrator must be notified by you or your covered dependent within 60 days from the date of the second qualifying event.

A covered spouse and/or other covered dependents whose initial qualifying event was the end of employment or a reduction in hours may be eligible to extend their maximum continuation period in the event of a second qualifying event. Also, when the qualifying event is the end of employment or a reduction in hours, and the employee becomes entitled to Medicare benefits fewer than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Note

COBRA continuation coverage will be extended for an additional 11 or 18 months, as applicable, only if the Raytheon Technologies Benefits Center is notified in a timely manner of a qualifying event.

Extension of continuation coverage period to 29 months in case of disability

Notice that a qualified beneficiary was disabled at any time during the first 60 days of COBRA continuation coverage must be provided to the Raytheon Technologies Benefits Center prior to the end of the initial 18-month COBRA continuation period and within 60 days of the later of:

- The date of termination of employment or reduction of hours
- The date coverage is lost as a result of the event (termination of employment or reduction of hours)
- The date of the disability determination by the Social Security Administration
- The date the qualified beneficiary is furnished the general COBRA notice or this SPD

The cost for the additional 11 months of coverage will be 150% of the health plan premium.

The additional coverage period will end before the 11 months are up if the person receiving benefits is no longer considered disabled for Social Security purposes. In this situation, coverage may continue for the rest of the month in which they are no longer considered disabled plus the next calendar month. Then it will stop.

End of continuation coverage

COBRA continuation coverage will end for you and each of your covered dependent(s) earlier than the 18, 29 or 36 months described above if one of the following occurs:

- You or your covered dependent(s) fail to pay any required premium
- You or your covered dependent(s) become entitled to Medicare benefits (under Part A, Part B, Part D or all three)

- You or your covered dependent(s) become covered under another health plan
- The plan is terminated for all employees
- The maximum continuation period expires

Note

If you or your covered dependent(s) become eligible for Medicare after enrolling in COBRA, you must notify the COBRA administrator immediately. Company-sponsored COBRA continuation coverage will end upon enrollment in either Medicare Part A or Part B.

If you have Medicare Part A or B on or before the date of your COBRA election, you will be able to enroll in COBRA continuation coverage. Medicare will be your primary insurance, and COBRA will be secondary. (**Note:** If you are eligible for Medicare due to end-stage renal disease, COBRA continuation coverage will be primary during the 30-month coordination period.)

Notice of end of continuation coverage

Shortly before continuation coverage ends, you'll be sent a notice reminding you when continuation coverage will stop. In general, when continuation coverage ends, no individual conversion coverage is available. (Some regional fully insured medical plans may have a conversion option or other coverage if required by state law.)

Special note for Patient Protection and Affordable Care Act (PPACA) Health Insurance Marketplace special enrollment windows and how they relate to your COBRA continuation coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

Under the PPACA, you can enroll in a medical plan through your state's health care exchange during an open enrollment period or a designated special enrollment period. A special enrollment period will be available when you become eligible for COBRA and — if you elect COBRA continuation coverage — when your period of COBRA eligibility ends.

A special enrollment period will not be available to you if:

- You are eligible for but do not elect COBRA
- You voluntarily drop your COBRA continuation coverage
- You stop paying COBRA premiums

For more detailed information, please visit healthcare.gov.

Termination for nonpayment

If you are continuing coverage through COBRA, your coverage will end if you don't pay the required employee contributions toward the cost of coverage for 30 days. If this occurs, your coverage may be canceled retroactively as of the end of the last pay period you paid for coverage. Health plans may require you to repay any claims incurred and paid by the plan after the date your coverage is canceled.

If you have questions

If you have questions about your COBRA continuation coverage, you should contact the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the PPACA and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website. (Addresses and phone numbers of regional and district EBSA offices are available through the EBSA website.) For more information about the Marketplace, visit healthcare.gov.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the plan informed of any changes in the addresses of family members by contacting the Raytheon Technologies Benefits Center. You should also keep a copy for your records of any notices you send to the Raytheon Technologies Benefits Center.

Subrogation and right of recovery provisions

Subrogation and recoveries

Claims against others

A participant or beneficiary who recovers from a third party, whether through voluntary payment, settlement or a court action, and without regard to the characterization of such recovery for pain and suffering, mental anguish, punitive damages or any other basis for recovery, is obligated to repay the plan for amounts paid to or on behalf of the participant or beneficiary for claims (including, for example, claims for disability or lost wages) or for treatment of an injury or illness resulting from the wrongful conduct of the third party. In addition, the plan will be subrogated to, and have a lien against, all of the rights of the participant or beneficiary to any recovery.

The plan's right to recovery is not limited by the application of any make-whole theory and the amount thereof is not limited or reduced because the third party is found to be liable only in part, because the third party's resources are limited, or for any other reason.

You (and your dependents, or, if you are not legally competent, your legal representative) must inform the plan administrator when it appears that a third party is or may be liable for any condition for which covered services or benefits are provided. If requested to do so, you must complete and sign the applicable subrogation form from the plan before any benefits will be paid under that plan. You and your dependents must cooperate with the claims administrator and the plan administrator in the filing and processing of any and all claims you have from time to time.

At the plan's request, you and your dependents must take such action, furnish such information and assistance, and execute such documents as the claims administrator and the plan administrator may require in order to facilitate enforcement of the plan's rights. If you fail to do so, the plan will be entitled to deny your claim or any portion thereof. You and your dependents:

- Must do nothing after acceptance of benefits under the plan to prejudice the subrogation rights of the plan
- Must not release any third party from any liability without the consent of the claims administrator or the plan administrator
- Must notify any third party and any other individual or entity acting on behalf of the third party of the plan's right to reimbursement

If you or any of your dependents fail to cooperate with the claims administrator and the plan administrator and to satisfy your obligations under this provision, the applicable administrator may deny the claim or any portion thereof, and your coverage under the plan may be terminated.

If you or your dependent (or any trust established on behalf of you or your dependent) receives money from any third party in connection with a claim that implicates the plan's recovery rights, regardless of the characterization of the payment, you, your dependent or the trust will hold such money in trust for the plan to the extent of the plan's recovery rights. The plan's rights will not be affected by a release of any third party entered into without the consent of the plan administrator or by a judgment obtained in litigation in which the plan is not joined as a party. The plan may take any and all actions necessary or convenient to enforce its recovery rights.

Additional rights of recovery for overpayments or mistaken payments

All company-sponsored health and welfare plans have the right to recover benefits paid on you or your dependent's behalf that were:

- Made in error
- Made due to a mistake in fact
- Advanced during the time period of meeting the calendar-year out-of-pocket maximum

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

If the plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the plan will:

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

Right of recovery

The plan also has the right to recover benefits it has paid on your or your dependent's behalf that were:

- Made in error
- Due to a mistake of fact
- Advanced during the time period of meeting the calendar-year deductible
- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year

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

If the plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the plan will:

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

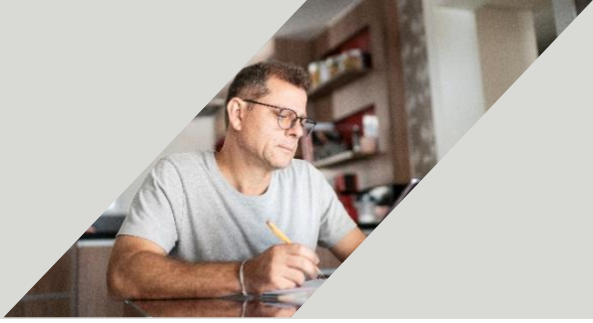
If the plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The plan has the right to recover benefits it has advanced by:

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

Assignment of benefits

The plans summarized in this document are used exclusively to provide benefits to you, and, in some cases, to your eligible dependents (including survivors, if you die). Generally, neither you nor the company, nor anyone else can assign, transfer or attach your benefits or use them for collateral.

Claims



Often, there are time limits for submitting your claims. Make sure you know the time limits of each component plan.

In this chapter

There are two categories of claims:

1. **Eligibility claims:** All claims relating to eligibility to participate in a plan are eligibility claims. Examples of eligibility claims include requests for coverage as a result of a qualified change in status event, dependent verification and timely payments. Please see the Eligibility claims section for additional information about these claims.
2. **Claims for benefits:** A claim for benefits is any request for benefits made by a claimant in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) requirements and a plan's procedures for filing benefit claims. Eligibility claims and inquiries aren't considered claims for benefits.

Claiming your benefits

The Raytheon Technologies Benefit Claims and Appeals Committee (the "Committee"), in certain cases acting through the Total Rewards staff, has the authority to determine eligibility to participate in a benefit plan. If you think you're eligible to participate in a benefit plan, but your participation has been denied, you must submit an eligibility claim to the Committee.

As plan administrator, Raytheon Technologies has delegated to the vendors, insurance companies or other third-party claims administrators discretionary authority to construe the terms of the applicable component plan and resolve all questions relating to claims for benefits under the component plan. If you think you're eligible for a certain benefit from any component plan, but believe you aren't receiving that benefit, you must submit a claim to the applicable vendor, insurance company or third-party administrator to receive that benefit.

The claims procedures included in this chapter provide benefit claims processing for component plans that are subject to ERISA's claims requirements including health plans (i.e., medical, dental and vision plans) and the health care spending account (HCSA). Information about filing Life insurance, Accidental Death and Dismemberment (AD&D) and Business Travel Accident (BTA) claims can be found in their benefit-specific chapters of this SPD.

Note

The Health Savings Account (HSA) is not an ERISA plan. Raytheon Technologies provides access to the HSA but it is an individual account with Fidelity Investments, and it is up to the participant to file HSA claims and follow the IRS guidance.

Specific instructions about submitting claims are included in this SPD. As a rule, in-network claims are submitted by the provider. Generally, you are required to submit out-of-network claims in the manner required by the claims administrator.

If your claim is denied, you have the right to appeal the claim. Your appeal must be in writing. There are time limits for submitting your appeal. Make sure you know the time limits of each component plan. If you delay submitting your claim, you could lose benefits. Your claim is not considered submitted until you have provided any additional documentation that is necessary for the claim.

Note

Special time frames apply to claims filed and requests for review under the Raytheon Technologies health plans. See Health plans claim and review time limits for more information.

If your claim is denied, you'll be notified in writing. This written notice will tell you the reason for the denial. It also will point out what additional information is needed, if any, that could change the decision to deny the claim. Finally, the notice will tell you how you can have the decision reviewed and appealed.

Eligibility claims

All claims and appeals relating to group health and welfare eligibility determinations and Healthy You Incentive engagement or achievement reward determinations are handled through Claims and Appeals Management (CAM).

Eligible claims and appeals include requests for employees and/or dependents to participate in a plan or plan option, change or drop coverage in a plan or receive reimbursement for employee/participant contributions under a health or welfare plan.

To the extent that a group health or welfare plan claim or appeal relates to medical or health plan-related issues such as coverage for services rendered or to be rendered, medical necessity or claim payment decisions rendered by a health plan vendor, the health plan vendor (claims administrator) retains the responsibility for determination. For information on how to file a claim or appeal with the health plan vendor, refer to the Claims for benefits section.

Procedures for filing or appealing an eligibility claim

This chart summarizes the procedures you must follow when submitting an eligibility claim or appeal. Note that you must file a Level I claim prior to filing a Level II appeal. Note that claims for benefits are not eligibility claims and are not subject to the following procedures.

Step	Claims and appeals procedures
To submit a claim	Obtain a Level I Claim Initiation Form from a Raytheon Technologies Benefits Center representative via **Access Direct** at **800-243-8135**.* Follow the prompts for health care and then representative. Benefits Center representatives are available to help you from 8 a.m. to 8 p.m., ET, Monday through Friday. You (or your authorized representative) must complete and return the form to Claims and Appeals Management (CAM) at the address on the form. **Note:** *The Benefits Center representative will attempt to resolve the Level I claim issue before providing the Level I Claim Initiation Form.*
If your claim is approved	You will be notified in writing.
If your claim is denied	If your Level I claim is denied, in whole or in part, you will receive written notice from CAM. Your written denial notice will set forth: • 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 • The plan's appeal procedures
If you disagree with the decision	Before you can bring any action at law or in equity to recover benefits, you must exhaust this process. Specifically, you must file an appeal as explained and the appeal must be finally decided by the Raytheon Technologies Benefit Claims Appeal Committee (the Committee). The Committee is authorized to finally determine appeals and interpret the terms of the plan in its sole discretion. All decisions by the Committee are final and binding on all parties.
How to file an appeal	If your Level I claim is denied and you want to appeal it, you must file your appeal within 180 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to the address specified on your claim denial notice. You should include: • A copy of your claim denial notice • The reason(s) for the appeal • Relevant documentation

Step	Claims and appeals procedures
The Committee will notify you in writing if your appeal is approved or denied	You will be notified of the decision within 60 days of the Committee's receipt of your appeal (120 days, when special circumstances apply). If your appeal is denied, in whole or in part, your written denial notice will set forth: • The specific reason(s) for denial • A statement regarding the documents to which you are entitled to receive access and copies • The plan provisions on which the denial was based • The decision on your appeal is final

Claims for benefits

A claim for benefits is any request for medical, dental, vision, HCSA, Life insurance, Accidental Death and Dismemberment insurance and Business Travel Accident insurance benefits made by an individual according to the plan's procedures for filing benefit claims. Note that eligibility claims are not claims for benefits and are not subject to the procedures in this section.

An individual cannot file suit in court until they have exhausted the mandatory procedures for claims for benefits described in this section or any other relevant sections related to claims for benefits.

Note

Health care providers often file claims on your behalf; however, if you are required to file a claim for benefits, you should submit all information that you consider relevant to your claim for benefits with your claim. At a minimum, you should include:

- The patient's name, age and relationship to the Raytheon Technologies employee
- The ID number as shown on your health plan ID card (if applicable)
- The name, address and phone number of the provider of the health care services
- A diagnosis from the health care provider
- The date of service
- An itemized bill from the health care provider

Procedures for filing or appealing a claim for benefits

This chart summarizes the procedures you must follow when submitting a health or welfare claim or appeal. Note that you must file a Level I claim prior to filing a Level II appeal.

Step	Claims and appeals procedures
To submit a claim	In-network claims are submitted by the provider. Generally, you are required to submit out-of-network claims in the manner required by the plan's claims administrator.
When you will be notified of the claim decision or your failure to provide sufficient information	You will be notified of the decision within the following time frames: • For a **preservice** claim (a claim submitted prior to receiving medical services), the plan's claims administrator will notify you within 15 days of receipt of your claim form. • For a **post-service** claim (a claim submitted after receiving medical services), the plan's claims administrator will notify you within 30 days of receipt of your claim form. The plan's claims administrator will notify you if additional time is needed to complete your claim and the new response deadline. The plan's claims administrator will also notify you of your failure to provide sufficient information and the deadline to submit additional information, if applicable.
If your claim is approved	You will be notified in writing.
If your claim is denied	If your Level I claim is denied, in whole or in part, you will receive written notice from the plan's claims administrator. Your written denial notice will set forth: • 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 • The plan's appeal procedures
If you disagree with the decision	Before you can bring any action at law or in equity to recover benefits, you must exhaust this process. Specifically, you must file an appeal as explained and the appeal must be finally decided by the plan's claims administrator. The plan's claims administrator is authorized to finally determine appeals and interpret the terms of the plan in its sole discretion. All decisions by the plan's claims administrator are final and binding on all parties.
How to file an appeal	If your Level I claim is denied and you want to appeal it, you must file your appeal within 180 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to the address specified on your claim denial notice. You should include: • A copy of your claim denial notice • The reason(s) for the appeal • Relevant documentation
The plan's claims administrator will notify you in writing if your appeal is approved or denied	You will be notified of the decision within 60 days of the claims administrator's receipt of your appeal (120 days, when special circumstances apply). If your appeal is denied, in whole or in part, your written denial notice will set forth: • The specific reason(s) for denial • A statement regarding the documents to which you are entitled to receive access and copies • The plan provisions on which the denial was based • The decision on your appeal is final

Deadlines for claims for benefits from medical, dental, vision, life insurance, AD&D insurance and BTA insurance

Often, there are time limits for submitting your claims. Make sure you know the time limits of each component plan. If you fail to submit a claim or appeal by the applicable deadline, you'll be considered to have permanently waived and abandoned them.

Claims for benefits from the medical, dental, vision, Employee Basic Life Insurance, Employee Supplemental Life Insurance, Dependent Supplemental Life Insurance, Accidental Death and Dismemberment Insurance and Business Travel Accident Insurance must be submitted by the deadlines in the following table. Refer to the *Contacts* chapter for address and phone number information for claims.

Insurance	Carrier/claims administrator	Deadline to submit a claim
Medical	Anthem BCBS	12 months from date of service
Medical	Kaiser	Please refer to your Kaiser Evidence of Coverage or call the customer service phone number on your medical plan ID card for details
Medical	Cigna Global	12 months from date of service
Prescription drug benefits (applies to Anthem BCBS medical plans)	CVS Caremark	12 months from date of service
Dental	Delta Dental	12 months from date of service
Vision	VSP	12 months from date of service
Life Insurance (Basic Life, Supplemental Life and Dependent Life)	New York Life	There is no timeline to file a claim. Contact the Raytheon Technologies Benefits Center as soon as possible.
Accidental Death and Dismemberment Insurance	AIG	Contact the Raytheon Technologies Benefits Center
Basic AD&D		30 days after the date of loss of soon thereafter as possible
Supplemental AD&D		20 days after the date of loss of soon thereafter as possible
AD&D for expats		20 days after the date of loss of soon thereafter as possible
Business Travel Accident Insurance	AIG	30 days after the date of loss of soon thereafter as possible

Claims for benefits from the HCSA

Claims for benefits from the HCSA must be submitted by the deadlines in the table below. Please contact Smart-Choice Accounts for information about the HCSA's claims and appeals procedures.

Insurance	Carrier/claims administrator	Deadline to submit a claim
HCSA	Smart-Choice Accounts	You can use your health care account debit card to pay for eligible expenses, or you can pay for eligible expenses and then submit a claim for reimbursement. You have until **April 15** of the year following the year in which you incur expenses to submit claims for reimbursement.

Appealing a denied HCSA claim

If you believe your HCSA claim was denied in error, you can file an appeal by contacting the Smart-Choice Accounts Service Center and request an Appeal Initiation Form.

Level I Appeal — A review of your claim will begin as soon as the Smart-Choice Accounts Service Center receives your Appeal Initiation Form, and it will generally be completed within 30 calendar days of receipt of the form. If the review can't be completed within 30 days, the reviewer may request a 15-day extension. The total review time cannot be longer than 45 calendar days. You will receive written communication indicating approval or denial of the Level 1 Appeal.

Level II Appeal — If the Level 1 Appeal is denied, you will be provided with the reason for denial and information on how to file a Level II Appeal if you choose to do so.

Health plans claim and review time limits

As the following table shows, special time frames apply to claims filed and requests for review under the component plans that are group health plans — medical, dental and vision. As you'll see, there are different time frames for:

- Urgent care[1]
- Preservice non-urgent care if the plan requires preapproval
- Post-service non-urgent care

Please note that although the times shown are the maximums established by law, the insurance carriers will try to handle every step as quickly as possible.

The **Urgent care claim** column below covers claims for both new treatment and for treatment that's already in progress. See the note below the table for ongoing treatment that's non-urgent.

Procedural step	Maximum time allowed for each activity		
	Urgent care claim	Preservice claim	Post-service claim
The plan makes its initial determination (timed from the receipt of claim)	72 hours (24 hours for an extension of ongoing treatment, as long as the claim is submitted at least 24 hours before it's due to end)	15 days	30 days

[1]Care for an unforeseen condition that requires medical treatment in the outpatient department of a hospital, clinic or doctor's office for the treatment of acute pain, acute infection or protection of public health. These conditions are not life-threatening but may cause serious medical problems if not promptly treated.

Procedural step	Maximum time allowed for each activity		
	Urgent care claim	Preservice claim	Post-service claim
Extra time is needed for a delay outside the plan's control (you'll be notified)	Not applicable to urgent care	15 days	30 days
The plan lets you know if your claim isn't complete	24 hours after claim receipt	15 days after claim receipt (or within five days after receipt if your claim was filed improperly)	30 days after claim receipt
You make the correction or provide the additional information	At least 48 hours	At least 45 days	At least 45 days
The plan makes a determination based on your new information	Generally, 48 hours	Within 15 days of receipt of the requested information	Within 30 days of receipt of the requested information
You request a review of an adverse determination	180 days (but see below)	180 days	180 days
The plan answers your request for a review	72 hours (if you request an expedited appeal orally or in writing, in which case you'll be sent all necessary information by phone, fax or other approved fast method)	30 days	60 days
You decide to file a civil lawsuit if your claim is still denied after the review process.	1 year	1 year	1 year

If the component plan has previously approved an ongoing course of treatment to be provided over a period of time or number of treatments, you'll be notified of any reduction or termination of the course of treatment in sufficient time before the end of the approved course of treatment to allow you to appeal the benefit determination. The appeal timing is the same as for non-urgent care in the table.

Claims for benefits from Cigna Global

Outside the U.S.

When you receive care from a provider who has established direct payment with Cigna Global Health Benefits, you do not have to file a claim form. Simply show your Cigna Global ID card. Your provider may request payment for any required coinsurance or charges for services that are not covered.

If direct payment is not established with your provider, you pay for your care when it is received and then file a claim for reimbursement.

You can submit claims via cignaenvoy.com, email, fax or post, and request reimbursement in more than 80 currencies via wire transfer to your bank or with a check.

If you have any questions, call Cigna at **855-448-5733** or **302-797-3784** (24/7, collect calls accepted from outside the U.S.).

Prescription drugs

If you or your covered dependents purchase prescriptions outside the U.S., Cigna Global Health Benefits will provide direct reimbursement to those pharmacies that will accept it. If you must pay for the prescription drugs out of pocket, submit a claim form for reimbursement.

Note

In most cases, you can receive reimbursement in the currency used to pay for care or services. International claims can be reimbursed in more than 80 currencies via check or wire transfer, when possible. If Cigna Global Health Benefits cannot send a payment in local currency, reimbursement will be made in U.S. dollars. (If a U.S.-based service cannot be paid directly to the provider, the claim will be reimbursed with a check in U.S. dollars.)

If it is necessary to make a conversion from one currency to another, Cigna Global Health Benefits uses the exchange rate in force on the date the services were incurred.

Within the U.S.

If you visit a Cigna OAP network provider, you generally do not have to file a claim form. Simply show your Cigna Global ID card. A network provider will not charge at the time of treatment of a covered health service, but may request payment for any required copays, coinsurance or charges for services that are not covered.

If you visit an out-of-network provider, you may be required to file the claim yourself, as described below.

Filing a claim

Regardless of your location, follow these steps to file a claim:

1. Be sure that you know your benefits. In order to get the most out of your benefits, it's important that you understand what is and is not covered, as well as how the plan pays benefits.
2. Get an itemized bill. Be sure the bill includes:

   - Name, phone number and address of the service provider
   - Patient's full name, address and date of birth
   - Employee's name and address
   - Membership ID number
   - Date of service
   - Description of the service/supply rendered
   - Procedure code
   - Amount charged
   - Diagnosis or nature of illness

   Canceled checks, cash register receipts, credit card receipts or personal itemizations are not acceptable as itemized bills.

3. Keep a copy of your itemized bill. Because you must submit originals, it's important that you keep a copy for your records. Once your claim is received, itemized bills cannot be returned.
4. Complete a claim form. Make sure all information is completed properly and then date and sign the form. Claim forms are available online or by calling Cigna.

5. Submit your claim form. You can do this either online or by hard copy. If you choose to mail in your claim, be sure to attach your itemized bill(s) and send the materials to:

   Cigna Global Health Benefits
   PO Box 15050
   Wilmington, DE 19850

Types of claims — health plans

In general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested and the type of health plan. Medical necessity determinations are made on either a preservice, concurrent, post-service or urgent care basis, as described below.

Certain services, such as organ transplants, require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." Contact your plan's Member Services department to find out if an anticipated service requires prior authorization.

You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described below, and in your provider's network participation documents, as applicable.

When services or benefits are determined to be not medically necessary, you or your representative will receive a written description of the adverse determination and may appeal the determination. Appeal procedures are described in this section of the SPD, in your provider's network participation documents, and in the determination notices.

The health plan vendors have the right to interpret the medical provisions of the plan. Their decisions are conclusive and binding. Benefits under this plan will be paid only if the health plan vendors, in their discretion, determine that the claimant is entitled to them.

Preservice claim: A claim for benefits where preapproval for any part of the care is a condition to receiving the care. Preservice claims may involve urgent care, as described below.

Concurrent care claim: A claim for benefits for an ongoing course of treatment to be provided for a period of time for treatment or for a number of treatments. Three situations may give rise to concurrent care claims:

- A decision to reduce or end the period of time for treatment or number of treatments
- Your request for an extension of the period of time for treatment or number of treatments
- Your request for an extension of the period of time for treatment or number of treatments involving urgent care, as described below

Post-service claim: A claim for benefits that have already been received and any claim for benefits for which preauthorization is not required.

Urgent care claim: A preservice or concurrent care claim becomes a claim involving urgent care when the normal time frame for making a determination would:

- Seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function (in the view of a prudent layperson acting on behalf of the medical plan who possesses an average knowledge of health and medicine, or a provider with knowledge of the claimant's medical condition); or
- Subject a claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim (in the view of the provider with knowledge of the claimant's condition).

Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care shall be treated as an urgent care claim.

Procedures regarding health plan claim payment determinations

Post-service claim determinations

When you or your representative requests payment for services which have been rendered, the claims administrator will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the claims administrator's control, the claims administrator will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice.

The determination period will be suspended on the date the claims administrator sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Payments of approved claims will be made as soon as administratively feasible after the required forms and documentation have been submitted to the plan administrator or to the insurance carrier or third-party administrator designated by the plan administrator, as applicable.

Recovery of payments

The plan has the right to deduct from any benefits properly payable under this plan the amount of any payment that has been made:

- In error
- Pursuant to a misstatement contained in a proof of loss
- Pursuant to a misstatement made to obtain coverage under this plan within two years after the date such coverage commences
- With respect to an ineligible person
- In anticipation of obtaining a recovery in subrogation
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This shall not be deemed to require the plan to pay benefits in any such instance.

Such deduction may be made against any claim for benefits under this plan by a covered person if such payment is made with respect to such covered employee or any person covered or asserting coverage as a dependent of such covered employee. Any such reduction in benefit shall be subject to the review and appeal process.

Notice of adverse determination

Every notice of an adverse benefit determination will be provided in writing or electronically and will include all of the following that pertains to the determination:

- The specific reason or reasons for the adverse determination
- Reference to the specific plan provisions on which the determination is based
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary
- A description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal

- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit
- In the case of a claim involving urgent care, a description of the expedited review process applicable to such claim

Appealing a denied medical or dental claim

Claims Appeal Process

For the purposes of this section, any reference to "you," "your" or "member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

Your health plan vendor has the right to interpret the provisions of the plan. Its decision is conclusive and binding. Medical benefits will only be paid if the health plan vendor claims administrator determines, in its discretion, that the claimant is entitled to them.

Claims appeal procedures vary by vendor. Please be sure to consult with your vendor before filing an appeal.

Start with Member Services

If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your ID card, explanation of benefits or claim form and explain your concern to one of the claims administrator's Member Services representatives. You can also express your concern by writing to the address that appears on your medical ID, explanation of benefits or claim form.

The claims administrator will do its best to resolve the matter on your initial contact. If the claims administrator needs more time to review or investigate your concern, the claims administrator will get back to you as soon as possible, but in any case, within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Plan vendor internal review program

Appeals procedure

The claims administrator has a two-step appeals procedure for coverage decisions.

To initiate an appeal, you must submit a request for an appeal in writing to the claims administrator at the address shown on your ID card (also found in the Contacts section) within 180 days of receipt of a denial notice on a claim that the claims administrator had initially processed under the plan. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Your appeal should also include:

- The patient's name and ID number as shown on the ID card
- The provider's name
- The date of medical or behavioral health service
- The reason you disagree with the denial
- Any documentation or other written information to support your request whether or not the comments, documents, records or information were submitted in connection with the initial claim

Level I appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision, and this person may not be a subordinate of the original decision maker. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

The initial determination will not have any influence on the review. You may request the names of each medical expert consulted in connection with the denial of your claim, regardless of whether the claims administrator relied upon the advice.

For Level I appeals, the claims administrator will respond in writing with a decision within 30 calendar days after it receives an appeal for a required preservice or concurrent coverage determination and within 60 calendar days after it receives an appeal for a post-service coverage determination. If more time or information is needed to make the determination, the claims administrator will notify you in writing to request any additional information needed to complete the review.

Level II appeal

If you are dissatisfied with the claims administrator's Level I appeal decision, you may request a second review.

To initiate a Level II appeal, follow the same process required for a Level I appeal.

Anyone involved in the decision from the Level I appeal will not be involved in the Level II appeal determination. For appeals involving medical necessity or clinical appropriateness, at least one physician will be consulted who is in the same or similar specialty as the care under consideration, as determined by the claims administrator's physician reviewer.

For Level II appeals the claims administrator will acknowledge in writing that it has received your request and will schedule a review. For required preservice and concurrent care coverage determinations, the review will be completed within 30 calendar days and for post-service claims, the review will be completed within 60 calendar days. If more time or information is needed to make the determination, the claims administrator will notify you in writing to request any additional information needed to complete the review. You will be notified in writing of the decision within five working days after the review meeting and within the review time frames above.

Expedited appeal request

You may request that the appeal process be expedited if either of the following conditions applies:

- The time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or, in the opinion of a physician with knowledge of your health condition, would cause you severe pain that cannot be managed without the requested services.
- Your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

The claims administrator's physician reviewer, in consultation with your treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, the claims administrator will respond orally with a decision within 36 to 72 hours, followed up in writing.

Health plan external review process

These additional external review provisions apply to the health claims described in this section. If the claim arises under an insured health program, an external review may be conducted in accordance with the external review procedures applicable to the insurance company that provides the plan.

The External Review Program offers an independent process for a review of the denial of a requested administrative or clinical service or procedure, or of the denial of payment for an administrative or clinical service or procedure.

The external review will be performed through an Independent Review Organization (IRO) by an independent physician who is qualified to decide whether the requested service or procedure is a covered service under the plan. Neither the IRO nor the reviewing physician can have any material affiliation with or interest in the plan, the claims administrator or the company.

The particular IRO used for the review will be assigned by the claims administrator on a rotating basis from a list of accredited IROs that the plan has contracted to perform external reviews. Neither you nor the claims administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. The IRO acts as a claims fiduciary of the plan with respect to the external reviews that are delegated to the IRO and that are binding on the plan.

The program is available:

- If a claim is denied based on clinical judgement or rescission (administrative claims and precertification denials are not eligible)
- After you exhaust the other appeal procedures described earlier in the Appealing a denied claim for benefits section and you receive a decision that is unfavorable; or
- If, after exhausting or being deemed to have exhausted your internal appeals on a health claim (for an administrative or clinical service or procedure), you are not satisfied with the final determination

Even if you have not exhausted the internal appeal process, you may request expedited external review of a denied claim if you have requested expedited internal appeal and the claim involves a medical condition for which the timeframe for completion of an expediated internal appeal would seriously jeopardize life or health or would jeopardize the ability to regain maximum function. You may also request expedited external review of a denied internal appeal if the appeal denial concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but you have not yet been discharged from the facility.

If the conditions for requesting external review are satisfied, you or an authorized representative may request an external review of the adverse benefit determination by contacting the toll-free customer service number on your plan ID card or by sending a written request to the address on your plan ID card. All requests for external review must be made within 120 days of the date you receive the adverse benefit determination. There is no charge to you for this external review.

Within five business days after receipt of your request for external review, the claims administrator will complete a preliminary review of your request to determine whether:

- You are or were covered under the plan at the time the health care item or service was requested or was provided;
- The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the plan's eligibility requirements;
- You have exhausted the internal appeal process, unless you are not required to exhaust it for reasons described earlier; and
- You have provided all the information and forms required to process an external review

Within one business day after completion of the preliminary review, the claims administrator will issue a written notice to you. If the request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete, and you may provide the needed materials by the end of the four-month filing period or the 48-hour period after receipt of the notice, whichever is later.

If there is any information or evidence that you or your physician wishes to submit in support of the request that was not previously provided, you may include this information with the request for an external review. Within five business days after assigning the request to an IRO, the claims administrator will forward your request for an independent review to the IRO, together with:

- All documents and information relied upon by the claims administrator in making a decision on the case; and
- All other information or evidence that you or your physician has already submitted to the claims administrator

The IRO will send you a notice that you may submit additional information in writing within 10 business days after receipt of this notice. The IRO will consider the additional information and forward it to the claims administrator.

The IRO will review the internal claim denial for which external review has been requested, without being bound by any decisions or conclusions reached during the claims administrator's internal review. The IRO will consider the documents and information that were provided in a timely manner as well as other information that the IRO considers relevant. The IRO will issue you and the claims administrator a written notice of its decision within 45 days after receiving the request for external review. If the reviewer needs additional information to make a decision, the prescribed time may be extended.

If you request expedited external review:

- The claims administrator's preliminary review to determine whether the request meets the requirements for standard external review must be performed expeditiously; and
- If the request meets the requirements, the claims administrator must notify you of such and send the relevant materials to the assigned IRO expeditiously

The IRO will issue a notice of its external review decision as expeditiously as your medical condition or circumstances require but no later than 72 hours after receiving the request for expedited external review. If the notice is not in writing, the IRO will issue a written confirmation within 48 hours after notifying you of its decision.

The reviewer's decision will include the clinical basis (if appropriate) for the determination. The IRO will provide you and the claims administrator with the decision, a description of the qualifications of the reviewer as well as any other information deemed appropriate by the IRO or required by applicable law.

If the final external review decision is to approve your claim, the plan will provide benefits for the claimed service or procedure pursuant to the final external review decision and in accordance with the terms and conditions of the plan, regardless of whether the plan intends to seek judicial review of the decision and unless or until there is a judicial decision otherwise. If the final external review decision is to deny your claim, the plan will not be obligated to provide benefits for the service or procedure.

For more information about your external appeal rights and the independent review process, contact the claims administrator at the toll-free customer service number on your plan ID card.

Legal action

You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. In most instances, you may not initiate legal action until you have exhausted all levels of the appeals process including the external review. If your appeal is expedited, there is no need to complete any additional appeal process prior to bringing legal action.

Appealing a denied prescription drug claim

If an application for prescription drug benefits is denied in whole or in part due to a prior authorization requirement or for a paper claim submission, you will receive a written notification. This statement will include the reasons for denial with a reference to the relevant plan provisions, a description of any additional information needed to process the claim, and an explanation of the claim review procedure. Within 180 days after receiving a denial, you may call CVS Caremark at **800-897-6435** to request reconsideration of your claim. You will be sent a Benefit Appeal form with an instruction letter.

You will receive a response within 30 days after receipt of the appeal and all of the relevant information required to rule on the appeal. The response will explain the reasons for the decision, again with references to the specific provisions on which the decision is based. CVS Caremark interprets the terms and provisions of the plan. Its decision is conclusive and binding. Prescription drug benefits will be paid under this plan only if CVS Caremark, in its discretion, determines that the claimant is entitled to them.

Independent physician specialist review — medical necessity appeals

If you are not fully satisfied with the decision of the CVS Caremark prescription appeals committee, and the reason for the denial is based on medical necessity or clinical appropriateness as determined by the committee, you may request that your appeal be referred to the Independent Review Organization contracted by CVS Caremark.

There is no charge for you to initiate the Independent Review process. CVS Caremark will abide by the decision of the Independent Review Organization. A decision will be made within 15 days after the appeal is received.

Appealing a denied VSP vision care claims

Grievance process

If you ever have a question or problem, your first step is to call VSP's Customer Service Department: the toll-free number is **888-426-3937**. The Customer Service Department will make every effort to answer your question and/or resolve the matter informally. Complaints and grievances include disagreements regarding access to care, quality of care, treatment or service.

Complaints and grievances

1. **Internal grievance process:** If the matter is not resolved to your reasonable satisfaction, you may initiate a formal grievance with VSP, by telephone, in person, by mail or by electronic means. Except where a time limit is waived or extended by mutual written agreement, VSP will: (i) reduce any oral grievance received to a writing, with a copy forwarded to you within 48 hours of receipt, or (ii) with respect to any other form of grievance, forward, within 15 business days of receipt, written acknowledgement. Records of any formal grievance received will be maintained by VSP for a period of seven years and will be subject to inspection by the Commissioner of Insurance and the Department of Public Health.

   In a manner consistent with state and federal law, you, or an authorized representative, will have access to any medical information and records relevant to the grievance, which is in the possession and under the control of VSP. Any request requiring the release or review of your confidential medical records relevant to the grievance must include your signature or an authorized representative, on a form authorizing the release of medical and treatment information, which form will be promptly provided by VSP on written request.

2. **External review process:** You may request an external review of a final adverse determination made by VSP by filing a written request with the Office of Patient Protection. Call **800-436-7757** to obtain the mailing address needed to file your request. You must file your request within 180 days of receipt of such final adverse determination.

Claiming Life, AD&D and BTA benefits

Information on filing a claim for Life, AD&D or BTA can be found within the applicable chapter.

Administration information

Some of the plans described in this 2023 Raytheon Technologies Health & Insurance Summary Plan Description are component plans under the Employee Group Health Plan of United Technologies Corporation and are subject to the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs certain employee benefit plans. Some component plans are also governed by the Internal Revenue Code (IRC). These component plans are identified in the table under ERISA-covered component plans in this section. The Employee Group Health Plan of United Technologies Corporation is, and is treated as, a single welfare benefit plan solely for purposes of annual report (Form 5500) filings.

In this chapter

For all other purposes under the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (IRC), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (PPACA), as amended, and any other applicable legal requirements, each component plan is, and is treated as, a separate plan.

This chapter describes your rights under ERISA for each component plan of the Employee Group Health Plan of United Technologies Corporation. It also provides other legally required information about all plans described in this SPD, such as how to have your claim for benefits reviewed.

One of ERISA's requirements is that you receive an understandable description of each plan called a Summary Plan Description, which is intended to provide an easy-to-understand explanation of your benefits. This document contains all or part of the individual SPDs for each of the component plans of the Employee Group Health Plan of United Technologies Corporation, which together comprise the SPD for the program itself.

Summary Plan Description

This document is the SPD for the following component plans of the Employee Group Health Plan of United Technologies Corporation:

- Anthem Gold with HSA
- Anthem Silver with HSA
- Out-of-Area Silver with HSA
- Out-of-Area Indemnity Plan
- Delta Dental Basic
- Delta Dental Plus
- Vision Plan
- Health Care Spending Account (HCSA)
- LifeResources
- Healthy You Incentives

The SPDs for the following component plans are comprised of multiple documents. Please see each specific section for a list of the applicable documents.

- Kaiser Gold with HSA (California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington and Washington, D.C.)
- Kaiser Hawaii HMO
- HMSA
- Cigna Global
- Employee Basic Life and Supplemental Life Insurance
- Spouse Life Insurance
- Child Life Insurance
- Employee Basic and Supplemental AD&D Insurance
- Spouse/Partner AD&D Insurance
- Child AD&D Insurance
- Business Travel Accident Insurance

The provisions of this SPD do not establish enforceable employee rights, contractual or otherwise, and they do not establish an employment relationship enforceable by employees. Nothing in this summary or any other Raytheon Technologies publication, policy or guideline may interfere with or limit in any way the right of Raytheon Technologies to terminate any employee's employment for any legal reason or no reason, with or without notice at any time; confer upon any employee any right to continue in the employ of Raytheon Technologies; or change an employee's existing at-will employee status. An employee's at-will employment status can only be changed in a writing signed by an authorized representative of Raytheon Technologies.

Raytheon Technologies sponsors the Employee Group Health Plan of United Technologies Corporation and each component plan listed in the following table for which this document comprises at least part of the SPD.

Note: The mailing addresses provided in the **Insurer** column are for submitting claims for benefits and appeals of denied claims for benefits.

Plan type/name	Plan number	Contributions and funding	Insurer
Employee Group Health Plan of United Technologies Corporation	**Health and welfare benefit plans**		
Medical plans including: • Anthem Gold with HSA • Anthem Silver with HSA • Out-of-Area Gold with HSA • Out-of-Area Indemnity Plan	503	Self-insured plans funded through employer and employee contributions	Anthem Blue Cross Blue Shield (BCBS) PO Box 105187 Atlanta GA 30348-5187 **866-251-1803**
• Kaiser Gold with HSA	503	Fully insured plan funded through employer and employee contributions	**Northern California** Kaiser Permanente Claims Administration Department P.O. Box 12923 Oakland, CA 94604-2923 **800-390-3510** **Southern California** Kaiser Permanente Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004 **800-390-3510** **Colorado** Kaiser Permanente P.O. Box 373150 Denver, CO 80237-7150 **800-632-9700** **Georgia** Kaiser Permanente Claims Administration P.O. Box 370010 Denver, CO 80237-9998 **Maryland, Virginia and Washington, D.C. (Mid-Atlantic States Region)** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. P.O. Box 6233 Rockville, MD 20849-6233 **800-777-7902**

Plan type/name	Plan number	Contributions and funding	Insurer
			Northwest (Portland, OR) Kaiser Permanente National Claims Administration – Northwest PO Box 370050 Denver, CO 80237-9998 **800-813-2000** **Washington (Seattle, WA)** Kaiser Foundation Health Plan of Washington P.O. Box 30766 Salt Lake City, UT 84130-0766 **888-901-4636**
• Kaiser Hawaii HMO	503	Fully insured plan funded through employer and employee contributions	Kaiser Foundation Health Plan, Inc. Attn: Claims Administration P.O. Box 378021 Denver, CO 80237 **800-966-5955**
• HMSA (Hawaii)	503	Fully insured plan funded through employer and employee contributions	HMSA Blue Cross Blue Shield 818 Keeaumoku St Honolulu, HI 96814 **800-776-4672**
• Cigna Global PPO	503	Self-insured plan funded through employer and employee contributions	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 U.S.A. **800-441-2668**
• Cigna Global HDHP	503	Self-insured plan funded through employer and employee contributions	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 U.S.A. **800-441-2668**
Prescription drugs — Anthem plans (CVS Caremark-administered prescription drug program for participants enrolled in a medical plan administered by Anthem)	503	Self-insured plan funded through employer and employee contributions	CVS Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 **800-897-6435**

Plan type/name	Plan number	Contributions and funding	Insurer
Dental Plans • Delta Dental Basic • Delta Dental Plus	503	Self-insured plans funded through employer and employee contributions	Delta Dental of Massachusetts 465 Medford Street Boston, MA 02129 **877-335-8227** Claims Appeals Delta Dental of Massachusetts Attn: Grievances and Appeals P.O. Box 9695 Boston, MA 02114
Vision	503	Self-insured plans funded through employer and employee contributions	VSP Vision Care Attn: Out-of-Network Claims P.O. Box 385018 Birmingham, AL 35238-0518 **888-426-3937**
Health Care Spending Account	503	Funded through employee pre-tax contributions	Smart-Choice Accounts P.O. Box 64030 The Woodlands, TX 77387-4030 **800-243-8135**
Employee Life Insurance	503	Basic: Fully insured plan funded through employer contributions Supplemental: Fully insured plan funded through employee contributions to a trust	New York Life Assurance Service Center 1455 Valley Center Parkway Bethlehem, PA 18107 **800-732-1603**
Dependent Supplemental Life Insurance (Spouse and Dependent Children)	503	Fully insured plan funded through employee contributions	New York Life Assurance Service Center 1455 Valley Center Parkway Bethlehem, PA 18107 **800-732-1603**
Accidental Death and Dismemberment Insurance (Employee, Spouse and Dependent Children)	503	Basic: Fully insured plan funded through employer contributions Supplemental: Fully insured plan funded through employee contributions to a trust	National Union Fire Insurance Company of Pittsburgh, Pa. (NUFIC) Claims Services An AIG Company P.O. Box 25987 Shawnee Mission, KS 66225-5987 **800-551-0824**

Plan type/name	Plan number	Contributions and funding	Insurer
Business Travel Accident	503	Fully insured plan funded through employer contributions	National Union Fire Insurance Company of Pittsburgh, Pa. (NUFIC) Claims Services An AIG Company P.O. Box 25987 Shawnee Mission, KS 66225-5987 **800-551-0824**
LifeResources	503	Self-insured plan funded through employer and employee contributions	ComPsych Corporation 455 N. Cityfront Plaza Drive Chicago, IL 60611 **866-640-7008**

Your rights under ERISA

As a participant in at least one component plan under the Employee Group Health Plan of United Technologies Corporation, you're entitled to certain rights and protections. ERISA provides that all participants in each component plan have the rights described below.

Receive information about each of your component plans and benefits

As a component plan participant, you can examine, without charge, all documents governing each component plan in which you participate, including insurance policy documents and a copy of the latest annual report (Form 5500 Series) filed by the Employee Group Health Plan of United Technologies Corporation with the U.S. Department of Labor and available at the Employee Benefits Security Administration (EBSA).

You can examine copies of these documents in the plan administrator's office, or you can write to the plan administrator and request that these documents be made available to you for examination.

You can obtain your own copies of the documents governing the operation of each component plan in which you participate, including insurance policy documents and copies of the latest annual report (Form 5500 Series) and updated SPDs, by writing to the plan administrator. You can also obtain a copy of the latest SPDs by writing or calling the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**. You may have to pay a reasonable charge to cover the cost of photocopying or printing. You may also view and print your own copy of the updated SPDs by visiting **Your Gateway**.

Your request must be in writing, and you must specifically identify the name of the plan and the particular documents you're requesting. Your request must be sent to the plan administrator at the following address:

Plan Administrator
Raytheon Technologies
c/o Corporate Benefits
870 Winter Street
Waltham, MA 02451-1219

781-522-3000

You automatically receive, as required by law, a summary of the Employee Group Health Plan of United Technologies Corporation's annual financial report and other required documents.

Continue group health plan coverage

If you're in a component plan that is a group health plan — medical, dental, vision, Health Care Spending Account (HCSA) and LifeResources — you can continue health care coverage for yourself, your spouse and/or your dependents if there is a loss of coverage under that component plan as a result of a COBRA-qualifying event. You or your dependents will have to pay for such coverage. Review the summary of the rules governing your COBRA continuation coverage rights in the *Other important information* chapter.

Rely on prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people responsible for the operation of a plan. The people who operate the plans, called "**fiduciaries**," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Enforce your rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a plan document or the latest annual report for the Employee Group Health Plan of United Technologies Corporation and don't receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan (see Claiming your benefits later in *Claims* chapter), 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 medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you're 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're 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 the court finds your claim is frivolous.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you're entitled under any plan or exercising your rights under ERISA.

Get assistance with your questions

If you have any questions about a plan, you should contact the plan administrator by calling **781-522-3000**. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area (addresses and phone numbers of regional and district EBSA offices are available through the EBSA website) or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA publication hotline at **866-444-3272**.

Plan administration and contact information

Raytheon Technologies sponsors the Employee Group Health Plan of United Technologies Corporation. Records for the Employee Group Health Plan of United Technologies Corporation and each component plan are kept on a calendar-year basis. The calendar year is the **plan year**.

Required information	Employee Group Health Plan of United Technologies Corporation
Plan name	Employee Group Health Plan of United Technologies Corporation
Plan number	503
Plan year	Calendar year
Plan sponsor	Raytheon Technologies 1000 Wilson Blvd. Arlington, VA 22209 Phone: **781-522-3000**
Plan administrator	Pension Administration Committee (PAC) 10 Farm Springs Road Farmington, CT 06032 Phone: **860-728-7000** PAC has delegated the implementation of administrative procedures and compliance and the eligibility for the group health plan, in accordance with IRS rules and regulations to: Raytheon Technologies Benefits Center Dept 01638 P.O. Box 1590 Lincolnshire, IL 60069-1590 Phone: **800-243-8135**
Plan sponsor tax ID number (EIN)	06-0570975
Agent for service of legal process	Secretary Raytheon Technologies Corporation 10 Farm Springs Road Farmington, CT 06032 Service of process may also be made to the plan trustee or the plan administrator.
Plan trustee	Chase Manhattan Bank, N.A. Institutional Asset Services 4 New York Plaza, 2nd Floor New York, NY 10004-2413
Type of plan	Group health and welfare benefits plan

Submitting forms to the Raytheon Technologies Benefits Center

Raytheon Technologies Benefits Center
Dept 01638
P.O. Box 1590
Lincolnshire, IL 60069-1590

You may send forms via overnight mail (e.g., FedEx, UPS, or USPS) to the following address:

Raytheon Technologies Benefits Center
Dept 01638
4 Overlook Point Ste 408
Lincolnshire, IL 60069

Participating employers

A complete list of Raytheon Technologies subsidiaries that are participating employers in the Employee Group Health Plan of United Technologies Corporation can be obtained from the plan administrator.

Collective bargaining agreements

Complete copies of any collective bargaining agreements relevant to your benefit plans and lists of signatories are available for examination upon written request to the plan administrator or can be obtained from the Labor Relations Department.

Plan documents

The Employee Group Health Plan of United Technologies Corporation and each component plan are based on official plan documents. Each component plan's SPD is a summary of the more important plan features. This SPD supersedes and replaces any prior communications, policies, rules, practices, standards and/or guidelines to the contrary, whether written or oral. You can find full component plan details in the official plan documents. If a component plan provision described in this SPD disagrees with the official plan document, the wording of the official plan document always governs. For information about how to obtain a copy of a plan document, see Receive information about each of your component plans and benefits.

Plan amendment and termination

Benefits under any plan, program or policy described in this document are available only while such plan, program or policy is effective and only pursuant to its terms. Raytheon Technologies has the exclusive right to amend, suspend or terminate any employee benefit plan or any other program or policy described in this document at any time without prior notice (except as required by law) to employees, former employees, their beneficiaries or any other person. Such amendments or modifications may be retroactive to meet statutory requirements or for any other reason. Participants and beneficiaries have no vested rights in the Employee Group Health Plan of United Technologies Corporation, any component plan or any program or policy; in particular, no vested rights arise in benefits currently made available to retirees after employment ends.

Because of the need for confidentiality, decisions regarding changes to the company's benefits plans, programs, practices or policies are generally not discussed or evaluated below the highest levels of management. Managers and their representatives below such levels don't know whether Raytheon Technologies will or will not change or adopt, for example, any particular benefit or retirement plan. Nor are they in a position to advise any employee on, or speculate about, future plans. Employees should make no assumptions about future changes, or the impact changes may have on their personal situation until any such change is formally announced by Raytheon Technologies.

Special rules for acquisitions

Raytheon Technologies may establish special eligibility rules applicable to designated acquisitions including insourcing of employees performing functions that had been outsourced previously. In certain situations, credit for past service may be granted. Affected individuals will be notified if any of these special provisions apply.

HIPAA Privacy Rights

The plan has certain obligations regarding the privacy of participants' and their enrolled dependents' medical information according to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The plan is committed to protecting participants' and their enrolled dependents' personal health information. The plan is required by law to (1) make sure that any medical information that identifies a participant or their enrolled dependents is kept private; (2) provide a participant and their enrolled dependent with certain rights with respect to their medical information; (3) give participants a notice of their legal duties and privacy practices; and (4) follow all privacy practices and procedures currently in effect.

Protected Health Information

The following provisions describe the permitted uses and disclosures of protected health information (including electronic protected health information) ("PHI") of participants and their enrolled dependents by the plan. These provisions are intended to comply with the regulations establishing Standards for Privacy of Individually Identifiable Health Information published by the U.S. Department of Health and Human Services under HIPAA (the "Privacy Rule"). These provisions shall be construed to be consistent with the Privacy Rule requirements. For a complete, detailed description of all privacy practices, please refer to the plan's Notice of Privacy Practices.

1. Restriction on Use of Genetic Information

The plan is prohibited from using or disclosing and will not use or disclose a participant's or their enrolled dependent's information that contains genetic information for underwriting purposes.

2. Use or Disclosure of PHI

The plan is prohibited from using or disclosing PHI other than as permitted or required under this plan or as permitted or required by the Privacy Rule. PHI may be used or disclosed for the following purposes, provided that the plan uses or discloses the least amount of PHI that is necessary for the intended purpose:

a) With valid authorization

Use or disclosure of PHI may be made with valid authorization from the participant or enrolled dependent (as appropriate) as provided by the Privacy Rule. For this purpose, authorization is such participant's or enrolled dependent's permission to use specified PHI for specified purposes or to disclose specified PHI, for specified purposes, to a specified third party. The plan cannot retaliate against a participant or enrolled dependent if they refuse to sign an authorization or revoke an authorization previously given.

b) Without authorization

Use or disclosure of PHI is permitted without authorization for treatment, payment or health care operations.

1. Treatment includes activities by the plan for the coordination of care or services between the plan and health care provider(s).
2. Payments include activities by the plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of or providing reimbursement for benefits to participants and their enrolled dependents under the plan. These activities include, but are not limited to:

    - Determinations of eligibility or coverage,
    - Coordination of benefits,

- Adjudication or subrogation of benefits,
- Risk adjusting amounts based on enrollee health status,
- Billing, claims management, collection activities, obtaining payment under a reinsurance contract and related data processing,
- Review of health care services with respect to medical necessity, coverage, appropriateness of care or justification of charges,
- Utilization review activities, including precertification and preauthorization of services and concurrent or retrospective review of services, and
- Disclosures to consumer reporting agencies for collection of premiums or reimbursements.

3. Health care operations include, but are not limited to:

   - Conducting quality assessment and improvement activities, including outcomes evaluations and development of clinical guidelines,
   - Population-based activities relating to improving health or reducing health care costs, such as chronic condition management and wellness programs offered through a contracted third party, plan participant online and paper resources to help facilitate their health care and facilitation of any incentive programs geared toward health care,
   - Protocol development, case management and care coordination,
   - Contacting health care providers and patients with information about treatment alternatives and related functions,
   - Evaluating provider and plan performance,
   - Accreditation, certification, licensing or credentialing activities,
   - Underwriting, premium rating and other activities relating to the creation, renewal or replacement of health insurance contracts or benefits,
   - Ceding, securing or placing a contract for reinsurance,
   - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
   - Conducting required plan audits in conjunction with government filings,
   - Business planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the plan, including formulary development and administration, development or improvement of methods of payment or coverage policies,
   - Business management and general administrative activities of the plan including management activities regarding compliance with the Privacy Rule and other Administrative Simplification Provisions under HIPAA or customer service, including the provision of data analyses for policy holders, Raytheon Technologies, as plan sponsor, or other customers,
   - Resolution of internal grievances
   - Activities related to the sale, transfer, merger or consolidation of the company.

4. PHI may be disclosed to a business associate of the plan if the plan's contract with such business associate restricts its use of PHI and sets forth its duties with respect to protecting PHI in accordance with the Privacy Rule.
5. Summary health information may be disclosed to Raytheon Technologies for the purpose of obtaining premium bids for the plan or for modifying, amending or terminating the plan.
6. De-identified PHI may be disclosed for any purpose.

3. Plan Compliance

Prior to disclosure of PHI from the plan to Raytheon Technologies, as plan sponsor, Raytheon Technologies shall certify that the plan has been amended to incorporate the provisions set forth in Section 4 below and that Raytheon Technologies agrees to comply with such provisions.

4. Terms of Compliance

a) Raytheon Technologies agrees (i) to abide by the terms of the plan regarding the permitted and required use and disclosure of PHI and (ii) to comply with the Privacy Rule regarding the required use and disclosure of PHI.
b) Raytheon Technologies shall ensure that any agent or subcontractor to whom it provides PHI received from the plan agrees to abide by the same restrictions and conditions that apply to the company with respect to the PHI.
c) Raytheon Technologies will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan.
d) Raytheon Technologies will ensure that any agents or subcontractors, to whom it gives electronic protected health information, agree to implement reasonable and appropriate security measures to protect such information.
e) Raytheon Technologies will not use or disclose PHI for employment-related actions or decisions or in connection with any of its other employee benefits or employee benefit plans, unless authorized by the participant or otherwise permitted by the Privacy Rule.
f) Raytheon Technologies will report to the plan any improper use or disclosure of PHI of which it becomes aware.
g) Raytheon Technologies will report any security incident of which it becomes aware.
h) Raytheon Technologies will make available to participants and their enrolled dependents PHI to permit them to access their PHI and to request that the PHI be amended in accordance with the Privacy Rule. Any amendments agreed upon will be incorporated into such PHI.
i) Raytheon Technologies will make available to participants and enrolled dependents PHI in order to provide, upon request, an accounting of all disclosures of their PHI for the immediately preceding six years, as provided under the Privacy Rule.
j) Raytheon Technologies will make available to the United States Department of Health and Human Services all of its practices, books and records relating to the use and disclosure of PHI received from the plan.
k) If feasible, once Raytheon Technologies no longer needs PHI for its intended purpose, Raytheon Technologies will return the PHI to the plan or destroy all copies of the PHI. If such action is not feasible, Raytheon Technologies will limit further use and disclosure to those purposes that make the return or destruction of the information infeasible.

5. Employee Access to PHI

In order to maintain adequate separation between the plan and Raytheon Technologies, as plan sponsor, employees in the following positions within Raytheon Technologies will be the only employees who will have access to PHI received from the plan for plan administration purposes:

a) The Vice President, Global Benefits (the “Vice President”) at Raytheon Technologies,
b) Staff of the Vice President, designated from time to time by the Pension Administration Committee or the Vice President at Raytheon Technologies, including without limitation, Benefits Managers,
c) Appropriate members of the Human Resources Departments of the various business units that participate in the plan, including, without limitation, members of the Benefit Claims Appeal

Committee, with respect to claims under the Healthcare Reimbursement Account portion of the plan, if applicable,

d) Appropriate members of the Shared Business Services, Payroll, HRIS and IT Departments (including contractors), and

e) Appropriate members of the Legal Department, including, without limitation, the Associate General Counsel, Counsel, Paralegal, Administrative Assistant and Legal Department Contractor.

This access to and use of PHI by these personnel is restricted to relevant plan administration functions, including health care payment and operations.

Raytheon Technologies shall establish an effective procedure for resolving any issues of noncompliance by any of the employees in the positions listed above in the event any such employee violates any of the provisions listed in this section. If Raytheon Technologies becomes aware that an employee or other individual listed above has failed to comply with the access or use limitation on PHI described in this section, Raytheon Technologies will inform the Privacy Officer and the Privacy Officer will determine, in accordance with the plan's policies and procedures, what sanctions, if any, should be imposed. This includes disciplinary action up to and including termination.

6. Privacy Officer

The plan has designated a Privacy Officer who will be responsible for overseeing the plan's compliance with the Privacy Rule.

7. Complaints

If a participant or their enrolled dependent believes their privacy rights have been violated, they have the right to file a complaint with the plan or with the Office for Civil Rights within the Department of Health and Human Services. The plan will not retaliate against an individual for making a complaint.

8. Breach Notification Rules

In accordance with certain revised HIPAA rules, a participant is entitled to receive notification from Raytheon Technologies if the confidentiality of any of the participant's PHI maintained in an unsecured form is compromised. This notification may come directly from the plan or it may come from a third-party service provider working with the plan to provide participant benefits.

Contacts

See the following contact information for the insurance carriers and service providers for our benefits plans and programs.

In this chapter

For general questions about your benefits, visit **Your Gateway** or call the Raytheon Technologies Benefits Center via **Access Direct** at **800-243-8135**.

General questions

	Website and phone	Mailing Address
Raytheon Technologies Benefits Center	Via **Your Gateway**: yourtotalrewards.com/rtx Via Access Direct: **800-243-8135**	Raytheon Technologies Benefits Center Dept 01638 P.O. Box 1590 Lincolnshire, IL 60069-1590

Medical

Carrier	Website and phone	Mailing address
Anthem Blue Cross Blue Shield	anthem.com/rtx **866-251-1803**	Anthem BCBS P.O. Box 105187 Atlanta, GA 30348-5187
Kaiser Permanente	kp.org Customer Service call the number on the back of your medical plan ID card Claims call the number listed below for your region **Northern & Southern CA** **800-390-3510** **Colorado** **303-338-3600** **Georgia** **404-261-2825** **Hawaii** **877-875-3805** **Mid-Atlantic** **800-777-7902** **Oregon** **503-735-2727** **Washington** **888-901-4636**	**Northern CA** 2829 Watt Avenue, Suite #130 Sacramento, CA, 95821 **Southern CA** P.O. Box 7004 Downey, CA 90242-7004 **Colorado** P.O. Box 373150 Denver, CO 80237 **Georgia** P.O. Box 370010 Denver, CO 80237-9998 **Hawaii** P.O. Box 378021 Denver, CO 80237 **Mid-Atlantic** P.O. Box 371860 Denver, CO 80237-9998 **Oregon** P.O. Box 370050 Denver, CO 80237-9998 **Washington** Claims Processing P.O. Box 30766 Salt Lake City, UT 84130-0766
HMSA	hmsa.com **800-776-4672**	**HMSA Blue Cross Blue Shield** 818 Keeaumoku St Honolulu, HI 96814
Cigna Global PPO	cignaenvoy.com **855-448-5733** **+1-302-797-3784**	**Cigna** P.O. Box 15050 Wilmington, DE 19850 U.S.A

Carrier	Website and phone	Mailing address
Cigna Global HDHP	cignaenvoy.com **855-448-5733** **+1-302-797-3784**	**Cigna** P.O. Box 15050 Wilmington, DE 19850 U.S.A

Prescription drugs

Carrier	Website and phone	Mailing address
CVS Caremark (If you're enrolled in a medical plan with Anthem)	https://info.caremark.com/oe/raytheon Customer Care **800-897-6435** FastStart **800-378-5697**	CVS Caremark P.O. Box 52196 Phoenix, AZ 85072-2196

Dental

Carrier	Website and phone	Mailing address
Delta Dental	deltadentalma.com/raytheon **877-335-8227**	Delta Dental of Massachusetts P.O. Box 2907 Milwaukee, WI 53201-2907

Vision

Carrier	Website and phone	Mailing address
VSP	vsp.com **888-426-3937**	VSP Vision Care Attn: Out-of-Network Claims P.O. Box 385018 Birmingham, AL 35238-0518

Health Savings Account (HSA)

Service provider	Website and phone	Mailing address
Fidelity Investments	netbenefits.com/raytheon **800-544-3716**	Fidelity Institutional Retirement Services Company Raytheon Claims & Appeals Unit P.O. Box 770003 Cincinnati, OH 45277-1060

Spending Accounts

Service provider	Website, phone and fax	Mailing address
Smart-Choice Accounts	yourtotalrewards.com/rtx Phone: **800-243-8135** Fax: **855-673-6719**	Smart-Choice Accounts P.O. Box 64009 The Woodlands, TX 77387-4009

Life Insurance

Carrier	Website and phone	Mailing address
New York Life Assurance	yourtotalrewards.com/rtx **800-243-8135**	Raytheon Technologies Benefits Center Dept 01638 P.O. Box 1590 Lincolnshire, IL 60069-1590

Accidental Death and Dismemberment Insurance

Carrier	Phone	Mailing address
AIG (National Union Fire Insurance Company of Pittsburgh, Pa. (NUFIC) Claims Services)	**800-551-0824**	National Union Fire Insurance Company of Pittsburgh, Pa. (NUFIC) Claims Services An AIG Company P.O. Box 25987 Shawnee Mission, KS 66225-5987

Business Travel Accident Insurance

Service provider	Phone	Mailing address
AIG (National Union Fire Insurance Company of Pittsburgh, Pa. (NUFIC) Claims Services)	**800-551-0824**	National Union Fire Insurance Company of Pittsburgh, Pa. (NUFIC) Claims Services An AIG Company P.O. Box 25987 Shawnee Mission, KS 66225-5987

LifeResources

Service provider	Website and phone	Mailing address
ComPsych	liferesourcesray.com **866-640-7008**	ComPsych Corporation 455 N Cityfront Plaza Dr. Chicago, IL 60611

Healthy You Incentives

Service provider	Email
Alight Well	Health Pro coach or benefits questions alightwell@alight.com App support support@alightwell.com

Appendix

The Appendix provides detailed information about your health plan coverage, including copays, coinsurance, out-of-pocket maximums and limitations on covered services.

In this chapter

For specific questions about your benefits, call your carrier listed on the back of your member ID card or at the number listed in the Contacts chapter.

At-home COVID-19 test kit benefit

Beginning Jan. 1, 2022, through May 11, 2023, group health plans for active employees were required to cover the cost of over-the-counter, at-home COVID-19 test kits without a prescription as part of the Coronavirus Aid, Relief and Economic Security Act (CARES Act) and the Families First Coronavirus Response Act (FFCRA).

Effective May 12, 2023, over-the-counter COVID-19 test kits are no longer covered under any Raytheon Technologies medical or pharmacy plans. Additionally, PCR COVID-19 tests will change from being covered at 100% to being covered subject to plan deductibles and coinsurance. Read on to learn what's covered by the Raytheon Technologies medical plans and how to submit a claim.

Note

Effective May 12, 2023, over-the-counter COVID-19 test kits are no longer covered under any Raytheon Technologies medical or pharmacy plans. Additionally, PCR COVID-19 tests will change from being covered at 100% to being covered subject to plan deductibles and coinsurance.

What's covered

Effective Jan. 15, 2022, through May 11, 2023, Raytheon Technologies medical plan coverage for at-home COVID-19 test kits is as follows:

- **If you don't have a prescription:** Up to eight at-home COVID-19 rapid antigen test kits are covered every 30 days for each enrolled family member. Each test in a test kit package counts toward the eight-test kit limit. For example, a test kit package with two tests would count as two tests.
- **If you have a prescription:** At-home COVID-19 test kits are covered as prescribed. Prescribed at-home test kits don't count toward the nonprescribed eight test kit limit.

Note

- At-home test kits are for your use may not be resold or used for work-related purposes.
- At-home test kits purchased before Jan. 15, 2022, **or after May 11, 2023**, without a prescription aren't eligible for reimbursement from any Raytheon Technologies medical or pharmacy plans.
- At-home rapid antigen test kits must have FDA Emergency Use Authorization (EUA) to be eligible for reimbursement. If you're enrolled in a medical plan with Anthem Blue Cross Blue Shield, at-home rapid antigen test kits that are seeking FDA EUA or plan to seek FDA EUA will also be eligible for reimbursement.
- Effective May 12, 2023, COVID-19 tests performed at a testing location (such as CVS, Walgreens or at a health care facility) continue to be covered by the Raytheon Technologies medical plans subject to the plan deductible and coinsurance. This includes PDR, rapid PCR and antigen tests.

Eligible test kits

Eligible tests include single-use, cartridge-based tests (for example, Flowflex, BinaxNow or Ongo).

You won't be reimbursed for tests that:

- Have to be sent to a lab (for example, Pixel, MyLab Box)
- You can't administer and read yourself
- Require a health care professional (doctor or nurse) to administer or read the test (for example, polymerase chain reaction (PCR) or rapid tests)

Note

You can buy your test at any pharmacy, other retailer or online. If the pharmacy can bill directly under your pharmacy benefit, there will be no out-of-pocket cost. If the pharmacy can't bill directly under your benefit, or if you buy at another retailer or online, you will have to pay for the test and request reimbursement.

Some pharmacies may not be able to process claims for at-home COVID-19 test kits at the pharmacy counter at this time. If this happens, you can pay for the test, then submit a request for reimbursement.

Submitting a claim

Generally, you'll need to provide the following information:

- Your mailing address
- The number and type of test kits you bought
- Where you bought the test kits
- A copy of your receipt dated between Jan. 15, 2022, and May 11, 2023.

You'll need to confirm that the test kit was used to diagnose a possible COVID-19 infection.

You do not need to submit:

- A prescription from your doctor
- The test results

Additional information about Caremark point-of-sale claim adjudication

SPECIAL NOTE: The federal emergency period ended on May 11, 2023. Effective May 12, 2023, over-the-counter test kits will no longer be covered by any Raytheon Technologies medical or pharmacy plans.

CVS Caremark's point-of-sale claim adjudication solution currently covers **certain** test kits through point-of-sale adjudication. Contact CVS Caremark for additional information. **Member's cost share for point-of-service claims is $0.**

Carrier	How to submit a claim for test kits purchased on or after Jan. 15, 2022, through May 11, 2023
CVS Caremark *If you're enrolled in a medical plan with Anthem Blue Cross Blue Shield*	**Without a prescription and purchased on or after Jan. 15, 2022, through May 11, 2023:** • Log in to caremark.com to submit a claim for reimbursement to CVS Caremark. Click **Plan & Benefits** in the top navigation and then **Submit Prescription Claim**. Follow the on-screen prompts to submit your claim. • No out-of-pocket expense or claim for reimbursement is required when test kits are purchased at the counter of an in-network pharmacy using your CVS Caremark ID card. • You'll need to submit a claim if test kits are purchased at the pharmacy store's regular retail counter, at a non-network pharmacy or without your CVS Caremark ID card. **With a prescription:** • No out-of-pocket expense or claim for reimbursement is required when test kits are purchased at the counter of an in-network pharmacy using your CVS Caremark ID card. • You'll need to submit a claim if test kits are purchased at the pharmacy store's regular retail counter, at a non-network pharmacy or without your CVS Caremark ID card. **Note: Test kit claims submitted to Anthem Blue Cross Blue Shield will not be covered. They must be submitted to CVS Caremark.**
Kaiser Permanente	**Without a prescription and purchased on or after Jan. 15, 2022, through May 11, 2023:** Log in to your Kaiser Permanente account at kp.org. Click **Coverage & Costs** and then **Submit a claim**. **With a prescription:** No out-of-pocket expense or claim for reimbursement is required. Prescribed test kits must be received from Kaiser Permanente. **Note:** Log in to your Kaiser Permanente account at kp.org for information on when kits will be available for order directly through Kaiser Permanente without a written prescription.
Cigna Global	**With OR without a prescription and purchased on or after Jan. 15, 2022, through May 11, 2023:** • Log in to CignaEnvoy.com to submit a COVID OTC At Home Claim Form (look under **Documents** > **Your Claim Form**). • Completed claim forms also can be submitted via mail to the address on the back of your Cigna ID card or by fax (**800-243-6998** or **302-797-3150**). **Note:** To be eligible for reimbursement, at-home test kits must be purchased within the U.S. Test kits purchased outside the U.S. or purchased within the U.S. and then shipped outside the U.S. aren't eligible for reimbursement. For more information about filing a claim with Cigna Global, log in to CignaEnvoy.com.

Questions?

To speak with someone about at-home COVID-19 test kit reimbursement, call your plan carrier:

- CVS Caremark (if enrolled in a medical plan with Anthem Blue Cross Blue Shield): **800-897-6435**
- Kaiser Permanente: Refer to the back of your medical plan ID card for the phone number.
- Cigna Global: **855-448-5733** (or +**1-302-797-3784**)

Anthem Gold HSA & Silver HSA

		Anthem Gold		Anthem Silver	
		In network	Out of network	In network	Out of network
Deductible What you pay before the plan shares the cost of care	You Only	$1,750	$3,500	$3,000	$6,000
	You + Spouse or You + Children	$3,000	$6,000	$4,500	$9,000
	You + Family	$3,500	$7,000	$6,000	$12,000
Covered services What the plan pays	Preventive Care	100%	60%	100%	60%
	Coinsurance	80%	60%	80%	60%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250	$4,500	$2,000	$4,000
	You + Spouse or You + Children	$3,000	$6,000	$3,000	$6,000
	You + Family	$4,500	$9,000	$4,000	$8,000
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000	$8,000	$5,000	$10,000
	Individual on Family Coverage[1]	$7,500	$16,000	$7,500	$20,000
	You + Spouse or You + Children	$6,000	$12,000	$7,500	$15,000
	You + Family	$8,000	$16,000	$10,000	$20,000
Lifetime maximum		Unlimited		Unlimited	

[1] $7,500 is the most that one covered family member will have to pay toward the **in-network deductible and/or coinsurance** combined. If a covered family member reaches that amount, the company will pay 100% of covered in-network services for **that individual** for the rest of the year.

Anthem Gold HSA & Silver HSA services	The plan pays	
	In network	Out of network
Preventive Care	100% no deductible	60% after deductible
Acupuncture	80% after deductible	60% after deductible
Allergy		
Testing	80% after deductible	60% after deductible
Treatment	80% after deductible	60% after deductible

Anthem Gold HSA & Silver HSA services	The plan pays	
	In network	Out of network
Ambulance (emergency only)		
Emergency	80% after deductible	80% after deductible
Nonemergency	Not covered	Not covered
Ambulatory surgical center	80% after deductible	60% after deductible
Anesthesia	80% after deductible	60% after deductible
Bariatric surgery	80% after deductible	60% after deductible
Biofeedback	Not covered	Not covered
Blood processing and storage	80% after deductible	60% after deductible
Chiropractic	80% after deductible	60% after deductible
Dental For injury to sound teeth, mouth or face within 12 months of the injury	80% after deductible	60% after deductible
Diabetes maintenance		
Diabetes education/nutritional counseling (limit 6 visits per year)	80% after deductible	60% after deductible
Diabetic supplies	80% after deductible	60% after deductible
Diagnostic X-ray, lab and diagnostic services		
Nonroutine dense breast ultrasound	100% after deductible	60% after deductible
Nonroutine other	80% after deductible	60% after deductible
Durable medical equipment (DME)		
DME purchase and rental	80% after deductible	60% after deductible
Medical supply	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Orthotics (includes custom fitted orthotics)	80% after deductible	60% after deductible
Hearing aid services (both ears)		
Evaluation (limit 1 every 36 months)	80% after deductible	60% after deductible
Hearing aids (limit $3,000 every 3 years)	80% after deductible	60% after deductible
Vision hardware (for glasses/contacts after cataract surgery, refer to Vision/Post-Surgical Vision)	Not covered	Not covered

Anthem Gold HSA & Silver HSA services	The plan pays	
	In network	Out of network
Wigs/toupees Limit 1 per year (hair loss must be due to a medical condition, including but not limited to chemotherapy, radiation or alopecia)	80% after deductible	60% after deductible
Emergency care		
True emergency	80% after deductible	80% after deductible
Nonemergency	60% after deductible	60% after deductible
Foot care	Not covered	Not covered
Home health/home infusion/PDN		
Home health care	80% after deductible	60% after deductible
Home infusion therapy	80% after deductible	60% after deductible
Private duty nursing (covered only in the home)	80% after deductible	60% after deductible
Hospice/bereavement		
Hospice (including respite care)	80% after deductible	60% after deductible
Bereavement counseling	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Immunizations	80% after deductible	60% after deductible
Injections	80% after deductible	60% after deductible
Inpatient care	80% after deductible	60% after deductible
Accommodations and ancillaries	80% after deductible	60% after deductible
Physical medical rehab	80% after deductible	60% after deductible
Skilled nursing facility	80% after deductible	60% after deductible
Professional medical care	80% after deductible	60% after deductible
Mental health		
Applied behavioral analysis therapy	80% after deductible	60% after deductible
Alcohol/substance abuse	80% after deductible	60% after deductible
Attention deficit disorders	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Inpatient, outpatient mental health	80% after deductible	60% after deductible
Nutritional counseling (non-diabetic) (outpatient limit 6 visits per year)	80% after deductible	60% after deductible

Anthem Gold HSA & Silver HSA services	The plan pays	
	In network	Out of network
Obstetrics, family planning and sterilization		
Contraceptives (not included in Women's Health Provision)	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Contraceptives (covered under Women's Health Provision)	100% (no deductible)	Covered at the benefit level of the services billed
Maternity care		
Routine preventive prenatal visits covered 100% (no deductible)	100% (no deductible)	60% after deductible
Ultrasounds, labs, visits to monitor pregnancy related conditions, non-routine prenatal visits	80% after deductible	60% after deductible
Infertility services	80% after deductible	Not covered
Infertility treatment (artificial insemination, invitro fertilization)	80% after deductible	Not covered
Genetic counseling	80% after deductible	60% after deductible
Sterilization (for services that do not meet Women's Health Provision requirements)	80% after deductible	60% after deductible
Outpatient hospital services	80% after deductible	60% after deductible
Professional physician services	80% after deductible	60% after deductible
Consultation, second opinion	80% after deductible	60% after deductible
Home visits	80% after deductible	60% after deductible
Onsite clinics	80% after deductible	Not covered
Retail health clinics	80% after deductible	60% after deductible
Expanded preventive care for chronic conditions	100% no deductible	60% after deductible
Online visits (telehealth)		
Doctor On Demand	80% after deductible	Not covered
Online visits (telehealth)	80% after deductible	60% after deductible
Telephonic visits	80% after deductible	60% after deductible
Surgery benefits		
Assistant surgeon	80% after deductible	60% after deductible
Oral surgery (limited to charges made for continuous course of dental treatment within 12 months of injury to sound, natural teeth)	80% after deductible	Covered at the Surgical Level

Anthem Gold HSA & Silver HSA services	The plan pays	
	In network	Out of network
Office, outpatient and inpatient	80% after deductible	60% after deductible
Therapies		
Cardiac rehab	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible
Dialysis/hemodialysis therapy	80% after deductible	Not covered
Infusion	80% after deductible	60% after deductible
Occupational	80% after deductible	60% after deductible
Physical	80% after deductible	60% after deductible
Radiation	80% after deductible	60% after deductible
Respiratory	80% after deductible	60% after deductible
Speech	80% after deductible	60% after deductible
Temporomandibular (TMJ)	80% after deductible	60% after deductible
Transgender medical services		
Behavior health services	80% after deductible	60% after deductible
Hormone therapy	80% after deductible	60% after deductible
Feminization/masculinization-related procedures	80% after deductible; precertification required	60% after deductible; precertification required
Gender affirmation surgery	80% after deductible; precertification required	60% after deductible; precertification required
Transplants		
Performed at a BDCT facility		
Live donor health services[1]	100% after deductible	Not covered
Bone marrow donor search fee	100% after deductible	Not covered
Organ transplant BDCT facility[2]	100% after deductible	Not covered
Travel and lodging BDCT facility[3]	100% after deductible	Not covered

[1] Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to the maximum allowed amount, including complications from the donor procedure for up to six weeks from the date of procurement.

[2] Donor expenses are covered.

[3] Limited to $10,000 per transplant.

Anthem Gold HSA & Silver HSA services	The plan pays	
	In network	Out of network
Performed at a non-BDCT facility		
Live donor health services[1]	80% after deductible	60% after deductible
Bone marrow donor search fee	80% after deductible	Not covered
Organ transplant[2]	80% after deductible	60% after deductible
Travel and lodging	Not covered	Not covered
Urgent care (non-emergency)	80% after deductible	60% after deductible
Vision		
Glasses/contacts Following cataract surgery (limit 1 occurrence per surgery)	80% after deductible	60% after deductible
Exams (nonroutine)	80% after deductible	60% after deductible
Vision therapy	80% after deductible	60% after deductible

CVS prescription drugs[3]

	In network	Out of network
Preventive prescription drugs	100% for generic drugs No deductible	60% after deductible
All other eligible prescription drugs	80% after deductible	60% after deductible plus the difference between the amount charged by a CVS Caremark Pharmacy and the out-of-network pharmacy

[1] Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to the maximum allowed amount, including complications from the donor procedure for up to six weeks from the date of procurement.

[2] Donor expenses are covered.

[3] If your provider prescribes — or you request — a preferred brand name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available, you pay the difference between the retail cost of the brand name drug and its generic equivalent plus the applicable generic coinsurance. **The cost difference you pay does not apply to your medical plan's deductible or out-of-pocket maximum.**

Anthem Out-of-Area Gold HSA

		You pay
Deductible What you pay before the plan shares the cost of care	You Only	$1,750
	You + Spouse or You + Children	$3,000
	You + Family	$3,500
Covered services What the plan pays	Preventive Care	100%
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250
	You + Spouse or You + Children	$3,000
	You + Family	$4,500
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000
	Individual on Family Coverage[1]	$7,500
	You + Spouse or You + Children	$6,000
	You + Family	$8,000
Lifetime maximum		Unlimited

[1] $7,500 is the most that one covered family member will have to pay toward the **in-network deductible and/or coinsurance** combined. If a covered family member reaches that amount, the company will pay 100% of covered in-network services for **that individual** for the rest of the year.

Out-of-Area Gold HSA services	The plan pays
Preventive care	100% no deductible
Acupuncture	80% after deductible
Allergy	
Testing	80% after deductible
Treatment	80% after deductible
Ambulance (emergency only)	
Emergency	80% after deductible
Nonemergency	Not covered
Ambulatory surgical center	80% after deductible
Anesthesia	80% after deductible

Out-of-Area Gold HSA services	The plan pays
Bariatric surgery	80% after deductible
Biofeedback	Not covered
Blood processing and storage	80% after deductible
Chiropractic	80% after deductible
Dental For injury to sound teeth, mouth or face within 12 months of the injury	80% after deductible
Diabetes maintenance	
Diabetes education/nutritional counseling (limit 6 visits per year)	80% after deductible
Diabetic supplies	80% after deductible
Diagnostic X-ray, lab and diagnostic services	
Nonroutine dense breast ultrasound	100% after deductible
Nonroutine other	80% after deductible
Durable medical equipment (DME)	
DME purchase and rental	80% after deductible
Medical supply	80% after deductible
Prosthetics	80% after deductible
Orthotics (includes custom fitted orthotics)	80% after deductible
Hearing aid services (both ears)	
Evaluation (limit 1 every 36 months)	80% after deductible
Hearing aids (limit $3,000 every 3 years)	80% after deductible
Vision hardware (for glasses/contacts after cataract surgery, refer to Vision/Post-Surgical Vision)	Not covered
Wigs/toupees Limit 1 per year (hair loss must be due to a medical condition, including but not limited to chemotherapy, radiation or alopecia)	80% after deductible
Emergency care	
True emergency	80% after deductible
Nonemergency	60% after deductible
Foot care	Not covered

Out-of-Area Gold HSA services	The plan pays
Home health/home infusion/PDN	
Home health care	80% after deductible
Home infusion therapy	80% after deductible
Private duty nursing (covered only in the home)	80% after deductible
Hospice/bereavement	
Hospice (including respite care)	80% after deductible
Bereavement counseling	80% after deductible
Immunizations	80% after deductible
Injections	80% after deductible
Inpatient care	80% after deductible
Accommodations and ancillaries	80% after deductible
Physical medical rehab	80% after deductible
Skilled nursing facility	80% after deductible
Professional medical care	80% after deductible
Mental health	
Applied behavioral analysis therapy	80% after deductible
Alcohol/substance abuse	80% after deductible
Attention deficit disorders	80% after deductible
Inpatient, outpatient mental health	80% after deductible
Nutritional counseling (non-diabetic) (outpatient limit 6 visits per year)	80% after deductible
Obstetrics, family planning and sterilization	
Contraceptives (not included in Women's Health Provision)	80% after deductible
Contraceptives (covered under Women's Health Provision)	100% (no deductible)
Maternity care	
Routine preventive prenatal visits covered 100% (no deductible)	100% (no deductible)
Ultrasounds, labs, visits to monitor pregnancy related conditions, non-routine prenatal visits	80% after deductible
Infertility services	80% after deductible
Infertility treatment (artificial insemination, invitro fertilization)	80% after deductible
Genetic counseling	80% after deductible

Out-of-Area Gold HSA services	The plan pays
Sterilization (for services that do not meet Women's Health Provision requirements)	80% after deductible
Outpatient hospital services	80% after deductible
Professional physician services	80% after deductible
Consultation, second opinion	80% after deductible
Home visits	80% after deductible
Onsite clinics	80% after deductible
Retail health clinics	80% after deductible
Expanded preventive care for chronic conditions	100% (no deductible)
Online visits (telehealth)	
Doctor On Demand	80% after deductible
Online visits (telehealth)	80% after deductible
Telephonic visits	80% after deductible
Surgery benefits	
Assistant surgeon	80% after deductible
Oral surgery (limited to charges made for continuous course of dental treatment within 12 months of injury to sound, natural teeth)	80% after deductible
Office, outpatient and inpatient	80% after deductible
Therapies	
Cardiac rehab	80% after deductible
Chemotherapy	80% after deductible
Dialysis/hemodialysis therapy	80% after deductible
Infusion	80% after deductible
Occupational	80% after deductible
Physical	80% after deductible
Radiation	80% after deductible
Respiratory	80% after deductible
Speech	80% after deductible
Temporomandibular (TMJ)	80% after deductible
Transgender medical services	
Behavioral health services	80% after deductible

Out-of-Area Gold HSA services	The plan pays
Hormone therapy	80% after deductible
Feminization/masculinization-related procedures	80% after deductible; precertification required
Gender affirmation surgery	80% after deductible; precertification required
Transplants	
Performed at a BDCT facility	
Live donor health services[1]	100% after deductible
Bone marrow donor search fee	100% after deductible
Organ transplant BDCT facility[2]	100% after deductible
Travel and lodging BDCT facility[3]	100% after deductible
Performed at a Non-BDCT Facility	
Live donor health services[4]	80% after deductible
Bone marrow donor search fee	80% after deductible
Organ transplant[5]	80% after deductible
Travel and lodging non-BDCT facility	Not covered
Urgent Care (non-emergency)	80% after deductible
Vision	
Glasses/contacts Following cataract surgery (limit 1 occurrence per surgery)	80% after deductible
Exams (nonroutine)	80% after deductible
Vision therapy	80% after deductible

[1] Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to the maximum allowed amount, including complications from the donor procedure for up to six weeks from the date of procurement.

[2] Donor expenses are covered.

[3] Limited to $10,000 per transplant.

[4] Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to the maximum allowed amount, including complications from the donor procedure for up to six weeks from the date of procurement.

[5] Donor expenses are covered.

CVS prescription drugs[1]

	The plan pays
Preventive prescription drugs	100% generic drugs (no deductible)
All other eligible prescription drugs	80% after deductible

[1] If your provider prescribes — or you request — a preferred brand name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available, you pay the difference between the retail cost of the brand name drug and its generic equivalent plus the applicable generic coinsurance. **The cost difference you pay does not apply to your medical plan's deductible or out-of-pocket maximum.**

Out-of-Area Indemnity Plan

		What you pay
Deductible What you pay before the plan shares the cost of care	You Only	$200
	You + Spouse or You + Children	$300
	You + Family	$400
Covered services What the plan pays	Preventive Care	100% (no deductible)
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,300
	You + Spouse or You + Children	$3,450
	You + Family	$4,600
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$2,500
	You + Spouse or You + Children	$3,750
	You + Family	$5,000
Lifetime maximum		Unlimited

Out-of-Area Indemnity Plan	The plan pays
Office visits	
Preventive care/screenings/immunizations	100% (no deductible)
Primary care visit to treat an injury or illness	80% after deductible
Specialist visit	80% after deductible
Tests	
Diagnostic test (X-ray, blood work)	80% after deductible
Imaging (CT/PET scans, MRIs)	80% after deductible
Emergency and urgent care[1]	
Emergency room care	80% after deductible
Emergency medical transportation	80% after deductible

[1] Non-plan providers are covered when temporarily outside the service area.

Out-of-Area Indemnity Plan	The plan pays
Urgent care	80% after deductible
Inpatient care	
Facility fee (e.g., hospital room)	80% after deductible
Physician/surgeon fees	80% after deductible
Outpatient surgery	
Facility fee (e.g., ambulatory surgery center)	80% after deductible
Physician/surgeon fees	80% after deductible
Maternity care	
Office visits	100% (no deductible)
Childbirth/delivery professional services	80% after deductible
Childbirth/delivery facility services	80% after deductible
Mental health, behavioral health, substance abuse	
Outpatient services	80% after deductible
Inpatient services	80% after deductible
Home health care[1]	100% after deductible
Rehabilitation services[2]	
Inpatient services	80% after deductible
Outpatient services	80% after deductible
Habilitation services	80% after deductible
Skilled nursing care[3]	80% after deductible
Durable medical equipment[4]	80% after deductible
Hospice services	80% after deductible
Child's vision and dental care	
Child's eye exam	Not covered

[1] Must be noncustodial.

[2] Outpatient physical and occupational therapy limited to specific medically necessary diagnoses, as determined by the plan.

[3] Must be prescribed and performed in a noncustodial facility.

[4] Prior authorization may be required. If preauthorization is required and not received, a financial penalty may apply or item may not be covered.

Out-of-Area Indemnity Plan	The plan pays
Child's glasses	Not covered
Child's dental check-up	Not covered

Prescription drugs[1]	You pay	
	Retail	Mail order
Generic preventive drugs	$0	$0
Generic (up to a 30-day supply retail and 90-day supply mail order)	$7 copay	$14 copay
Preferred brand-name drugs (up to a 30-day supply retail and 90-day supply mail order)	20% coinsurance	20% coinsurance
Non-preferred brand-name drugs (up to a 30-day supply retail and 90-day supply mail order)	20% coinsurance	20% coinsurance
Specialty drugs (up to a 30-day supply retail)	See your costs above for preferred and nonpreferred brand.	

Other covered services

Limitations may apply to these services; check your Evidence of Coverage for a complete list.

- Acupuncture (plan provider referral)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Nonemergency care when traveling outside the U.S.
- Private-duty nursing

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Cosmetic surgery
- Dental care (adult and child)
- Long-term care
- Routine eye care (adults)
- Routine foot care
- Weight-loss programs

[1] All prescription drugs are subject to formulary guidelines.

Kaiser Permanente — Gold HSA

Kaiser Gold HSA California

		In network only
Deductible What you pay before the plan shares the cost of care	You Only	$1,750
	Individual on Family Coverage	$3,000
	You + Spouse or You + Children	$3,500
	You + Family	$3,500
Covered services What the plan pays	Preventive Care	100% (no deductible)
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250
	Individual on Family Coverage	$1,000
	You + Spouse or You + Children	$4,500
	You + Family	$4,500
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000
	Individual on Family Coverage	$4,000
	You + Spouse or You + Children	$8,000
	You + Family	$8,000
Lifetime maximum		Unlimited

Kaiser Gold HSA California services	The plan pays for in-network services only
Office visits	
Preventive care/screenings/immunizations	100% (no deductible)
Primary care visit to treat an injury or illness	80% after deductible
Specialist visit	80% after deductible
Tests	
Diagnostic test (X-ray, blood work)	80% after deductible
Imaging (CT/PET scans, MRIs)	80% after deductible

Kaiser Gold HSA California services	The plan pays for in-network services only
Emergency and urgent care[1]	
Emergency room care	80% after deductible
Emergency medical transportation	80% after deductible
Urgent care	80% after deductible
Inpatient care	
Facility fee (e.g., hospital room)	80% after deductible
Physician/surgeon fees	80% after deductible
Outpatient surgery	
Facility fee (e.g., ambulatory surgery center)	80% after deductible
Physician/surgeon fees	80% after deductible
Maternity care	
Office visits[2]	100% (no deductible)
Childbirth/delivery professional services	80% after deductible
Childbirth/delivery facility services	80% after deductible
Mental health, behavioral health, substance abuse	
Outpatient services	80% after deductible
Inpatient services	80% after deductible
Home health care[3]	100% (no deductible)
Rehabilitation services	
Inpatient services	80% after deductible
Outpatient services	80% after deductible
Habilitation services	80% after deductible
Skilled nursing care[4]	80% after deductible

[1] Non-plan providers are covered when temporarily outside the service area.

[2] Depending on the type of services, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described in the Evidence of Coverage.

[3] There is a two-hour limit per visit, three visits per day, 100 visits per year.

[4] There is a 100-day limit per benefit period.

Kaiser Gold HSA California services	The plan pays for in-network services only
Durable medical equipment (DME)[1]	80% after deductible
Hospice services	No charge
Child's vision and dental care	
Child's eye exam	80%, deductible does not apply
Child's glasses	Not covered
Child's dental check-up	Not covered
Prescription drugs[2]	
Preventive drugs	100%, deductible does not apply
Generic (up to a 100-day supply retail and mail order)	80% up to $50
Preferred brand-name drugs (up to a 100-day supply retail and mail order)	80% up to $100
Non-preferred brand-name drugs (up to a 100-day supply retail and mail order)	80% up to $100
Specialty drugs (up to a 30-day supply retail)	80% up to $250

Other covered services

Limitations may apply to these services; check your Evidence of Coverage for a complete list.

- Acupuncture (plan provider referral)
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Routine eye care (adult)

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight-loss programs

[1] Prior authorization is required.

[2] All prescription drugs are subject to formulary guidelines.

Kaiser Gold HSA Colorado

		In network only
Deductible What you pay before the plan shares the cost of care	You Only	$1,750
	You + Spouse or You + Children	$3,500
	You + Family	$3,500
Covered services What the plan pays	Preventive Care	100% (no deductible)
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250
	You + Spouse or You + Children	$4,500
	You + Family	$4,500
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000
	You + Spouse or You + Children	$8,000
	You + Family	$8,000
Lifetime maximum		Unlimited

Kaiser Gold HSA Colorado services	The plan pays for in-network services only
Office visits	
Preventive care/screenings/immunizations	100% (no deductible)
Primary care visit to treat an injury or illness	80% after deductible
Specialist visit	80% after deductible
Tests	
Diagnostic test (X-ray, blood work)	80% after deductible
Imaging (CT/PET scans, MRIs)	80% after deductible
Emergency and urgent care[1]	
Emergency room care	80% after deductible
Emergency medical transportation	80% after deductible
Urgent care	80% after deductible

[1] Non-plan providers are covered when temporarily outside the service area.

Kaiser Gold HSA Colorado services	The plan pays for in-network services only
Inpatient care	
Facility fee (e.g., hospital room)	80% after deductible
Physician/surgeon fees	80% after deductible
Outpatient surgery	
Facility fee (e.g., ambulatory surgery center)	80% after deductible
Physician/surgeon fees	80% after deductible
Maternity care	
Office visits[1]	80% after deductible
Childbirth/delivery professional services	80% after deductible
Childbirth/delivery facility services	80% after deductible
Mental health, behavioral health, substance abuse	
Outpatient services	80% after deductible
Inpatient services	80% after deductible
Home health care[2]	100% (no deductible)
Rehabilitation services	
Inpatient services	80% after deductible
Outpatient services	80% after deductible
Habilitation services	80% after deductible
Skilled nursing care[3]	80% after deductible
Durable medical equipment[4]	80% after deductible
Hospice services	80% after deductible
Child's vision and dental care	
Child's eye exam	80% after deductible
Child's glasses	Not covered

[1] Cost sharing doesn't apply to preventive services. Maternity care may include tests and services described in the Evidence of Coverage.

[2] Limited to fewer than 8 hours per day and 28 hours per week.

[3] There is a 100-day limit per year.

[4] Prior authorization is required.

Kaiser Gold HSA Colorado services	The plan pays for in-network services only
Child's dental check-up	Not covered
Prescription drugs[1]	
Preventive drugs	100%, deductible does not apply
Generic (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Preferred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Non-referred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Specialty drugs (up to a 30-day supply retail)	80% after deductible

Other covered services

Limitations may apply. This isn't a complete list. Check your Evidence of Coverage for more information.

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing (inpatient)
- Routine eye care (adult)

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight-loss programs

[1] All prescription drugs are subject to formulary guidelines.

Kaiser Gold HSA Georgia

		In network only
Deductible What you pay before the plan shares the cost of care	You Only	$1,750
	You + Spouse or You + Children	$3,500
	You + Family	$3,500
Covered services What the plan pays	Preventive Care	100% (no deductible)
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250
	You + Spouse or You + Children	$4,500
	You + Family	$4,500
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000
	You + Spouse or You + Children	$8,000
	You + Family	$8,000
Lifetime maximum		Unlimited

Kaiser Gold HSA Georgia services	The plan pays for in-network services only
Office visits	
Preventive care/screenings/immunizations	100% (no deductible)
Primary care visit to treat an injury or illness	80% after deductible
Specialist visit	80% after deductible
Tests	
Diagnostic test (X-ray, blood work)	80% after deductible
Imaging (CT/PET scans, MRIs)	80% after deductible
Emergency and urgent care[1]	
Emergency room care	80% after deductible
Emergency medical transportation	80% after deductible
Urgent care	80% after deductible

[1] Non-plan providers are covered when temporarily outside the service area.

Kaiser Gold HSA Georgia services	The plan pays for in-network services only
Inpatient care	
Facility fee (e.g., hospital room)	80% after deductible
Physician/surgeon fees	80% after deductible
Outpatient surgery	
Facility fee (e.g., ambulatory surgery center)	80% after deductible
Physician/surgeon fees	80% after deductible
Maternity care	
Office visits[1]	80% after deductible
Childbirth/delivery professional services	80% after deductible
Childbirth/delivery facility services	80% after deductible
Mental health, behavioral health, substance abuse	
Outpatient services	80% after deductible
Inpatient services	80% after deductible
Home health care	100% (no deductible)
Rehabilitation services	
Inpatient services	80% after deductible
Outpatient services	80% after deductible
Habilitation services	80% after deductible
Skilled nursing care[2]	80% after deductible
Durable medical equipment[3]	80% after deductible
Hospice services	80% after deductible
Child's vision and dental care	
Child's eye exam[4]	80% after deductible
Child's glasses	Not covered

[1] Cost sharing doesn't apply to preventive services. Maternity care may include tests and services described in the Evidence of Coverage.

[2] There is a 100-day limit per year.

[3] Prior authorization is required.

[4] For refractive exam.

Kaiser Gold HSA Georgia services	The plan pays for in-network services only
Child's dental check-up	Not covered
Prescription drugs[1]	
Preventive drugs	100%, deductible does not apply
Generic (up to a 30-day supply retail and network pharmacy or 90-day supply mail order)	80% after deductible (retail and mail order) 70% after deductible (network pharmacy)
Preferred brand-name drugs (up to a 30-day supply retail and network pharmacy or 90-day supply mail order)	80% after deductible (retail and mail order) 70% after deductible (network pharmacy)
Non-referred brand-name drugs (up to a 30-day supply retail and network pharmacy or 90-day supply mail order)	80% after deductible (retail and mail order) 70% after deductible (network pharmacy)
Specialty drugs (up to a 30-day supply retail and network pharmacy)	80% after deductible (retail) 70% after deductible (network pharmacy)

Other covered services

Limitations may apply. This isn't a complete list. Check your Evidence of Coverage for more information.

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight-loss programs

[1] All prescription drugs are subject to formulary guidelines.

Kaiser Gold HSA Mid-Atlantic States

		In network only
Deductible What you pay before the plan shares the cost of care	You Only	$1,750
	You + Spouse or You + Children	$3,500
	You + Family	$3,500
Covered services What the plan pays	Preventive Care	100% (no deductible)
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250
	You + Spouse or You + Children	$4,500
	You + Family	$4,500
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000
	You + Spouse or You + Children	$8,000
	You + Family	$8,000
Lifetime maximum		Unlimited

Kaiser Gold HSA Mid-Atlantic States services	The plan pays for in-network services only
Office visits	
Preventive care/screenings/immunizations	100% (no deductible)
Primary care visit to treat an injury or illness	80% after deductible
Specialist visit	80% after deductible
Tests	
Diagnostic test (X-ray, blood work)	80% after deductible
Imaging (CT/PET scans, MRIs)	80% after deductible
Emergency and urgent care[1]	
Emergency room care	80% after deductible
Emergency medical transportation	80% after deductible
Urgent care	80% after deductible

[1] Non-plan providers are covered when temporarily outside the service area.

Kaiser Gold HSA Mid-Atlantic States services	The plan pays for in-network services only
Inpatient care	
Facility fee (e.g., hospital room)	80% after deductible
Physician/surgeon fees	80% after deductible
Outpatient surgery	
Facility fee (e.g., ambulatory surgery center)	80% after deductible
Physician/surgeon fees	80% after deductible
Maternity care	
Office visits[1]	100% (no deductible)
Childbirth/delivery professional services	80% after deductible
Childbirth/delivery facility services	80% after deductible
Mental health, behavioral health, substance abuse	
Outpatient services[2]	80% after deductible
Inpatient services	80% after deductible
Home health care	100% (no deductible)
Rehabilitation services	
Inpatient services	80% after deductible
Outpatient services	80% after deductible
Habilitation services[3]	80% after deductible
Skilled nursing care[4]	80% after deductible
Durable medical equipment (DME)[5]	80% after deductible
Hospice services	80% after deductible
Child's vision and dental care	

[1] Cost sharing doesn't apply to preventive services. Maternity care may include tests and services subject to cost sharing as described in the Evidence of Coverage.

[2] No coverage for psychological testing for ability, aptitude, intelligence or interest.

[3] Limited to children under age 3 with a congenital or genetic birth defect.

[4] There is a 100-day limit per year.

[5] Prior authorization is required.

Kaiser Gold HSA Mid-Atlantic States services	The plan pays for in-network services only
Child's eye exam[1]	80% after deductible
Child's glasses[2]	No charge
Child's dental check-up	Not covered
Prescription drugs[3]	
Preventive drugs	100%, deductible does not apply
Generic (up to a 30-day supply retail and network pharmacy or 90-day supply mail order)	80% after deductible (retail and mail order) 70% after deductible (network pharmacy)
Preferred brand-name drugs (up to a 30-day supply retail and network pharmacy or 90-day supply mail order)	80% after deductible (retail and mail order) 70% after deductible (network pharmacy)
Non-referred brand-name drugs (up to a 30-day supply retail and network pharmacy or 90-day supply mail order)	80% after deductible (retail and mail order) 70% after deductible (network pharmacy)
Specialty drugs (up to a 30-day supply retail and network pharmacy)	80% after deductible (retail) 70% after deductible (network pharmacy)

Other covered services

Limitations may apply. This isn't a complete list. Check your Evidence of Coverage for more information.

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Cosmetic surgery
- Dental care (adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight-loss programs

[1] For refractive exam.

[2] Limited to one pair of frame and lenses or contact lenses per year.

[3] All prescription drugs are subject to formulary guidelines.

Kaiser Gold HSA Northwest (Oregon)

		In network only
Deductible What you pay before the plan shares the cost of care	You Only	$1,750
	You + Spouse or You + Children	$3,500
	You + Family	$3,500
Covered services What the plan pays	Preventive Care	100% (no deductible)
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250
	You + Spouse or You + Children	$4,500
	You + Family	$4,500
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000
	You + Spouse or You + Children	$8,000
	You + Family	$8,000
Lifetime maximum		Unlimited

Kaiser Gold HSA Northwest (Oregon) services	The plan pays for in-network services only
Office visits	
Preventive care/screenings/immunizations	100% (no deductible)
Primary care visit to treat an injury or illness	80% after deductible
Specialist visit	80% after deductible
Tests	
Diagnostic test (X-ray, blood work)	80% after deductible
Imaging (CT/PET scans, MRIs)[1]	80% after deductible
Emergency and urgent care[2]	
Emergency room care	80% after deductible
Emergency medical transportation	80% after deductible

[1] Some services may require prior authorization.

[2] Non-plan providers are covered when temporarily outside the service area.

Kaiser Gold HSA Northwest (Oregon) services	The plan pays for in-network services only
Urgent care	80% after deductible
Inpatient care[1]	
Facility fee (e.g., hospital room)	80% after deductible
Physician/surgeon fees	80% after deductible
Outpatient surgery[2]	
Facility fee (e.g., ambulatory surgery center)	80% after deductible
Physician/surgeon fees	80% after deductible
Maternity care	
Office visits[3]	100% (no deductible)
Childbirth/delivery professional services	80% after deductible
Childbirth/delivery facility services	80% after deductible
Mental health, behavioral health, substance abuse	
Outpatient services	80% after deductible
Inpatient services[4]	80% after deductible
Home health care[5]	100% (no deductible)
Rehabilitation services[6]	
Inpatient services	80% after deductible
Outpatient services	80% after deductible
Habilitation services[7]	80% after deductible
Skilled nursing care[8]	80% after deductible

[1] Prior authorization is required for all inpatient care.

[2] Prior authorization is required for all outpatient surgery.

[3] Cost sharing doesn't apply to preventive services. Maternity care may include tests and services described in the Evidence of Coverage.

[4] Prior authorization is required for inpatient mental health services.

[5] Limited to130 visits per year. Prior authorization is required.

[6] Limited to 130 visits per year outpatient. Prior authorization is required for all rehabilitation services.

[7] Limited to 130 visits per year. Prior authorization is required.

[8] There is a 100-day limit per year. Prior authorization is required.

Kaiser Gold HSA Northwest (Oregon) services	The plan pays for in-network services only
Durable medical equipment (DME)[1]	80% after deductible
Hospice services[2]	80% after deductible
Child's vision and dental care	
Child's eye exam[3]	80% after deductible
Child's glasses	Not covered
Child's dental check-up	Not covered
Prescription drugs[4]	
Preventive drugs	100% (no deductible)
Generic (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Preferred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Non-referred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Specialty drugs (up to a 30-day supply retail)	80% after deductible

Other covered services

Limitations may apply. This isn't a complete list. Check your Evidence of Coverage for more information.

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight-loss programs

[1] Subject to formulary guidelines. Prior authorization is required.

[2] Prior authorization is required.

[3] For refractive exams.

[4] All prescription drugs are subject to formulary guidelines.

Kaiser Gold HSA Washington (Seattle area)

		In network only
Deductible What you pay before the plan shares the cost of care	You Only	$1,750
	You + Spouse or You + Children	$3,500
	You + Family	$3,500
Covered services What the plan pays	Preventive Care	100% (no deductible)
	Coinsurance	80%
Coinsurance maximum Most you'll pay in coinsurance per year after the deductible is met	You Only	$2,250
	You + Spouse or You + Children	$4,500
	You + Family	$4,500
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals your deductible + the coinsurance maximum)	You Only	$4,000
	You + Spouse or You + Children	$8,000
	You + Family	$8,000
Lifetime maximum		Unlimited

Kaiser Gold HSA Washington (Seattle area) services	The plan pays for in-network services only
Office visits	
Preventive care/screenings/immunizations	100% (no deductible)
Primary care visit to treat an injury or illness	80% after deductible
Specialist visit	80% after deductible
Tests	
Diagnostic test (X-ray, blood work)	80% after deductible
Imaging (CT/PET scans, MRIs)[1]	80% after deductible

[1] Requires prior authorization.

Kaiser Gold HSA Washington (Seattle area) services	The plan pays for in-network services only
Emergency and urgent care[1]	
Emergency room care[2]	80% after deductible
Emergency medical transportation	80% after deductible
Urgent care	80% after deductible
Inpatient care[3]	
Facility fee (e.g., hospital room)	80% after deductible
Physician/surgeon fees	80% after deductible
Outpatient surgery	
Facility fee (e.g., ambulatory surgery center)	80% after deductible
Physician/surgeon fees	80% after deductible
Maternity care	
Office visits[4]	80% after deductible
Childbirth/delivery professional services[5]	80% after deductible
Childbirth/delivery facility services[3]	80% after deductible
Mental health, behavioral health, substance abuse	
Outpatient services	80% after deductible (no charge after deductible for group visits)
Inpatient services[6]	80% after deductible
Home health care[7]	100% (no deductible)
Rehabilitation services[5]	
Inpatient services	80% after deductible (no charge after deductible for group visits)

[1] Non-network providers are covered when temporarily outside the service area.

[2] You must notify Kaiser Permanente within 24 hours if admitted to a non-network provider.

[3] Prior authorization is required for all inpatient care.

[4] Cost sharing doesn't apply to preventive services. Maternity care may include tests and services described in the Evidence of Coverage.

[5] You must notify Kaiser Permanente within 24 hours of admission or as soon as medically possible. Newborn services cost shares are separate from that of the mother.

[6] Prior authorization is required for inpatient mental health services.

[7] Prior authorization is required.

Kaiser Gold HSA Washington (Seattle area) services	The plan pays for in-network services only
Outpatient services	80% after deductible
Habilitation services[5]	80% after deductible
Skilled nursing care[1]	80% after deductible
Durable medical equipment[2]	80% after deductible
Hospice services[3]	80% after deductible
Child's vision and dental care	
Child's eye exam[4]	80% after deductible
Child's glasses	Not covered
Child's dental check-up	Not covered
Prescription drugs[5]	
Preventive drugs	100% (no deductible)
Generic (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Preferred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Non-referred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	80% after deductible
Specialty drugs (up to a 30-day supply retail)	80% after deductible

Other covered services

Limitations may apply. This isn't a complete list. Check your Evidence of Coverage for more information.

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

[1] There is a 100-day limit per year. Prior authorization is required.

[2] Subject to formulary guidelines. Prior authorization is required.

[3] Prior authorization is required.

[4] For refractive exams.

[5] All prescription drugs are subject to formulary guidelines.

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight-loss programs

Kaiser Permanente Hawaii HMO

This plan covers in-network services only.

		In network only
Deductible This plan does not have a deductible. You don't need to meet a deductible before the plan pays for any services.	You Only	$0
	You + Spouse or You + Children	$0
	You + Family	$0
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals the coinsurance maximum)	You Only	$1,500
	Individual on Family Coverage	$1,500
	You + Spouse or You + Children	$4,500
	You + Family	$4,500
Lifetime maximum		Unlimited

Kaiser Hawaii HMO services	What you pay for in-network services
Office visits	
Preventive care/screenings/immunizations	No charge
Primary care visit to treat an injury or illness[1]	$14 copay per visit
Specialist visit	$14 copay per visit
Tests	
Diagnostic test (X-ray, blood work)	10% coinsurance
Imaging (CT/PET scans, MRIs)	10% coinsurance
Emergency and urgent care[2]	
Emergency room care[3]	$50 copay per visit
Emergency medical transportation	20% coinsurance
Urgent care	$14 copay per visit; 20% coinsurance when out of area

[1] No charge for children through age 17.

[2] Non-plan providers are covered when temporarily outside the service area.

[3] You must notify Kaiser Permanente within 48 hours if admitted to a non-plan provider. Copay waived if admitted directly to the hospital as an inpatient.

Kaiser Hawaii HMO services	What you pay for in-network services
Inpatient care	No charge
Outpatient surgery	$14 copay per visit
Maternity care	
Office visits[1]	No charge
Childbirth/delivery professional services	No charge
Childbirth/delivery facility services	No charge
Mental health, behavioral health, substance abuse	
Outpatient services	$14 copay per visit
Inpatient services	No charge
Home health care[2]	No charge
Rehabilitation services	
Outpatient services	No charge
Inpatient services	$14 copay per visit
Habilitation services	Not covered
Skilled nursing care[3]	No charge
Durable medical equipment (DME)[4]	No charge
Hospice services[5]	No charge
Child's vision and dental care	
Child's eye exam[6]	$14 copay per visit
Child's glasses	Not covered
Child's dental check-up	Not covered

[1] Depending on the type of service, a copay or coinsurance may apply. Maternity care may include tests and services described in the Evidence of Coverage.

[2] Physician visit covered at primary care visit cost share.

[3] There is a 120-day limit per year.

[4] Diabetic supplies: 50% coinsurance. Subject to formulary guidelines.

[5] Includes two 90-day periods, followed by unlimited number of 60-day periods.

[6] For refractive exams.

Kaiser Hawaii HMO services	What you pay for in-network services
Prescription drugs[1]	
Generic (up to a 30-day supply retail or 90-day supply mail order)[2]	$5 copay (retail), $10 copay (mail order)
Preferred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	$20 copay (retail), $40 copay (mail order)
Non-referred brand-name drugs (up to a 30-day supply retail or 90-day supply mail order)	$20 copay (retail), $40 copay (mail order)
Specialty drugs (up to a 30-day supply retail)	$20 copay (retail)

Other covered services

Limitations may apply to these services. This isn't a complete list. Check your Evidence of Coverage for more information about these services.

- Bariatric surgery
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Acupuncture
- Children's glasses
- Chiropractic care
- Cosmetic surgery
- Dental care (adult and child)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight-loss programs

[1] All prescription drugs are subject to formulary guidelines.

[2] No charge for contraceptives.

HMSA Hawaii

This plan covers in-network services only.

		In network only
Deductible This plan does not have a deductible. You don't need to meet a deductible before the plan pays for any services.	You Only	$0
	You + Spouse or You + Children	$0
	You + Family	$0
Out-of-pocket maximum Most you pay before the plan pays 100% of eligible costs for the rest of the year (equals the coinsurance maximum)	You Only	$2,500
	You + Spouse or You + Children	$7,500
	You + Family	$7,500
Lifetime maximum		Unlimited

HMSA Hawaii services	What you pay for in-network services
Office visits	
Preventive care/screenings/immunizations	No charge
Primary care visit to treat an injury or illness[1]	$20 copay per visit
Specialist visit[2]	$20 copay per visit
Psychologist	$20 copay per visit
Nurse practitioner	$20 copay per visit
Diagnostic tests	
Inpatient	10% coinsurance
Outpatient	20% coinsurance
X-ray	
Inpatient	10% coinsurance
Outpatient	$10 copay per test
Blood work	
Inpatient	10% coinsurance

[1] No charge for children through age 17.

[2] Requires a referral from your primary care provider.

HMSA Hawaii services	What you pay for in-network services
Outpatient	$10 copay per test
Imaging (CT/PET scans, MRIs)	10% coinsurance
Inpatient	10% coinsurance
Outpatient	20% coinsurance
Emergency and urgent care	
Emergency room care	$100 copay per visit
Emergency medical transportation[1]	20% coinsurance
Urgent care	$20 copay per visit
Inpatient care	10% coinsurance
Outpatient surgery	$14 per visit
Facility fee	10% coinsurance
Physician visits	$20 copay per visit
Surgeon fees	$20 copay
Maternity care	
Office visits[2]	10% coinsurance
Childbirth/delivery professional services	10% coinsurance
Childbirth/delivery facility services	10% coinsurance
Mental health, behavioral health, substance abuse	
Outpatient physician services	$20 copay per visit
Inpatient services	10% coinsurance
Home health care	No charge
Rehabilitation services[3]	$20 copay per visit
Habilitation services	Not covered

[1] Limited to the nearest adequate hospital to treat your illness or injury. Air transport is limited to the State of Hawaii unless transportation to the continental U.S. is necessary for critical care in accord with HMSA plan's medical policy.

[2] Cost sharing does not apply to preventive services. Depending on the type of service, a copay or coinsurance may apply. Maternity care may include tests and services described in the Evidence of Coverage.

[3] Services may require prior authorization. Excludes cardiac rehabilitation.

HMSA Hawaii services	What you pay for in-network services
Skilled nursing care[1]	10% coinsurance
Durable medical equipment (DME)[2]	20% coinsurance
Hospice services[3]	No charge
Child's vision and dental care	
Child's eye exam[4]	$20 copay per visit
Child's glasses[5]	$25 copay per set
Child's dental check-up	Not covered

Prescription drugs	What you pay per prescription	
	In network	Out of network
Tier 1 (mostly generic) retail[6] mail order[7]	 $7 copay $11 copay	 $7 copay + 20% coinsurance Not covered
Tier 2 (mostly preferred formulary) retail[6] mail order[7]	 $30 copay $65 copay	 $30 copay + 20% coinsurance Not covered
Tier 3 (mostly non-preferred formulary) retail[8] mail order[9]	 $30 copay $65 copay	 $30 copay + 20% coinsurance Not covered
Tier 4 (mostly preferred formulary specialty) 30-day supply retail only	$100 copay	Not covered
Tier 5 (mostly non-preferred formulary specialty) 30-day supply retail only	$200 copay	Not covered

[1] There is a 120-day limit per year.

[2] Services may require prior authorization.

[3] Includes two 90-day periods, followed by unlimited number of 60-day periods.

[4] Limited to one exam per year.

[5] Single vision lenses and frames selected within a designated group.

[6] One retail copay for a 1–30-day supply, two retail copays for a 31–60-day supply, three retail copays for a 61–90-day supply.

[7] One mail order copay for an 84–90-day supply at a retail network or contracted mail order provider.

[8] In addition to your copay and/or coinsurance, you will be responsible for a $45 Tier 3 Cost Share per retail copay. Cost to you for retail Tier 3 drugs: One copay plus one Tier 3 Cost Share for 1–30-day supply, two copays plus two Tier 3 Cost Shares for 31–60-day supply, three copays plus three Tier 3 Cost Shares for 61–90-day supply.

[9] In addition to your copay and/or coinsurance, you will be responsible for a $135 Tier 3 Cost Share per mail order copay. Cost to you for mail order Tier 3 drugs: One mail order copay for an 84–90-day supply at a retail network or contracted mail order provider.

Other covered services

Limitations may apply to these services. This isn't a complete list. Check your Evidence of Coverage for more information about these services.

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (adult)

Services generally not covered

Your plan generally doesn't cover the following services. Check your Evidence of Coverage for more information and a list of excluded services.

- Acupuncture
- Cardiac rehabilitation
- Cosmetic surgery
- Dental care (child)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight-loss programs

Cigna Global Choice with HSA

This is a summary only and further details can be found in the Certificate of Coverage booklet.

	International (outside the U.S.)	U.S. in network	U.S. out of network
Coverage area	Worldwide		
U.S. medical network	OAP		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime maximum	Unlimited		
Calendar year deductible			
• Per individual	$3,000	$3,000	$6,000
• Per family	$6,000	$6,000	$12,000
Coinsurance (The percentage of covered expenses the plan pays after the deductible has been met)	80%	80%	60%
Out-of-pocket maximum (includes deductible)			
• Per individual	$5,000	$5,000	$10,000
• Per family	$10,000	$10,000	$20,000

Cigna Global Choice with HSA services	International (outside the U.S.)	U.S. in network	U.S. out of network
Physician's services			
Physician's office visit	80% after deductible	80% after deductible	60% after deductible
Surgery performed in the physician's office	80% after deductible	80% after deductible	60% after deductible
Preventive care			
Routine preventive care — adult	100% (no deductible)	100% (no deductible)	60% after deductible
Immunizations — adult	100% (no deductible)	100% (no deductible)	60% after deductible
Routine preventive care — child	100% (no deductible)	100% (no deductible)	60% after deductible
Immunizations — child	100% (no deductible)	100% (no deductible)	60% after deductible
Travel immunizations (immunizations as required for travel)	100% (no deductible)	100% (no deductible)	60% after deductible
Mammograms, PSA, PAP smear and colorectal cancer screenings	100% (no deductible)	100% (no deductible)	60% after deductible

Cigna Global Choice with HSA services	International (outside the U.S.)	U.S. in network	U.S. out of network
Inpatient hospital			
Inpatient hospital — facility services	80% after deductible	80% after deductible	60% after deductible
Inpatient hospital physician visits/consultations	80% after deductible	80% after deductible	60% after deductible
Inpatient professional services (surgeon, radiologist, pathologist, anesthesiologist)	80% after deductible	80% after deductible	60% after deductible
Outpatient services			
Outpatient facility services	80% after deductible	80% after deductible	60% after deductible
Outpatient professional services	80% after deductible	80% after deductible	60% after deductible
Emergency care			
Emergency room	80% after deductible	80% after deductible	60% after deductible
Urgent care services	80% after deductible	80% after deductible	60% after deductible
Ambulance	80% after deductible	80% after deductible	60% after deductible
Laboratory services			
Physician office visit	80% after deductible	80% after deductible	60% after deductible
Outpatient facility	80% after deductible	80% after deductible	60% after deductible
Laboratory services at an independent lab facility	80% after deductible	80% after deductible	60% after deductible
Radiology services			
Physician office visit	80% after deductible	80% after deductible	60% after deductible
Outpatient facility	80% after deductible	80% after deductible	60% after deductible
Advanced radiology (e.g., MRIs, MRAs, CAT scans, PET scans)			
Physician office visit	80% after deductible	80% after deductible	60% after deductible
Inpatient facility	80% after deductible	80% after deductible	60% after deductible
Outpatient facility	80% after deductible	80% after deductible	60% after deductible
Short-term rehabilitation			
Physician office visit	80% after deductible	80% after deductible	60% after deductible
Outpatient hospital facility	80% after deductible	80% after deductible	60% after deductible
Calendar year maximum	*60 days for all therapies combined (**Note:** The limit is not applicable to mental health and substance use disorder conditions.)*		

***Note:** The short-term rehabilitation therapy maximum does not apply to the treatment of autism. Includes: Cardiac and pulmonary rehab, speech, occupational and cognitive therapy.*

Cigna Global Choice with HSA services	International (outside the U.S.)	U.S. in network	U.S. out of network
Short-term rehabilitation — physical therapy/physiotherapy			
Physician office visit	80% after deductible	80% after deductible	60% after deductible
Outpatient hospital facility	80% after deductible	80% after deductible	60% after deductible
Calendar year maximum	*Unlimited for all therapies combined*		
Chiropractic care	80% after deductible	80% after deductible	60% after deductible
Calendar year maximum	*Unlimited*		
Maternity care services			
Initial visit to confirm pregnancy	80% after deductible	80% after deductible	60% after deductible
All subsequent prenatal and postnatal visits	80% after deductible	80% after deductible	60% after deductible
Visits and physician's delivery charges (i.e., global maternity fee)	80% after deductible	80% after deductible	60% after deductible
Physician's office visits in addition to the global maternity fee when performed by an OB/GYN or specialist	80% after deductible	80% after deductible	60% after deductible
Delivery — facility			
• **Inpatient hospital**	80% after deductible	80% after deductible	60% after deductible
• **Birthing center**	80% after deductible	80% after deductible	60% after deductible
Infertility services **Diagnosis of Infertility is covered under general physician office visits. Coverage will be provided for the following services:** • **GIFT, ZIFT, etc.** • **In-vitro** • **Artificial Insemination**			
Physician office visit and counseling	80% after deductible	80% after deductible	60% after deductible
Lab and radiology tests	80% after deductible	80% after deductible	60% after deductible
Inpatient facility	80% after deductible	80% after deductible	60% after deductible
Outpatient facility	80% after deductible	80% after deductible	60% after deductible
Hearing exam	80% after deductible	80% after deductible	60% after deductible
1 exam every 24 months			

Cigna Global Choice with HSA services	International (outside the U.S.)	U.S. in network	U.S. out of network
Hearing device/aids **Limited to dependent children under 24 years** **1 per ear every 36 months up to $3,000**	80% after deductible	80% after deductible	60% after deductible
Mental health			
Physician office visit	80% after deductible	80% after deductible	60% after deductible
Inpatient facility	80% after deductible	80% after deductible	60% after deductible
Outpatient facility	80% after deductible	80% after deductible	60% after deductible
Substance use disorder	80% after deductible		
Physician office visit	80% after deductible	80% after deductible	60% after deductible
Inpatient facility	80% after deductible	80% after deductible	60% after deductible
Outpatient facility	80% after deductible	80% after deductible	60% after deductible

Prescription drug benefits	
Purchased outside the U.S.	**You pay 20% after plan deductible**

Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at healthcare.gov) are payable at 100% with no copay or deductible, when purchased from a network pharmacy. A written prescription is required.

Purchased within the U.S. only	U.S. In-Network Pharmacy	U.S. Out-of-Network Pharmacy
Retail pharmacies	**The amount you pay for a 30-day supply**	
Tier 1 – Generic Drugs on the Prescription Drug List	You pay 20% not subject to plan deductible	You pay 40% after plan deductible
Tier 2 – Brand-name drugs designated as preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	You pay 40% after plan deductible
Tier 3 – Brand-name drugs designated as non-preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	You pay 40% after plan deductible
Home delivery/mail order pharmacies	**The amount you pay for a 90-day supply**	
Tier 1 – Generic drugs on the Prescription Drug List	You pay 20% not subject to plan deductible	In-network coverage only
Tier 2 – Brand-name drugs designated as preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	In-network coverage only

Tier 3 – Brand-name drugs designated as non-preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	In-network coverage only

Pharmacy plan features for prescriptions drugs purchased within the U.S. only

Dispense as Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copay and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copay and/or coinsurance, if applicable
Prescription Drug List	Performance 3-Tier
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.

To see if your medication is covered, you can view Cigna's Prescription Drug List by going to Cigna.com/druglist and selecting "Performance 3 Tier"

Cigna Global PPO

This is a summary only and further details can be found in the Certificate of Coverage booklet.

	International (outside the U.S.)	U.S. in network	U.S. out of network
Coverage area	Worldwide		
U.S. medical network	OAP		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime maximum	Unlimited		
Calendar year deductible			
• **Per individual**	$0	$500	$1,000
• **Per family**	$0	$1,000	$2,000
Coinsurance (The percentage of covered expenses the plan pays after the deductible is met)	100%	90%	70%
Out-of-pocket maximum (includes deductible)			
• **Per individual**	$0	$3,000	$6,000
• **Per family**	$0	$6,000	$12,000

Cigna Global PPO services	International (outside the U.S.)	U.S. in network	U.S. out of network
Physician's services			
Physician's office visit	100% after deductible	90% after deductible	70% after deductible
Surgery performed in the physician's office	100% after deductible	90% after deductible	70% after deductible
Preventive care			
Routine preventive care — adult	100% no deductible	100% no deductible	70% after deductible
Immunizations — adult	100% no deductible	100% no deductible	70% after deductible
Routine preventive care — child	100% no deductible	100% no deductible	70% after deductible
Immunizations — child	100% no deductible	100% no deductible	70% after deductible
Travel immunizations (immunizations as required for travel)	100% no deductible	100% no deductible	70% after deductible
Mammograms, PSA, PAP smear and colorectal cancer screenings	100% no deductible	100% no deductible	70% after deductible

Cigna Global PPO services	International (outside the U.S.)	U.S. in network	U.S. out of network
Inpatient hospital			
Inpatient hospital — facility services	100% no deductible	90% after deductible	70% after deductible
Inpatient hospital physician visits/consultations	100% no deductible	90% after deductible	70% after deductible
Inpatient professional services (surgeon, radiologist, pathologist, anesthesiologist)	100% no deductible	90% after deductible	70% after deductible
Outpatient services			
Outpatient facility services	100% no deductible	90% after deductible	70% after deductible
Outpatient professional services	100% no deductible	90% after deductible	70% after deductible
Emergency care			
Emergency room	100% no deductible	90% after deductible	70% after deductible
Urgent care services	100% no deductible	90% after deductible	70% after deductible
Ambulance	100% no deductible	90% after deductible	70% after deductible
Laboratory services			
Physician office visit	100% no deductible	90% after deductible	70% after deductible
Outpatient facility	100% no deductible	90% after deductible	70% after deductible
Laboratory services at an independent lab facility	100% no deductible	90% after deductible	70% after deductible
Radiology services			
Physician office visit	100% no deductible	90% after deductible	70% after deductible
Outpatient facility	100% no deductible	90% after deductible	70% after deductible
Advanced radiology (i.e., MRIs, MRAs, CAT scans, PET scans)			
Physician office visit	100% no deductible	90% after deductible	70% after deductible
Inpatient facility	100% no deductible	90% after deductible	70% after deductible
Outpatient facility	100% no deductible	90% after deductible	70% after deductible
Short-term rehabilitation			
Physician office visit	100% no deductible	90% after deductible	70% after deductible
Outpatient hospital facility	100% no deductible	90% after deductible	70% after deductible
Calendar year maximum	*60 days for all therapies combined (**Note:** The limit is not applicable to mental health and substance use disorder conditions.)*		

Note: *The short-term rehabilitation therapy maximum does not apply to the treatment of autism. Includes: Cardiac and pulmonary rehab, speech, occupational and cognitive therapy.*

Cigna Global PPO services	International (outside the U.S.)	U.S. in network	U.S. out of network
Short-term rehabilitation — physical therapy/physiotherapy			
Physician office visit	100% no deductible	90% after deductible	70% after deductible
Outpatient hospital facility	100% no deductible	90% after deductible	70% after deductible
Calendar year maximum	*Unlimited for all therapies combined*		
Chiropractic care	100% no deductible	90% after deductible	70% after deductible
Calendar year maximum	*Unlimited*		
Maternity care services			
Initial visit to confirm pregnancy	100% no deductible	90% after deductible	70% after deductible
All subsequent prenatal and postnatal visits	100% no deductible	90% after deductible	70% after deductible
Visits and physician's delivery charges (i.e., global maternity fee)	100% no deductible	90% after deductible	70% after deductible
Physician's office visits in addition to the global maternity fee when performed by an OB/GYN or specialist	100% no deductible	90% after deductible	70% after deductible
Delivery — facility			
• **Inpatient hospital**	100% no deductible	90% after deductible	70% after deductible
• **Birthing center**	100% no deductible	90% after deductible	70% after deductible
Infertility services			
Diagnosis of Infertility is covered under general Physician Office Visits. Coverage will be provided for the following services: • **GIFT, ZIFT, etc.** • **In-vitro** • **Artificial Insemination**			
Physician office visit and counseling	100% no deductible	90% after deductible	70% after deductible
Lab and radiology tests	100% no deductible	90% after deductible	70% after deductible
Inpatient facility	100% no deductible	90% after deductible	70% after deductible
Outpatient facility	100% no deductible	90% after deductible	70% after deductible
Hearing exam **1 exam every 24 months**	100% no deductible	90% after deductible	70% after deductible

Cigna Global PPO services	International (outside the U.S.)	U.S. in network	U.S. out of network
Hearing device/aids	100% no deductible	90% after deductible	70% after deductible
Limited to dependent children under 24 years			
1 per ear every 36 months up to $3,000			
Mental health			
Physician office visit	100% no deductible	90% after deductible	70% after deductible
Inpatient facility	100% no deductible	90% after deductible	70% after deductible
Outpatient facility	100% no deductible	90% after deductible	70% after deductible
Substance use disorder			
Physician office visit	100% no deductible	90% after deductible	70% after deductible
Inpatient facility	100% no deductible	90% after deductible	70% after deductible
Outpatient facility	100% no deductible	90% after deductible	70% after deductible

Prescription drug benefits		
Purchased outside the U.S.	**You pay 20% after plan deductible**	
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at healthcare.gov) are payable at 100% with no copay or deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Purchased within the U.S. only	**U.S. in-network pharmacy**	**U.S. out-of-network pharmacy**
Retail pharmacies	**The amount you pay for a 30-day supply**	
Tier 1 – Generic drugs on the Prescription Drug List	You pay 10% not subject to plan deductible	You pay 30% after plan deductible
Tier 2 – Brand-name drugs designated as preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	You pay 30% after plan deductible
Tier 3 – Brand-name drugs designated as non-preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	You pay 30% after plan deductible
Home delivery/mail order pharmacies	**The amount you pay for a 90-day supply**	
Tier 1 – Generic drugs on the Prescription Drug List	You pay 10% not subject to plan deductible	Not covered
Tier 2 – Brand-name drugs designated as preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	Not covered

Tier 3 – Brand-name drugs designated as non-preferred on the Prescription Drug List	You pay 10% not subject to plan deductible	Not covered

Pharmacy plan features for prescriptions drugs purchased within the U.S. only	
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copay and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copay and/or coinsurance, if applicable
Prescription Drug List	Performance 3-Tier
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.

To see if your medication is covered, you can view Cigna's Prescription Drug List by going to cigna.com/druglist and selecting "Performance 3 Tier"

Travel Guard®

What you need to know for your trip.

With a wide array of travel, medical and concierge services, AIG Travel helps millions of travelers solve problems andmanage risks worldwide. We provide a full array of services that are available to you before you begin your trip throughto the claims process. Wherever your travels may take you, in the event of a medical emergency, security issue or unexpected travel problem, we are never more than a phone call away.

Before you go

Install the AIG Travel Assistance App from the Apple App Store or Android Play Store from your smartphone.

- Tap on “Register” then “Country where coverage was purchased” and select: **United States – A&H**
- Input the required fields and the policy number: **9051307**

  After completing registration, you may also access the full website, using your existing login credentials, at: aig.com/us/travelguardassistance
- Use the app to call for Travel Guard® Assistance, locate nearby medical providers and leave feedback on your experience. Also, check out the drug brand equivalency tool, medical translation tools and specific country reports.
- If you need assistance, call the numbers listed below under Contact AIG Travel.

While traveling

AIG Travel can assist with the following services:

Medical assistance:

- Make arrangements for the person requiring assistance to receive appropriate medical care.
- Provide medical monitoring assistance during medical care abroad.
- Provide physician/hospital/dental/vision care referral details when medical attention is required and assist with appointments.
- Assist with emergency prescription replacement while abroad.
- Provide regular updates to an authorized company, school or family representative.
- Coordinate medical evacuation arrangements.

Concierge assistance:

- Restaurant referrals and reservations
- Event ticketing
- Ground transportation coordination
- Golf tee-time referrals and reservations
- Floral services
- Find, wrap and delivery of gifts
- Special occasion/appointment reminders

Expenses incurred from third-party vendors as well as AIG administrative case fees for assistance services not covered as part of a filed insurance plan are the responsibility of the policyholder

General travel assistance:

- Lost/stolen luggage
- Lost or stolen documents
- Embassy and consulate information
- Immunization, visa and passport information
- Emergency cash transfer assistance
- Emergency language interpretation

Identity theft assistance:

- Review your credit files with the you to determine the accuracy of the file and potential areas of fraud.
- Research and investigate potential damage to your identity.
- Provide assistance with filing a police report.
- When necessary, notify merchants that a fraudulent transaction occurred.

Note that identity-theft assistance services are not available for individuals residing in New York State or outside of the U.S.

Contact AIG Travel

Email: medicalsp@aig.com

Toll-Free within the U.S.A.: **877.249.5187**

Call Collect/Reverse Charge: **+1.715.295.9624**

Helpful information to have available

- Client name
- Contact phone number
- Current medical facility/ physician
- Current location
- Secondary point of contact
- Visa or alien number
- Symptoms and medical reports (if available)
- Email address
- Date of birth
- Passport information
- Details of incident, condition of person(s) needing assistance

AIG Travel, a member of American International Group, Inc., provides travel insurance and global assistance through innovative product offerings. Travel Guard® is the marketing name for its portfolio of travel insurance and travel-related services. From lost luggage to a medical emergency, our 24/7 multilingual assistance team is always just a phone call away. Through our global service centers and a network of experienced providers, we deliver medical and security assistance to help our customers travel with confidence. AIG Travel is a socially responsible and inclusive organization that meets the diverse needs of leisure and corporate travelers alike. Learn more at aig.com/travel or travelguard.com, and follow us on Twitter, Facebook, Instagram and LinkedIn.

This is a summary only of products and services offered. Actual offerings may vary by group size and are subject to state insurance law, and the benefits/provisions as described may vary due to such law. All products are subject to the policy terms, conditions, limitations, reductions, exclusions and termination provisions. Please see policy and certificate for details.

AT-12702-20 R11/21 (U.S. non-security)

Raytheon Technologies Benefits Center
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P.O. Box 1590
Lincolnshire, IL 60069-1590