This Summary Plan Description (SPD) provides an overview of the Medical Plan options for active employees covered under the ABB Inc. Flexible Benefits Plan. In the event of any discrepancy between this SPD and the official plan documents, the plan documents shall govern.

The Company expressly reserves the right to amend, suspend, discontinue or terminate any of its benefits plans, or to change any statement made in this SPD, at any time.

The Company's decision to amend, suspend, discontinue or terminate the plans may be due to changes in federal or state laws governing welfare or pension benefits, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974, as amended, (ERISA), Company policy, or any other reason.

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits, and to take any other actions with respect to questions arising in connection with the plans, including the interpretation of the terms of the plans. The Claims Administrator has authority to determine the amount of benefits payable. All decisions, determinations and interpretations of the Plan Administrator and/or the Claims Administrator are conclusive and binding on all persons.
Participant Rights and Responsibilities

As a Participant, You Have the Right to:

- Receive information regarding rules and regulations of your health care benefits;
- Be treated respectfully and with consideration;
- Receive all the benefits to which you are entitled, as described under this Summary Plan Description;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage;
- Participate with your Physician in decision making about your health care treatment;
- Refuse treatment and be informed by your Physician of the medical consequences;
- Express concern and complaints about the care and services provided by Physicians and other Providers to the Claims Administrator and to have the Claims Administrator, on behalf of ABB, investigate and take appropriate action;
- File a complaint with the Claims Administrator or ABB, to appeal that decision as outlined in the section of this SPD entitled, “BlueAdvantage’s Complaints and Appeals Provision”;
- Confidentiality and privacy.

As a Participant, You Have the Responsibility to:

- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship with that Physician;
- Provide complete and honest information about your health care status;
- Follow the treatment plan recommended by the Provider responsible for your care;
- Understand how to access care in routine, emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Co-insurance, etc.;
- Notify your Provider or the Claims Administrator about concerns you have regarding the services or medical care you receive;
- Be considerate of the rights of other Participants, Providers and the Claims Administrator’s staff;
• Read and understand “The Health Reimbursement and Health Savings Medical Plans offered through BlueAdvantage Administrators of Arkansas” and “Summary of Benefits for the HRP and HSP”; and,

• Provide accurate and complete information to the Claims Administrator about other health care coverage and/or insurance benefits you may carry.
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Introduction

Medical coverage is the benefit people often think about first when they think about their benefits program.

The Medical Plan is an important part of the benefits available through ABB. You may choose from two medical options, each of which provides coverage for medical care, mental health and substance abuse treatment, and Prescription Drug expenses. Each medical option is a Preferred Provider Organization (PPO) plan using the BlueAdvantage PPO network of Providers. Each medical option has a health account associated with it, which may be fully or partially funded by ABB. You can use the money in your health account to pay for eligible health care expenses.

This SPD describes the ABB PPO medical options, administered by BlueAdvantage. Please use it as a reference if you have questions about your coverage under the BlueAdvantage plans. The Medical Plans are benefit plans of your employer (ABB Inc.). These benefits are not insured with BlueAdvantage, but will be paid from funds provided by ABB Inc. BlueAdvantage will provide certain administrative services under the plan, as outlined in the Administrative Services Contract between BlueAdvantage and the contract holder.

Who Is Eligible

You are eligible to participate in the Medical Plan if you are:

- Employed on a regular salaried or hourly basis by the Company in a business that has adopted the program; and,
- A member of a group of employees for whom the plan has been adopted; and,
- Not represented by a collective bargaining agent unless the collective bargaining agreement provides for coverage under the plan.

Part-time employees are eligible if they are:

- Regularly scheduled to work 20 hours or more each week.

Casual employees and other individuals employed on a temporary basis, leased employees and independent contractors or consultants are not eligible to participate in the plan.
Your Dependents

You also may enroll your eligible dependents, who include:

- Your legal spouse (excluding your legally separated or divorced spouse);

- Your same-sex or opposite-sex domestic partner who meets the following requirements:
  - Living at the same address for six (6) months or more;
  - Not married to anyone else nor a member of another domestic partnership that has not been terminated, dissolved or annulled;
  - Not a blood relative in a way that would prevent either person from being married to each other under the laws of the state of residence;
  - Mentally competent to enter into binding contracts at the beginning of the domestic partnership;
  - Jointly responsible for each other’s care and living expenses; and,
  - Over 18 years of age;

- Your/spouse/domestic partner’s children from birth up to their 26th birthday (including your own children, stepchildren, legally adopted children, children placed for adoption, legal foster children and children for whom you are the legal guardian);

- Your/spouse/domestic partner’s unmarried children of any age who are incapable of self-support and chiefly dependent upon you for support because of a physical or mental handicap that began before the dependent reached the limiting age, if the child was covered by the plan at the time he or she reached the age 26 coverage limit. (You must submit proof of your child’s handicap to the ABB Benefits Service Center within 31 days after the child reaches the age 26 coverage limit. The Claims Administrator may request proof periodically); and,

- Your/spouse/domestic partner’s unmarried children who become eligible for medical coverage under the terms of a Qualified Medical Child Support Order (QMCSO). Contact the ABB Benefits Service Center for more information.

No other persons or relatives may be covered under the health care program.
How to Enroll

Enrollment is done online through NetBenefits or via the phone by calling the ABB Benefits Service Center. More information is included in the overall “Introduction to the ABB Inc. Flexible Benefits Plan” SPD, which you can find on the ABB HR Portal at http://us.inside.abb.com/hr or by contacting the ABB HR Center at 1-888-694-7762 or MYHRSMART@us.abb.com.

Please refer to the “Introduction to the ABB Inc. Flexible Benefits Plan” SPD for details about Annual Enrollment, family status changes, and any exceptions that might be authorized for late enrollees. Generally, you will have the opportunity to enroll in or make changes to your coverage during the Annual Enrollment period each year, or within 31 days of a qualified change in family status.
About the ABB Medical Plan

The ABB Medical Plan includes two medical options: a Health Reimbursement Plan (HRP) and a Health Savings Plan (HSP). Both are PPO medical plans with an associated health account. In some cases, depending on the geographic area in which you live, a traditional indemnity medical option or a Health Maintenance Organization (HMO) medical option may be available.

The medical options cover basic and major medical services. They also provide 100% coverage in-network for preventive care and health screenings. They differ in:

- The amount you pay toward required contributions;
- The amount you pay toward plan Deductibles and Out-of-Pocket Maximums;
- Prescription Drug coverage; and,
- The type of health account associated with your plan (either an HRA or HSA).

Summary of Your Medical Options

The Health Reimbursement Plan (HRP)

What is the HRP?

The HRP is a traditional PPO plan. It gives you the flexibility to choose Network or Non-Network Providers each time you need medical care. Within the health plan’s PPO network, you have the freedom to select any participating Provider — there are no referrals required. When you use Network Providers, you receive a higher level of benefits. You also have the freedom to choose Providers who do not participate in the health plan’s network and still receive benefits, although at a lower rate of reimbursement.

Whether you use Network or Non-Network Providers, you pay an individual or family Deductible before the plan pays benefits. Then Covered Services are reimbursed based on a Co-insurance percentage. For the HRP, in some cases, such as primary care office visits, you only have to pay a Copayment. Your Copayment does not count toward your Deductible.

Both the HRP and HSP offer the same Covered Services. They differ in the amount you pay in Deductibles and Co-insurance toward Covered Services.

The Health Reimbursement Arrangement (HRA)

The HRP also includes an associated health account called the HRA. The HRA is a tax-advantaged account (the HRA is a bookkeeping account and not a trust of any sort) that you can use to pay toward your out-of-pocket health care costs. These include covered expenses for routine medical care, such as office visits and lab tests.
ABB makes an annual contribution to the HRA for you and your covered dependents based on your participation in the TotalHealth Rewards program (see the section of this SPD entitled, “TotalHealth Rewards”). Covered medical expenses (both in-network and out-of-network) are automatically paid from the account (with the exception of Prescription Drugs covered under the CVS Caremark Managed Pharmacy Program), even if you have not met your annual Deductible. The account is fully funded by ABB; you are not permitted to make any contribution toward the account. The amount allocated to your HRA annually is determined by ABB and depends on the coverage category you choose. Amounts allocated are per coverage category and not per family member. ABB’s contributions generally are limited to the amount of TotalHealth Rewards an employee and his/her spouse or domestic partner can earn for participating in that program.

Your HRA benefit dollars may only be used for Covered Services, as defined in this SPD. However, HRA benefit dollars can not be used to pay for Prescription Drugs covered under the CVS Caremark Managed Pharmacy Program. If your employment terminates for any reason or you retire, your HRA benefit dollars will be forfeited and the benefit dollars in your HRA will revert back to the Company, unless you elect COBRA coverage.

If you elect COBRA coverage, any HRA benefit dollars remaining at the time employment terminates can be used to assist you in paying your medical expenses while COBRA coverage is in effect. You will remain eligible to participate in the ABB TotalHealth program while on COBRA; however, you will not be eligible to earn additional HRA contributions from ABB.

Where is the HRP offered?

The HRP is offered in locations that have a BlueAdvantage PPO network available, as outlined in your enrollment materials.

What’s the advantage?

The advantage of the HRP is the flexibility to choose Network or Non-Network Providers. The advantage of the associated HRA is having tax-free money available from the first dollar of health care expenses you incur to cover charges before you meet your annual Deductible.

The Health Savings Plan (HSP)

What is the HSP?

The HSP is a federally-qualified High Deductible Health Plan (HDHP) that provides medical services as a PPO plan.

The HSP has similar features to the HRP described above. One difference is how Prescription Drugs are covered. See the section of this SPD entitled, “The CVS Caremark Managed Pharmacy Program” for more information. Another difference is the HSP has a higher Deductible and family Out-of-Pocket Maximum than the HRP. If you enroll in this plan, you may also open a Health Savings Account into which ABB and you can make contributions.
In accordance with federal regulations, if you enroll in the HSP and open a Health Savings Account, neither you nor any of your covered dependents may be covered by any other health plan — including a traditional Health Care Spending Account.

The Health Savings Account (HSA)
The HSA is a tax-advantaged account you use to set aside tax-free money to pay for out-of-pocket medical expenses like the annual Deductible and Co-insurance, or to build your savings to cover future medical expenses, typically in retirement. You may invest your savings in any of numerous investment options. Any money you do not use in your account during one calendar year will roll over to the next calendar year, allowing your savings to grow.

Unlike the HRA, ABB funds this account in two different ways, and you can also make employee contributions. ABB “seed” contributions are provided as a flat dollar amount to help offset the higher plan Deductible; and separate ABB contributions are made for participation in TotalHealth Rewards. Also unlike the HRA, this account is portable. If you leave ABB, you will be able to take the value of your account with you. Please see the section of this SPD entitled, “A Quick Look at the HRA and HSA” for complete details on funding both accounts.

If you leave ABB and elect COBRA continuation coverage, you will remain eligible to participate in the ABB TotalHealth program while on COBRA; however, you will not be eligible to earn additional TotalHealth Rewards contributions for your HSA, nor will ABB provide any further “seed” contributions to your account.

Where is the HSP offered?
The HSP is offered in locations that have a BlueAdvantage PPO network available, as outlined in your enrollment materials.

What’s the advantage?
The advantage of the HSP is the flexibility to choose Network or Non-Network Providers. The advantage of the HSA is the ability to offset current medical costs and to save money tax-free for future medical expenses.

Other Medical Options
Depending on the business you work for, HMOs or other PPO plans may be available. These other options are offered on a very limited basis, and benefits vary by plan. If you are eligible for any other plans, you will receive specific information about these options — including how they work and what expenses they cover — during the Annual Enrollment period. If you have medical coverage available from another plan outside of ABB, you may also choose “No Coverage.”

If you need more information about your benefit options, please contact the ABB Benefits Service Center. If you need more information about what is covered by the plan, contact BlueAdvantage at the toll-free number on your Medical ID card.
TotalHealth

The ABB TotalHealth program gives each of us the opportunity for improved health, better health care and reduced costs. It includes online tools, health information resources and the personal support and coaching you need to make informed decisions.

The TotalHealth program includes the following resources at no additional cost to you:

- Chronic Condition Management;
- Coaching and Wellness Programs;
- Tobacco Cessation Program;
- Employee Assistance Program (EAP) and Work/Life resources.

TotalHealth encourages you to GET, BE, and STAY healthy.

TotalHealth Rewards

To encourage your participation in the TotalHealth program, ABB provides incentive contributions through TotalHealth Rewards that are used to fund your HRA or HSA.

The ABB TotalHealth Rewards program year runs from October 1st through September 30th and allows you to earn monetary contributions to your HRA or HSA (when you are enrolled in either the HRP or the HSP). There are four incentive periods for 2014 in which to earn points for completing healthy activities—points which translate to dollars.

The TotalHealth Rewards you earn for deposit to your HRA or HSA may be used to cover out-of-pocket medical expenses or, if you have an HSA, you may use these funds to cover future medical expenses in retirement.

You may earn TotalHealth Rewards points by participating in activities like physical activity, health screenings, health assessments, wellness challenges, online or telephonic coaching programs, community events (such as a 5K), and doing community service. When you complete wellness activities, there are multiple ways to receive your points:

- You can log your own physical exercise/activity into the Boost activity tracker at www.redbrickhealth.com.
- Completed online and phone coaching programs through RedBrick Health are automatically credited for you.
- Community and ABB wellness events and community service are credited after you submit an activity completion form that you can download from the TotalHealth Rewards page on the ABB HR Portal. Alternatively, you can indicate your participation for these activities directly through the RedBrick portal by clicking on “HealthMap” then “Overview” and under ‘Healthy Activities’ select “More Healthy Activities.”
- Health screenings completed at an onsite screening event are automatically credited for you. Health screenings completed by your Physician will be credited once the completed Health screening form is submitted (you can download your personalized form from
RedBrick’s website and follow the instructions for submission). You also have the option to use the Community Access Program to complete your health screening any time during the year at a participating pharmacy/lab Provider in your area – more information on this option is available via [www.redbrickhealth.com](http://www.redbrickhealth.com).

- If you don’t have online access, you can call RedBrick Health at 1-877-777-3150 and ask a representative to record your activities for you or send you a needed form.

### Incentive Opportunity

<table>
<thead>
<tr>
<th>Incentive Opportunity</th>
<th>Employee Only</th>
<th>Employee + Spouse/ Domestic Partner</th>
<th>Employee + Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Assessment and Health Screening</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Health Assessment and Screening between 10/1/13 and 9/30/14 and earn:</td>
<td>$110</td>
<td>$220*</td>
<td>$310</td>
</tr>
<tr>
<td><strong>Healthy Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Healthy Activities each quarter and earn:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1 10/1/13 - 12/31/13</td>
<td>Up to $85 per Quarter</td>
<td>Up to $85** per Quarter</td>
<td>Up to $85 per Quarter</td>
</tr>
<tr>
<td>Q2 1/1/14 – 3/31/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3 4/1/14 – 6/30/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4 7/1/14 – 9/30/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Potential HRA/HSA Incentive Contribution</strong>*:</td>
<td>$450</td>
<td>$900</td>
<td>$650</td>
</tr>
</tbody>
</table>

Note: children do not complete any of these activities.

* The employee and covered spouse/domestic partner can EACH earn up to $110; if only one completes the assessment and screening, the incentive is only $110.

** The employee and covered spouse/domestic partner can EACH earn up to $85 for completing healthy activities each quarter.

*** Incentive dollars will be deposited to your HRA/HSA in the month following the end of the quarter completed.
Overview of the HRP and HSP

The HRP and HSP are administered for ABB by BlueAdvantage. They are an important element of ABB’s overall benefits strategy to provide quality care options at a cost that is affordable for you and ABB.

Both plans provide benefits for the same Covered Services. They also use the same BlueAdvantage network of PPO Providers. They differ in how much you pay in contributions and out-of-pocket costs. In general, the more you pay in up-front contributions, the less you pay in out-of-pocket costs when you use health care services.

The HSP covers the same services as the HRP, but pays certain benefits differently in order to comply with federal regulations governing HDHPs and HSAs. For information about the Deductible and Out-of-Pocket Maximum, refer to the section of this SPD entitled, “Shared Cost Benefits.” For information about how the HSP covers Prescription Drugs, refer to the section of this SPD entitled, “The CVS Caremark Managed Pharmacy Program.”

Provider Network

Both PPO medical options use a carefully selected network of Providers to direct you to health care resources and help manage costs. This is done in two ways.

- By emphasizing preventive care, the PPO plans and HMOs, where available, can help you get medical care early, when treatment is often less expensive and more effective.
- Network Providers have agreed to treat plan members at special, negotiated rates.

When you use the plan’s PPO Network Providers, you get these important features:

- You pay a lower Co-insurance rate (after Deductible) for office visits and other Covered Services. And for the HRP, you only pay a $25 Copayment for primary care office visits.
- Preventive care — annual physicals, well-baby care, immunizations, well-woman care and well-man care — is covered at 100% in-network — there are no Deductibles to meet and no Co-insurance costs.
- There are no claim forms to fill out.

The plans give you the option of receiving care outside of the health care network. You pay more when you do so, but the choice is yours.
Provider Directories

Provider directories are available at no cost to you. You may access a Provider directory for the HRP and HSP administered by BlueAdvantage at: www.blueadvantagearkansas.com.

While network status may change from time to time, www.blueadvantagearkansas.com is the most current source of Provider information. Use the Provider directory as a reference whenever you need to select a Network Provider for yourself or covered members of your family.

The Role of the Primary Care Physician

You do not have to select a Primary Care Physician (PCP) with either of the PPO plans. You are free to set up your own appointment and to direct your own care within the health plan’s network.

However, it is always a good idea to have a personal Physician to provide your general health care. A PCP understands your overall medical condition and family health history. He or she can provide your general medical care, and if you would like a referral, the PCP can refer you to a network specialist.

To locate a network PCP, you may access Provider directories on the internet at: www.blueadvantagearkansas.com. Or, call BlueAdvantage Member Services for Provider information at the toll-free number on your Medical ID card.

Shared Cost Benefits

The ABB Medical Plan is a shared cost benefit. You and ABB share the cost of the medical option you elect, with the Company absorbing the major share of the cost. As you can see in the chart below, ABB pays a larger share of the cost for the HSP than for the HRP.

Each medical option has a premium cost associated with it. The options available to you and the cost of each one is included with your enrollment materials. You pay your share of the cost of the Medical Plan you elect through paycheck deductions, which are based on your salary band and the coverage tier you choose (Employee, Employee + 1, or Employee + Family).

For purposes of determining your “medical cost sharing salary band,” the following definitions apply:

- For new hires, salary means your current annual base salary;

- For existing employees, your salary for the next plan year is based on your annual base salary, plus net commissions, shift differentials paid, and the most recent incentive compensation paid in the preceding 12 months as of August 31st of the prior plan year.
**Tobacco Free Credit**

Employees who are not tobacco users pay lower medical premiums than those employees who use tobacco. If you are not a tobacco user (for at least the last six months), or are in a tobacco cessation program, and you want to pay the lower medical premiums, you must actively indicate your non-tobacco use when making your medical plan election during the benefits enrollment process. If you do not, you will pay the higher tobacco user medical contribution. The amount of the credit is $40 per month or $9.23 per week.

**Find Your Salary Band**

**Non-tobacco Users**

<table>
<thead>
<tr>
<th>If your salary is...</th>
<th>If you attest you are tobacco free, you pay this percentage of the per paycheck health plan premium...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Reimbursement Plan</td>
</tr>
<tr>
<td></td>
<td>Employee</td>
</tr>
<tr>
<td>&lt;$40,000</td>
<td>11%</td>
</tr>
<tr>
<td>$40,000 to &lt;$60,000</td>
<td>17%</td>
</tr>
<tr>
<td>$60,000 to &lt;$75,000</td>
<td>22%</td>
</tr>
<tr>
<td>$75,000 to &lt;$90,000</td>
<td>27%</td>
</tr>
<tr>
<td>$90,000 and above</td>
<td>31%</td>
</tr>
</tbody>
</table>

**Tobacco Users**

<table>
<thead>
<tr>
<th>If your salary is...</th>
<th>If you attest you are a tobacco user, you pay this percentage of the per paycheck health plan premium...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Reimbursement Plan</td>
</tr>
<tr>
<td></td>
<td>Employee</td>
</tr>
<tr>
<td>&lt;$40,000</td>
<td>20%</td>
</tr>
<tr>
<td>$40,000 to &lt;$60,000</td>
<td>26%</td>
</tr>
<tr>
<td>$60,000 to &lt;$75,000</td>
<td>30%</td>
</tr>
<tr>
<td>$75,000 to &lt;$90,000</td>
<td>35%</td>
</tr>
<tr>
<td>$90,000 and above</td>
<td>40%</td>
</tr>
</tbody>
</table>

ABB considers those who earn more as better able to afford medical coverage. Therefore, higher-paid employees are asked to contribute more toward coverage than lower-paid employees.
Other Ways Costs Are Shared

You also share the cost of coverage when you use health care services or purchase Prescription Drugs through Deductibles, Copayments and Co-insurance. You must first meet an annual Deductible before the plans pay benefits. Then, costs are shared based on a Co-insurance percentage. Your Deductible and Co-insurance vary based on which PPO option you elect, your coverage category and whether you use Network or Non-Network Providers. Your out-of-pocket costs are limited each year to an annual Out-of-Pocket Maximum.

Because you are responsible for a share of health care costs, it is very important to take an active role in understanding any medical condition you might have, as well as treatment alternatives. For example, you may want to ask your Physician about the reason for a test or treatment, and whether alternatives are available, before having services performed.

Preventive Care – 100% Coverage

The goal of all the ABB Medical Plans is to help you stay healthy. To encourage you to take advantage of preventive care and health screening benefits, Covered Charges for services provided in-network are paid at 100%, with no annual Deductible required. There is no coverage for preventive care and screenings provided out-of-network.

Deductible

The annual Deductible is the amount you or a covered family member must pay each year for Covered Services, other than preventive care, before the plan will pay benefits. The annual Deductible amount varies based on how many people you cover, and whether you obtain health care services from in-network or out-of-network Providers. However, the expenses you incur for in-network and out-of-network care will cross apply toward meeting your Deductible (i.e., in-network to out-of-network or out-of-network to in-network). For both plans, the Deductible is lower when you use Network Providers.

A Quick Look at the Family Deductible

The family Deductible limits the amount your family has to pay in Deductibles each year for Covered Services.

For the HRP, your covered expenses, and those of your covered family members that are applied to their individual Deductibles, are pooled to meet the annual family Deductible.

For example, the HRP has an in-network family Deductible of $1,600. Let’s assume your spouse, Mary, has a minor surgical procedure in January performed by a Network Provider. Charges for Covered Services come to $2,000, and $800 of those charges is applied to meet her individual in-network Deductible. The plan then pays 80% of the remaining $1,200 of her expenses.

By the end of March, each of your two children has $400 in expenses for in-network Covered Services applied to their individual Deductibles. Because the expenses of all family...
members contribute toward meeting the family Deductible, your family has met the annual family Deductible of $1,600 for in-network services received that calendar year. Any further Covered Services for any of your family members will be paid by the plan at 80% Co-insurance in-network, up to the annual Out-of-Pocket Maximum.

For the HSP, the family Deductible of $3,000 applies to expenses for your family as a whole. Let’s assume Mary had the same outpatient surgical procedure performed by a Network Provider and charges for Covered Services were $2,000. Here’s how the family Deductible would work for the Health Savings Plan (HSP). In the HSP, if you have family coverage, there is no individual Deductible. In this case, Mary would have to pay the entire $2,000 in expenses out of her own pocket. The plan would pay nothing until the entire $3,000 in-network family Deductible has been met. By the end of March, each of your two children has $300 in in-network expenses credited toward the family Deductible ($600 total). Together, Mary’s expenses, plus those of the children, come to $2,600. Since you and your family have still not met the family Deductible of $3,000, all expenses must continue to be paid out-of-pocket until the $3,000 family Deductible has been met.

Once the in-network family Deductible is met, any further in-network medical and Prescription Drug expenses will be paid by the plan at 80% Co-insurance, up to the annual Out-of-Pocket Maximum.

This is a big difference between the two plans. Even if one family member reaches the single coverage Deductible amount, the plan will not begin to pay benefits for that family member—or any other family member—until the entire family Deductible has been met, in any combination of covered expenses.

Copayments

Copayments (Copays) are the flat fee that is your payment in full under the CVS Caremark Managed Pharmacy Program when you purchase Generic Drugs. Copayments also apply to non-specialist office visits and Urgent Care visits in the Health Reimbursement Plan. However, for lab, X-ray and other charges in connection with the office visit or Urgent Care, you pay 20%, after Deductible.

Co-insurance

Once you have met the annual Deductible, you and the plan share in the cost of Covered Services. The sharing of expenses between you and the plan is called Co-insurance.

If you use Network Providers, your Co-insurance is applied to the lower network Negotiated Fee. Network Providers negotiate their charges in advance with the Claims Administrator and will not exceed the Maximum Allowable Amount for a service or supply.

If you use Non-Network Providers, your Co-insurance is applied to the Maximum Allowable Amount for a Covered Service or supply. If your Covered Charges exceed what is considered the Maximum Allowable Amount by the Claims Administrator, the plan will pay benefits based only on the Maximum Allowable Amount. You will be responsible for any amount that exceeds the Maximum Allowable Amount.
**Out-of-Pocket Maximum**

The Out-of-Pocket Maximum is the maximum amount you and your covered family members have to pay for covered expenses in a calendar year. Your Out-of-Pocket Maximum includes your Deductible and your share of the Co-insurance. It also includes the non-specialist Physician and Urgent Care office visit Copayments in the HRP. The Out-of-Pocket Maximum amount varies based on how many people you cover and whether you obtain health care services in-network or out-of-network. Expenses for services obtained in-network **count only** toward meeting the in-network Out-of-Pocket Maximum; expenses for services obtained out-of-network **count only** toward meeting the out-of-network Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met, the plan pays 100% of most charges for Covered Services for the remainder of the year.

The following expenses do not count toward your individual or family Out-of-Pocket Maximum:

- Penalties imposed for not following precertification procedures (see the section of this SPD entitled, “Precertification” for more information);
- Charges in excess of the Maximum Allowable Amount;
- Co-insurance and Copayments for Prescription Drugs under the HRP;
- Charges for Prescription Drugs obtained at a non-participating pharmacy; and,
- Expenses not covered by the plan.

**Family Out-of-Pocket Maximum**

The family Out-of-Pocket Maximum provides additional protection against the financial impact of a catastrophic illness by limiting the amount of covered expenses your family has to pay each year in Co-insurance. Your covered expenses and those of your covered family members may be used to satisfy the family Out-of-Pocket Maximum.

For the **HRP**, although each family member has an individual maximum, it is not necessary for any one family member to first satisfy the individual maximum. Once the family maximum is reached, all Co-insurance requirements for your family are satisfied for that year. The plan will then pay 100% of most charges for Covered Services for the remainder of that year.

For the **HSP**, if you have family coverage, there is no individual Out-of-Pocket Maximum. Your family must meet the family Out-of-Pocket Maximum, in any combination of covered expenses, before the plan begins to pay 100% for all family members.

The limitations described above apply to the family Out-of-Pocket Maximum as well as to the individual Out-of-Pocket Maximum.
Unlimited Maximum Lifetime Benefit

There is no lifetime maximum benefit under the Medical Plan. You and each of your covered dependents can receive care for Covered Services with no lifetime payment limit from the ABB-sponsored medical option of your choice. This provides significant financial protection if you or a covered dependent suffers a serious Illness or Injury.
A Closer Look at the HRP and HSP

You should find the answers to most of your questions about these medical options in this SPD — including what they cover and how benefits are paid. The following sections of this SPD also have important information about precertification procedures you must follow before a Hospital admission, certain medical procedures, mental health or substance abuse disorder treatment, or an organ transplant. If you do not follow these procedures, your benefits may be either reduced or not paid at all.

If you need more information about your benefit options, please contact the ABB Benefits Service Center. If you need more information about what the health plans cover, please call BlueAdvantage at the toll-free number on your Medical ID card.

The following chart compares the features, benefits and out-of-pocket costs of the two medical options. A Summary of Benefits and Coverage (SBC) for each medical option is also available, along with a Uniform Glossary, to help you compare your medical options. The SBCs are available via NetBenefits.

Out-of-network benefits are based on the Maximum Allowable Amount for Covered Services and supplies that are necessary for the diagnosis and treatment of an Illness or Injury. If a charge exceeds the Maximum Allowable Amount, you pay your share of Covered Services, plus any amount above the Maximum Allowable Amount. Network benefits are based on a Negotiated Fee, which is not more than the Maximum Allowable Amount for a service or supply.

Most of the rules surrounding the HSP and HSA are based on federal regulations. Neither ABB nor your Provider can make an exception to the rules.
# Summary of Benefits for the HRP and HSP

<table>
<thead>
<tr>
<th>Freedom of Choice of Providers</th>
<th>The Health Reimbursement Plan (HRP)</th>
<th>The Health Savings Plan (HSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>You do not have to use Network Providers to use the plan. To get in-network benefits, you do.</td>
<td>You do not have to use Network Providers to use the plan. To get in-network benefits, you do.</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Prescription Drugs

- **Retail & Specialty, 30-day supply, you pay per prescription:**
  - **Generic:** $10
  - **Formulary:** 25% (subject to $30 minimum and $50 maximum payment per prescription)
  - **Non-Formulary:** 50% (subject to $70 minimum and $90 maximum payment per prescription)
  - Not covered
  - 20% after Deductible and Co-insurance
  - Not covered (Reimbursable through the HSA)

- **Mail Order, 90-day supply, you pay per prescription:**
  - **Generic:** $20
  - **Formulary:** 25% (subject to $60 minimum and $100 maximum payment per prescription)
  - **Non-Formulary:** 50% (subject to $140 minimum and $180 maximum payment per prescription)
  - Not covered
  - 20% after Deductible and Co-insurance
  - Not covered (Reimbursable through the HSA)

## Preventive Care

- Plan pays 100% (No Deductible)
- Not covered
- Plan pays 100% (No Deductible)
- Not covered (Reimbursable through the HSA)

## Annual Deductible

<table>
<thead>
<tr>
<th></th>
<th>Single Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>$800</td>
<td>$800/individual</td>
</tr>
<tr>
<td></td>
<td>$1,600</td>
<td>$1,600/individual</td>
</tr>
<tr>
<td></td>
<td>$1,500</td>
<td>$3,200/individual</td>
</tr>
<tr>
<td></td>
<td>$3,000</td>
<td>$3,000/family*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$6,000/family*</td>
</tr>
</tbody>
</table>
# Summary of Benefits for the HRP and HSP

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Emergency</td>
<td>Covered Services subject to an annual Deductible and Co-insurance</td>
<td>Covered Services subject to an annual Deductible and Co-insurance</td>
<td>Covered Services subject to an annual Deductible and Co-insurance</td>
<td>Covered Services subject to an annual Deductible and Co-insurance</td>
</tr>
<tr>
<td>Note: If not a true Medical Emergency the plan will pay $0.</td>
<td>Plan pays 80%, after Deductible; You pay $150 (in addition to Deductible/Co-insurance)</td>
<td>Plan pays 80% after Deductible; You pay $150 (in addition to Deductible/Co-insurance)</td>
<td>Plan pays 80%, after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>You pay a $40 Copayment</td>
<td>Plan pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible</td>
<td>Plan pays 80%, after Deductible</td>
<td>Plan pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible</td>
</tr>
<tr>
<td>Primary Care Physician Office Visits</td>
<td>You pay a $25 Copayment</td>
<td>Plan pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible</td>
<td>Plan pays 80%, after Deductible</td>
<td>Plan pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible</td>
</tr>
<tr>
<td>Specialist Office Visits Inpatient Hospital** Outpatient Surgery</td>
<td>Plan pays 80%, after Deductible</td>
<td>Plan pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible</td>
<td>Plan pays 80%, after Deductible</td>
<td>Plan pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible</td>
</tr>
</tbody>
</table>

## Annual Out-of-Pocket Maximum

| - Single Coverage | $4,500 | $9,000 | $5,000 | $10,000 |
| - Family Coverage | $4,500/individual $9,000/family | $9,000/individual $18,000/family | $10,000/family* | $20,000/family* |

## Mental Health

| - Outpatient | Plan pays 80%, after Deductible | Plan Pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible | Plan pays 80%, after Deductible | Plan pays 60% of the Maximum Allowable Amount for covered expenses, after Deductible |
### Summary of Benefits for the HRP and HSP

<table>
<thead>
<tr>
<th></th>
<th>The Health Reimbursement Plan (HRP)</th>
<th>The Health Savings Plan (HSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td>Plan pays 80%, after Deductible</td>
<td>Plan pays 80%, after Deductible</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>60% of the Maximum Allowable Amount for covered expenses, after Deductible</td>
<td>Plan pays 60% of the Maximum Allowable Amount for covered expenses after Deductible</td>
</tr>
</tbody>
</table>

* Individual Deducible and Out-of-Pocket Maximum do not apply to family coverage in the HSP.

** Subject to a $250 penalty per Hospital/facility admission if out-of-network inpatient medical and mental health admissions are not pre-certified as required.
A Quick Look at the HRA and HSA

Each medical option has a health account associated with it. The health accounts are linked to the TotalHealth program. Generally, you earn TotalHealth Rewards to fund all or part of your account, depending on the plan you choose. When you have health care expenses, you can use your account to pay toward your Deductible and other out-of-pocket costs. This chart shows how the accounts are funded and some of the key differences.

<table>
<thead>
<tr>
<th>Health Reimbursement Arrangement (HRA)</th>
<th>Health Savings Account (HSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associated Medical Plan</td>
<td>Health Reimbursement Plan</td>
</tr>
<tr>
<td>Federally Qualified High Deductible Health Plan (HDHP)</td>
<td>No</td>
</tr>
<tr>
<td>Who Can Make Contributions?</td>
<td>Employer only</td>
</tr>
<tr>
<td>Source of Contributions</td>
<td>● TotalHealth Rewards</td>
</tr>
</tbody>
</table>

2014 TotalHealth Rewards Employer Contributions

<table>
<thead>
<tr>
<th></th>
<th>Employee Only</th>
<th>Employee + Spouse/Domestic Partner (with or without covered Children)</th>
<th>Employee + Child(ren) (with no covered Spouse/Domestic Partner)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Employee Only</td>
<td>Up to $450</td>
<td>Up to $900</td>
<td>Up to $650</td>
</tr>
<tr>
<td>- Employee + Spouse/Domestic Partner (with or without covered Children)</td>
<td>Up to $900</td>
<td>Up to $900</td>
<td>Up to $650</td>
</tr>
<tr>
<td>2014 Maximum Employee Contributions</td>
<td>- Employee Only</td>
<td>Not permitted</td>
<td>$3,300 (includes ABB’s rewards and seed contributions)</td>
</tr>
<tr>
<td>- Family</td>
<td>Not permitted</td>
<td>$6,550 (includes ABB’s rewards and seed contributions)</td>
<td></td>
</tr>
</tbody>
</table>

| Account Earns Interest/Investment Income | No | Yes |
| Account is Portable if You Leave the Plan or ABB | No | Yes |

* Employer contribution amounts are prorated if you are covered for less than 12 months (e.g., if you join 7/1/14, the contribution would be 50% of the annual amount or $75 for Employee Only, $150 for Employee + Spouse/Domestic Partner, and $200 for Employee + Child(ren)).
Setting Up Your Account

**HRA:** The HRA is automatically set up for you by your medical plan carrier. Your allocation from ABB, if earned, will be credited to your HRA periodically during the year according to the TotalHealth Rewards period (described in the section of this SPD entitled, “TotalHealth Rewards”).

**HSA:** You must open an account to participate in an HSA. Once opened, you can make tax-free contributions up to IRS limits each year. The HSA is administered by HealthSCOPE Benefits; you enroll directly with them. Your account will be effective the first of the month following enrollment. You can find enrollment instructions posted on the ABB HR Portal and NetBenefits. It is important to enroll for the HSA even if you do not personally contribute to it because that is where ABB’s contributions will be deposited.

Portability

In both accounts, unused money at the end of the plan year will roll over to the next plan year. In this manner your account may “grow” almost like a savings account.

However, HRA funds are not portable. If you leave the HRP or ABB, and have money left in your HRA, it will be forfeited, unless you enroll for COBRA coverage.

Money remaining in the HSA belongs to you and is portable if you leave the HSP or ABB.

**Important Note about COBRA:** If you leave ABB and enroll for medical coverage under COBRA, you will continue to be eligible to participate in the ABB TotalHealth program. However, you will no longer be eligible to earn TotalHealth Rewards, nor will ABB make “seed” contributions to the HSA on your behalf.
How the Medical Plans Work

Network Services and Benefits

If your care is rendered by a Network Provider, benefits will be provided at the network level. Within the network, you may select any network Physician to provide the routine and preventive health care services you need. You do not have to select a Primary Care Physician (PCP), although it is always a good idea to have a personal care doctor to provide and coordinate your routine care.

If specialist care is required, you can also choose any specialist within the network. There are no specialist referrals required.

When you need health care services, simply show your Medical ID card at your Physician’s office or other health care Provider. For in-network services, your Network Provider will bill the plan for the cost of services. BlueAdvantage will process that claim and send you an Explanation of Benefits (EOB), which will show how much was paid to the Provider, and how much (if any) you should pay the Provider.

Please note: If you are enrolled in the HRP, your in-network expenses that are subject to the Deductible and Co-insurance will be deducted automatically from your HRA until any balance in your account is exhausted. You are not required to file any claim forms for in-network services any time you use Network Providers.

Preventive care, including annual physicals, well-baby care, well-woman care, well-man care and immunizations (schedule based on age), is paid at 100% with no Deductible when you use Network Providers.

For other Covered Services, you must first meet an annual individual or family Deductible. The plan then pays a percentage of the cost of Covered Services, based on the health plan’s Negotiated Fee. You pay the balance of covered expenses up to an annual Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the plan will pay 100% of covered expenses for Hospital, surgical and most other services for the remainder of that calendar year.

The Claims Administrator is allowed by ABB to determine whether services or supplies are Medically Necessary and to determine the Medical Necessity of the service or referral to be arranged.

The Claims Administrator, on behalf of ABB, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment.

If the type of Provider is not included in the network, contact the Claims Administrator. The Claims Administrator, on behalf of ABB, may approve a Non-Network Provider for that service as an Authorized Service. Contact your Network Provider or the Claims Administrator, on behalf of ABB, to be sure that prior authorization and/or precertification has been obtained.
Out-of-Network Services and Benefits

You also have the freedom to use a Physician who is not a member of the network. You will still receive benefits, but they will be paid at a lower level. Preventive care *is not covered* when you use a Non-Network Provider.

To receive out-of-network benefits, you must first meet the applicable Deductible. Then the plan pays a percentage of Covered Charges up to the Maximum Allowable Amount. You are responsible for the balance of Covered Charges, plus any amount greater than the Maximum Allowable Amount.

You pay your share of the costs up to an annual Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the plan will pay 100% of Covered Charges up to the Maximum Allowable Amount for the remainder of that calendar year.

For services rendered by a Non-Network Provider, you are responsible for:

- Obtaining any precertification that is required;
- Filing claims; and,
- Higher cost sharing amounts.

Covered Charges for inpatient or outpatient services rendered by an out-of-network anesthesiologist, pathologist or radiologist in connection with an in-network facility will be reimbursed at the in-network level of coverage.

**Please note:** Claims for health services provided in a foreign country are *not covered* unless required as emergency health services.

You decide whenever you need health care services...

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>You choose any Physician or specialist in the network.</td>
<td>You choose any Physician you wish to use.</td>
</tr>
<tr>
<td>You pay an annual Deductible before the plans pay benefits for most Covered Services.</td>
<td>You pay a higher annual Deductible before the plans pay benefits for most Covered Services.</td>
</tr>
<tr>
<td>You pay a Copayment or Co-insurance percentage toward the Negotiated Fee for Covered Services.</td>
<td>You pay a higher Co-insurance percentage toward the Maximum Allowable Amount for Covered Services, plus any amount over the Maximum Allowable Amount.</td>
</tr>
<tr>
<td>Preventive care is paid at 100%, with no Deductible.</td>
<td>No coverage for preventive care.</td>
</tr>
<tr>
<td>There are no claim forms to file.</td>
<td>You file claims for reimbursement.</td>
</tr>
</tbody>
</table>

HOW THE MEDICAL PLANS WORK
Relationship of Parties (Claims Administrator – Network Providers)

The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Claims Administrator, nor is the Claims Administrator, or any employee of the Claims Administrator, an employee or agent of Network Providers.

The Claims Administrator shall not be responsible for any claim or demand as a result of damages arising out of, or in any manner connected with, any injuries suffered by you or a covered dependent while receiving care from any Provider or in any Provider’s facilities.

Your Network Provider’s agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers and Non-Network Providers and disease management programs. If you have questions regarding such incentive or risk sharing relationships, please contact your Provider or the Claims Administrator.

All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms and provisions described in this SPD, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service, and does not guarantee payment.

To receive maximum benefits for Covered Services, you must follow the terms described in this SPD, including use of Network Providers, and obtain any required prior authorization or precertification. Contact your Network Provider to be sure that prior authorization/precertification has been obtained. The Claims Administrator, on behalf of ABB, bases its decisions about prior authorization, precertification, Medical Necessity, Experimental/Investigative services and new technology on the Claims Administrator’s medical policy and clinical guidelines. The Claims Administrator, on behalf of ABB, may also consider published peer-reviewed medical literature, opinions of experts and the recommendations of nationally-recognized public and private organizations which review the medical effectiveness of health care services and technology.

If You Need a Network Specialist

If you need specialized care, you may refer yourself to any network specialist. You are free to contact the specialist directly and set up an appointment. There are no forms to fill out, and no authorization notices to wait for.

Whether you self-refer or have your network Physician refer you to a specialist, it is always your responsibility to make sure the specialist is in the network. Do not rely on your Physician to know what specialists are in the network. In the rare case that a specialist is not
available in the network, you or your network Physician may contact BlueAdvantage for a referral to a non-network specialist. If the Provider is approved, the plan will cover the specialist’s charges on the same basis as a network Physician, as long as BlueAdvantage has approved it in advance.

Otherwise, if you use a non-network specialist, the plan will pay a lower percentage of Covered Services up to the Maximum Allowable Amount, after you meet the out-of-network Deductible.

**Preventive Care**

Both plans emphasize preventive care as the key to maintaining health. When you use a Network Provider, preventive care is covered at 100% with no Deductible, as required by applicable law. There is no coverage for preventive care out-of-network. Preventive care includes (but is not limited to):

- Annual physicals;
- Well-baby care for children up to age six (including checkups and immunizations);
- Prostate specific antigen (PSA) tests, limited to one per calendar year;
- Bone density scans for women;
- Preventive tests and screenings for men and women;
- Flu shots;
- Routine HIV testing;
- Smoking cessation counseling;
- Diabetes Self-Management Training;
- Additional preventive services for women required under the Patient Protection and Affordable Care Act (PPACA), including:
  - Breastfeeding support, supplies and counseling;
  - FDA-approved contraceptive counseling and contraceptive methods including diaphragms (and fitting), Essure, IUDs, injectibles, implantables;
  - Gestational diabetes screening;
  - Domestic violence screening;
  - HIV screening and counseling;
  - HPV DNA testing;
- Hysteroscopies;
- Sexually transmitted infection counseling; and,
- Tubal Ligation.

- Routine physical examinations, limited to one per calendar year, including the following laboratory tests: urinalysis, complete blood count (CBC), hematocrit test, hemoglobin test, general health panel and lipid panel;

- Gynecological exam with pap smear, limited to one per calendar year;

- Mammograms for women age 35 and older, limited to one per calendar year;

- Colorectal cancer screening for men and women age 50 and older, including:
  - One colonoscopy every 10 years;
  - One flexible sigmoidoscopy every five years; and,
  - One fecal occult blood test per calendar year.

**In An Emergency**

In a Medical Emergency, you should go immediately to the nearest Hospital or Urgent Care Center to get the care you need. A “Medical Emergency” is defined as follows: medical care and treatment provided after the sudden onset of a medical condition that manifests itself by acute symptoms, including severe pain. Symptoms are severe enough that, in the judgment of a reasonable person, the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient’s health would be placed in serious jeopardy; or,
- Bodily function would be seriously impaired; or,
- There would be serious dysfunction of a bodily organ or other part of the body.

In addition, emergency care includes immediate treatment of a mental disorder when the lack of such treatment could reasonably be expected to result in the patient harming himself/herself and/or another individual.

Here is what to do if you need emergency care:

1. If possible, call your Physician for guidance.
2. Otherwise, get to the nearest Urgent Care Center or Hospital emergency room.
3. It is recommended that you or a family member should contact BlueAdvantage at 1-866-840-1045 within 48 hours of emergency treatment, if you are admitted to a Hospital.
4. If you need follow-up care, see your regular Physician for treatment.
If your emergency meets the definition of a “Medical Emergency,” benefits will be paid at the in-network Co-insurance percentage, after Deductible, whether care is provided in-network or out-of-network. Care provided in an emergency room for a non-emergency condition will not be covered.

Emergency ambulance service, including approved emergency air, water and non-transport, is covered at the in-network Co-insurance percentage, after Deductible, whether ambulance services are provided in-network or out-of-network. Non-emergency ambulance services will be covered only if transportation is provided for one of the following reasons:

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

If non-emergency ambulance transportation is provided for any other reason, no benefits will be paid.

**Urgent Care**

Often an urgent rather than an emergency medical problem exists. Urgent care services can be obtained from a Network or Non-Network Provider. If you experience an accidental Injury or a medical problem, the Claims Administrator, on behalf of ABB, will determine whether the Injury or condition is an urgent care or emergency care situation for coverage purposes, based on your diagnosis and symptoms.

An urgent care medical problem is an unexpected episode of Illness or an Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an emergency. Urgent care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an urgent care medical problem is not life-threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the “Summary of Benefits for the HRP and HSP” for emergency room services.
Covered Services

Both plans cover a wide range of health care needs after you meet an annual individual or family Deductible. Benefits are paid based on the type of service provided, and whether you use Network or Non-Network Providers. All services must be considered a Covered Service before any benefits are paid. (See the definition of “Covered Services” under the section of this SPD entitled, “Important Terms.”)

For mental health benefits, please see the section of this SPD entitled, “Mental Health and Substance Abuse Treatment.”

When provided by your network Physician, the following services are covered in-network at 80% of the Negotiated Fee after Deductible, unless otherwise noted. Out-of-network the plans pay 60% of the Maximum Allowable Amount, after the Deductible.

Physician Services

- Office visits to a Primary Care Physician (for the HRP, the office visit is covered at 100% in-network after a $25 Copayment. All other services provided during an office visit apply toward the Deductible and Co-insurance).

- Office visits to a specialist.

- Services provided by Registered Nurse Practitioners including Clinical Nurse Specialists and Advanced Nurse Practitioners.

- X-ray and lab work as part of an office visit.

- House calls when Medically Necessary.

- Anesthesia administered in a Physician’s office.

- Preventive care, as required by applicable law (covered at 100% in-network with no Deductible; no coverage out-of-network):
  - Well-baby and well-child care to age 6;
  - Phenylketonuria (PKU tests);
  - Immunizations,* as noted below;
  - Annual physical exam, including vision and hearing screenings;
  - Preventive tests and screenings for men and women;
  - Women’s preventive care services, as required under the Patient Protection and Affordable Care Act (see the section of this SPD entitled, “Preventive Care” for a listing);
  - Annual well-woman exam and related services (gynecological exam, routine PAP test and laboratory work, mammogram) when you use a Network Provider;
  - Colorectal screening;
  - Cervical cancer screening;
- PSA blood test and digital rectal exam;
- Bone mineral density tests; and,
- Flu shots.

* Covered childhood immunizations generally include: Diphtheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles-mumps-rubella (MMR), Conjugate haemophilus influenza type B, Hepatitis B, Rotavirus vaccine, Varicella (Chicken Pox) and human papilloma virus (HPV) vaccine for ages 9-18. The HPV vaccine is limited to one complete dosage per lifetime. Women over age 18 but under age 26 who have not yet received the vaccine may receive the vaccine.

- Allergy treatment involving Physician services. If the allergy shot is given by a nurse and the Physician is not seen and no office visit is charged, then there is no Deductible or Co-insurance required for the office visit. Deductible and Co-insurance would apply to the allergy shot/serum.

- Hearing exam is covered once every three years, subject to the Deductible and Co-insurance. One hearing aid per ear is covered once every three years. Deductible and Co-insurance apply to hearing aids. Replacements, parts, repairs and batteries are not covered.

- Prenatal and post-natal care.

- Acupuncture and acupuncture modalities for anesthesia and pain therapy, provided it is Medically Necessary and administered by a licensed Physician or acupuncturist; up to 20 visits per calendar year.

- Second surgical opinions.

- Outpatient short-term rehabilitation (up to 20 visits per calendar year) provided by a Physician or licensed therapist when required for rehabilitation following surgery, stroke, an accidental Injury, or due to a congenital defect of a covered dependent at birth. More visits may be approved based on review. Limits apply to each type of therapy, in-network and out-of-network sessions combined:
  - Occupational therapy;
  - Physical therapy; and,
  - Speech therapy.

Maintenance care is not covered.

- Chiropractic care up to 20 visits per year including:
  - Manipulations;
  - Modalities;
  - X-Ray and Lab;
  - Maintenance care is not covered.

- Podiatry services including surgical care and medical treatment.

- Genetic testing.
**Emergency**

- Emergency room care is covered both in-network and out-of-network for the use of the emergency room and related services (including ambulance transportation). For a true emergency, the plans pay the in-network Co-insurance percentage, after Deductible, for emergency care provided either in-network or out-of-network. (For the HRP, the Member pays $150 toward in-network and out-of-network network services in addition to the Deductible and Co-insurance.) The plans pay no benefits if emergency services are used in a situation that is not a true emergency.

**Urgent Care**

- Urgent care is covered when your Physician is not available during or after normal office hours. (For the HRP, the Urgent Care visit is covered at 100% in-network after a $40 Copayment. All other services provided during an Urgent Care visit apply toward the Deductible and Co-insurance.)

**Hospital/Facility**

Precertification is required for all inpatient stays. A $250 penalty will be charged for out-of-network inpatient stays that are not precertified.

- Hospital inpatient:
  - Room and board up to the Hospital’s most common semi-private rate;
  - Intensive care/cardiac rehabilitation and care;
  - Newborn/nursery charges;
  - Surgery and related expenses, including anesthesia, surgeon and assistant surgeon;
  - Physician’s in-Hospital visits;
  - Drugs and supplies; and,
  - Private duty nursing, if Medically Necessary.

- Inpatient physical rehabilitation.

- Maternity care:
  - Hospital and nursery services and supplies;
  - Midwife services;
  - Birthing Centers; and,
  - Circumcision for newborns (in-Hospital only).

Routine inpatient newborn care is charged to the mother until the mother is discharged. If the child remains hospitalized after the mother has been discharged, care is then charged under the child.

- Skilled Nursing Facility:
  - Maximum 200 days per calendar year.
**Surgical**

- Outpatient surgery/procedures:
  - Physician’s services, including surgeon and assistant surgeon; and,
  - Facility charge for outpatient surgery, including Ambulatory Surgery Facilities and office coverage.

- Family planning:
  - Tubal ligation (covered at 100% under PPACA); and,
  - Vasectomy.

  (Reversal of voluntary sterilization is not covered.)

- Surgical treatment of obesity is covered if treatment is provided by or under the direction of a Physician provided either of the following are true:
  - You have a minimum Body Mass Index (BMI) of 40; or,
  - You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.

  Surgical Reversals are not covered.

- Reconstructive surgery performed within one year of an Injury.

**Other Covered Health Services**

**Abortions**

- Medical Abortions (abortifacient drugs).

- Therapeutic Abortions.

Elective Abortions are NOT covered.

**Alternatives to Hospital Care**

Precertification is required for the below services. A $250 penalty will be charged for out-of-network services that are not precertified.

- Skilled Nursing Facility (place of service determines benefit levels):
  - Maximum 200 days per calendar year.

- Hospice care:
  - Home setting and inpatient care; and,
  - Bereavement counseling services for the patient, a covered spouse/domestic partner, and covered dependent children (up to 15 visits within 12 months after the patient’s death).
• Home health care:
  – Up to 100 visits per calendar year.

**Clinical Trials**

• Charges for certain expenses for individuals participating in an approved clinical trial for a life-threatening disease, such as cancer. Expenses will be covered based on the Deductible and Co-insurance for the medical option you elect.

**Diabetes Management**

• Diabetes Self-Management Training (covered 100% under Preventive).

• Insulin pumps (supplies provided under prescription coverage).

• Glucometers.

• Routine foot care (when required for prevention of complications associated with diabetes mellitus).

• Orthopedic shoes and custom foot orthotics.

• Diabetic retinopathy screening.

• Insulin, needles, and diabetic testing supplies are provided through prescription coverage.

**Durable Medical Equipment**

• Rental of equipment and supplies, including wheelchairs, Hospital beds, and respiratory devices (or purchase if the cost is less than the expected rental cost and if pre-approved by the Claims Administrator).
  – Repair and maintenance of equipment is not covered.

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

**Family Planning**

• Charges for birth control devices (contraceptive drugs are covered under the Prescription Drug Plan).

• Tubal ligation (covered at 100% under PPACA).

• Vasectomy (reversal of voluntary sterilization is not covered).

• Infertility drugs.
• Coverage for infertility services and associated expenses including:
  - Diagnosis and treatment of infertility when provided by, or under the direction of, a Physician;
  - In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment;
  - Embryo transport;
  - Donor ovum and semen and related costs, including collection and preparation; and,
  - Artificial insemination.

Any combination of in-network and out-of-network benefits for infertility services is limited to a lifetime maximum of $7,500 per covered person.

The cost of any prescription medication treatment for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures and zygote intrafallopian transfer (ZIFT) procedures, provided in-network or out-of-network, will be subject to Deductible and Co-insurance and will count toward the Medical Plan’s annual Out-of-Pocket Maximum.

**Hearing Care**

• Charges for an audiometric exam provided by a network otolaryngologist or otologist once every three years (subject to Deductible and Co-insurance).

• Charges for an electronic hearing aid prescribed during the audiometric exam, and installed based on that prescription. Limited to one hearing aid per ear every three year period subject to the Deductible or Co-insurance. Replacements, parts, repairs and batteries are not covered.

• Cochlear Implants (batteries covered as Durable Medical Equipment (DME)). No age or frequency limit.

**Hospital-Related Expenses**

• Blood products and services including processing and storage fees.

• Plasma.

• Blood transfusions.

• Radiation therapy and chemotherapy, including associated drugs.

• Pre-admission testing.

• Diagnostic testing.

• Organ transplants.

• Kidney dialysis — if dialysis continues more than 12 months, patient must apply for Medicare.
Mouth, Teeth and Jaws

- Charges for services and supplies to treat teeth, mouth, jaw or jaw joints or supporting tissues (bones, muscles and nerves).

- Inpatient surgery required to:
  - Treat a fracture, dislocation or wound;
  - Cut out cysts, tumors or other diseased tissues; and,
  - Alter the jaw, jaw joints, or bite relationship by a cutting procedure when appliance therapy alone cannot result in a functional improvement.

- Non-surgical treatment of infections or diseases, excluding those of, or related to, the teeth.

- Dental work, surgery and orthodontic treatment, as follows, when required due to Injury:
  - Services needed to remove, repair, replace, or restore or reposition natural teeth that have been damaged, lost or removed; or,
  - Services needed to repair other body tissues of the mouth that have been fractured or cut; or,
  - Crowns, dentures, bridgework or in-mouth appliances installed due to Injury.

  (Treatment must be started within three months of the accident and completed within twelve months of the accident. Teeth must have been free from decay, in good repair, and firmly attached to the jaw bone at the time of Injury. Crowns, dentures, bridgework and appliances are limited to the first course of treatment after the Injury.)

- Cranial Mandibular Disharmony (Dentofacial Anomalies).

- Coverage is provided for Hospital services, including anesthesia services in connection with treatment for a dental condition that requires medically recommended sedation.

Orthotics

- The plan covers purchase and rental of orthotics that are:
  - Molded to fit the foot; and,
  - To correct a deformity by repositioning; and,
  - Necessary for function.

Prescription Drugs

- For HRP participants: Coverage provided through the CVS Caremark Managed Pharmacy Program, as described in the section of this SPD entitled, “The CVS Caremark Managed Pharmacy Program.”
• For HSP participants: Coverage provided based on Deductible and Co-insurance through CVS Caremark’s participating pharmacies and mail order service, as described in the section of this SPD entitled, “The CVS Caremark Managed Pharmacy Program.”

**Prosthetic and Orthopedic Devices**

• Initial prosthetic or orthopedic devices for a loss or an Injury and appliances that replace a limb or body part, or help an impaired limb or body part work. These include, but are not limited to:
  - Artificial arms, legs, feet and hands;
  - Artificial face, eyes, ears and nose; and,
  - Breast Prostheses following mastectomy, including mastectomy bras and lymphedema stockings for the arm.

Note: If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device. The device must be ordered or provided either by a Physician or under a Physician’s direction. If you purchase a prosthetic device that exceeds these minimum specifications, the plan may reimburse only the amount it would have paid for the prosthetic device that meets the minimum specifications, and you may be responsible for paying any difference in cost.

• Replacement when required by pathological change or the user’s growth.  
  (Repair and maintenance is not covered.)

• Orthopedic shoes.

**Self-Inflicted Wounds**

**Vision Services**

• Eyeglasses or contact lenses needed as a result of an accidental Injury or cataract related.

• Cataract surgery.

**X-ray and Laboratory Tests**

• Independent labs.

• Independent radiologists.

• Independent pathologists.
Important Terms

There are a number of words and phrases that have a very specific meaning when used to describe the Medical Plan. Here is an explanation of those special terms to help you better understand your benefits.

**Alternative Care Facility** is a non-Hospital health care facility, or an attached facility designated as free standing by a Hospital, that the plan approves, which provides outpatient services primarily for but not limited to:

- Diagnostic services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
- Surgery; and,
- Therapy services or rehabilitation.

**Ambulatory Surgical Facility** is a Provider that:

- Is licensed as such, where required;
- Is equipped mainly to do surgery;
- Has the services of a Physician and a registered nurse (R.N.) at all times when a patient is present;
- Is not an office maintained by a Physician for the general practice of medicine or dentistry; and,
- Is equipped and ready to initiate emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

**Authorized Service** means a Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance by the Claims Administrator, on behalf of ABB, to be paid at the network level.

**Autism Spectrum Disorders** mean a group of neurobiological disorders that includes Autistic Disorder, Rhett’s Syndrome, Asperger’s Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

**Birthing Center** is a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:

- Constituted, licensed, and operated as set forth in the laws that apply;
- Equipped to provide low-risk maternity care;
- Adequately staffed with qualified personnel who:
- Provide care at childbirth;
- Are practicing within the scope of their training and experience;
- Are licensed if required; and,

- Equipped and ready to initiate emergency procedures in life-threatening events to mother and baby by personnel who are certified in Advanced Cardiac Lifesaving Skills.

**Body Mass Index (BMI)** is a calculation used in obesity risk assessment which uses a person’s weight and height to approximate body fat.

**Certified Registered Nurse Anesthetist** is any individual licensed as a registered nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists, or a course approved by that state’s appropriate licensing board, and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

**Claims Administrator** is the third party administrator responsible for paying claims. The Claims Administrator does not insure the benefits provided by the Medical or Prescription Drug plans, but will pay claims with funds provided by ABB.

**Co-insurance** is the portion of a charge for Covered Services or supplies that you must pay. The plan pays the rest.

**Copayment (Copay)** is the flat fee that is your payment in full under the CVS Caremark Managed Pharmacy Program when you purchase Generic Drugs. Copayments also apply to non-specialist Physician office visits and Urgent Care visits (for lab, x-ray and other charges in connection with the office visit or Urgent Care, you pay 20%, after Deductible) in the Health Reimbursement Plan.

**Cosmetic Surgery** is a treatment or procedure that is primarily intended to change appearance. It does not include surgery required to repair the malfunction of part of the body as the direct result of an accident or Illness that occurs while coverage is in effect, or to correct a child’s congenital birth defect if the child is born while the parent’s coverage is in effect.

**Cost Effective**, in relation to Durable Medical Equipment and prosthetic devices, means the least expensive equipment that performs the necessary function.

**Covered Charges** are medical and Prescription Drug expenses for which benefits are payable.

**Covered Services** are those health services, treatments, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, Injury, mental Illness, or substance abuse disorder or symptoms. Covered Services must be provided:

- When the plan is in effect;
• Prior to the date that any of the individual termination conditions set forth in this SPD occurs; and,

• Only when the person who receives services is a covered person and meets all eligibility requirements specified in the plan.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you.

A Covered Service must meet each of the following criteria:

• Medically Necessary or otherwise specifically included as a benefit under this SPD.

• Within the scope of the license of the Provider performing the service;

• Not Experimental/Investigative or otherwise excluded or limited by this SPD, or by any amendment or rider thereto; and,

• Authorized in advance by the Claims Administrator, on behalf of ABB, if such prior authorization is required in the plan.

• Is supported by national medical standards of practice; and,

• Is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes, and is based on trials that meet the following designs:
  
  - Well-conducted randomized controlled trials (two or more treatments are compared to each other, and the patient is allowed to choose which treatment is received);
  
  - Well-conducted cohort studies (patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group); and,
  
  - Is the most cost-effective method and yields a similar outcome to other available alternatives.

• Is a health service or supply that is described in this SPD as a Covered Service, and which is not listed as an excluded service in the section of this SPD entitled, “Expenses the Medical Plans Will Not Cover.”

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described above.

**Covered Transplant Procedure** means any Medically Necessary human organ and tissue transplant as determined by the Claims Administrator, on behalf of ABB, including necessary acquisition costs and preparatory myeloablative therapy.
**Covered Transplant Services** means all Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a covered transplant benefit period, including any diagnostic evaluation for the purpose of determining a Member’s appropriateness for a Covered Transplant Procedure.

**Creditable Coverage** means the certification that you had medical coverage under an employer-sponsored medical plan. If you have prior Creditable Coverage, it will reduce the length of any pre-existing condition limitation under your new job-based coverage. Creditable Coverage also verifies that the Prescription Drug benefits offered to you by ABB are at least as good as those provided by Medicare Part D. This determination is made annually by an actuary, and Creditable Coverage Certificates are then issued to ABB Medicare-eligible participants and/or their Medicare-eligible dependents.

**Custodial Care** means care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an Illness or Injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Custodial Care can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and,
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

**Deductible** is the amount you must pay each calendar year for in-network and out-of-network medical expenses before the plan begins paying benefits. There is no Deductible required for preventive care services, and there is no Deductible required for Prescription Drugs under
the Health Reimbursement Plan. Expenses incurred toward meeting the Deductible cross apply for in-network and out-of-network services.

**Durable Medical Equipment** (DME) is equipment designed for therapeutic purposes that meets the following criteria:

- It is designed for repeated use (not a consumable or disposable item);
- It is used primarily for a medical purpose;
- It is not of use to a person in the absence of sickness, Injury or disability; and,
- It is appropriate for use in the home.

Some examples of Durable Medical Equipment include:

- Appliances to replace a body organ or help an impaired one to function;
- Orthotic devices such as arm, leg, neck and back braces;
- Hospital-type beds;
- Equipment used to increase mobility, such as a wheelchair;
- Respirators or other equipment for the use of oxygen; and,
- Monitoring devices.

**Eligible Expenses** are charges for Covered Services that are provided while the plan is in effect. They are determined as follows: For a Network Provider, Eligible Expenses mean the contracted rate that has been negotiated with that Provider and the Claims Administrator or one of its vendors, affiliates or subcontractors. For services provided by a Non-Network Provider, Eligible Expenses are determined based on competitive fees in the area where the service was provided. If no fee information for a Covered Service is available, Eligible Expenses will be based on 50% of billed charges. Certain mental health and substance abuse treatment services are based on 80% of billed charges. Billed charges for mental health and substance abuse treatment services provided by a psychologist are reduced by 25% and those provided by a Masters-level counselor are reduced 35%. A copy of the guidelines related to your claim is available from the Claims Administrator.

**Experimental or Investigative** means 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 or the Claims Administrator’s designee, on behalf of ABB, determines in its sole discretion to be Experimental/Investigative. The Claims Administrator, on behalf of ABB, will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, on behalf of ABB, determines that one or more of the following criteria apply...
when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States 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; or,

- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or,

- 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 the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/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.

Any service not deemed Experimental or Investigative based on the criteria above may still be deemed Experimental or Investigative by the Claims Administrator, on behalf of ABB. In determining whether a service is Experimental or Investigative, the Claims Administrator, on behalf of ABB, will consider the information described below and assess whether:

- The scientific evidence is conclusive concerning the effect of the service on health outcomes;

- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and,

- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator, on behalf of ABB, to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigative under the above criteria may include one or more items from the following list which is not all inclusive:
• Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or,

• Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or,

• Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or,

• Documents of an IRB or other similar body performing substantially the same function; or,

• Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or,

• Medical records; or,

• The opinions of consulting Providers and other experts in the field.

**Formulary** (Formulary Brand Name Drug and Non-Formulary Brand Name Drug) means a clinically based drug list that contains FDA-approved brand name and Generic medications. These medications have been reviewed by CVS Caremark’s pharmacists and independent medical directors and Physicians, and approved as being appropriate for the treatment of most common medical conditions. The Formulary is updated regularly.

**Generic Drugs** are drugs which have been determined by the FDA to be bioequivalent to brand name drugs and are not manufactured or marketed under a registered trade name or trademark. Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, liquid, cream) as the counterpart brand name drug. On average, Generic Drugs cost about half as much as the counterpart brand name drug.

**Health Reimbursement Arrangement (HRA)** is a tax-advantaged account used in conjunction with the HRP that is funded by your employer to help offset your out-of-pocket health care costs. Amounts roll over from one year to the next, but are not portable if you leave the HRP or ABB.

**Health Savings Account (HSA)** is a tax-advantaged trust or custodial account used in conjunction with an HDHP. Eligible individuals (enrolled in the HSP) may establish an HSA to pay for medical expenses for themselves and family members. Both ABB and employee contributions are permitted. The account balance is portable if you leave the HSP or ABB.

**High Deductible Health Plan (HDHP)** means a plan that meets federal requirements with respect to Deductibles and Out-of-Pocket Maximums. Not all plans with a high Deductible are HDHPs; however, ABB’s HSP is a federally-qualified HDHP.
**Home Health Care Agency** is a public or private agency or organization licensed in the state in which it is located to provide home health care services.

**Hospice** is a coordinated plan of home, inpatient and outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Room and board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice; or,
- It is licensed in accordance with any applicable state laws; or,
- It meets the following criteria:
  - It provides 24-hour-a-day, 7-day-a-week service; and,
  - It is under the direct supervision of a duly qualified Physician; and,
  - It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients; and,
  - The main purpose of the agency is to provide Hospice services; and,
  - It has a full-time administrator; and,
  - It maintains written records of services given to the patient; and,
  - It maintains malpractice insurance coverage.

A Hospice, which is part of a Hospital, will be considered a Hospice for purposes of this plan.

**Hospital** is an institution which is primarily engaged in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient’s expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; or,
- It is approved by Medicare as a Hospital; or,
- It meets all of the following tests:
  - It maintains diagnostic and therapeutic facilities on its premises for the surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians; and,
  - It continuously provides 24-hour-a-day nursing services on the premises by or under the supervision of registered graduate nurses; and,
It is operated continuously with organized facilities for operative surgery on the premises.

The term Hospital 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;
- Treatment of alcohol abuse; or,
- Treatment of drug abuse.

**Illness** is a sickness or disease, including mental infirmity, which requires treatment by a licensed Physician or dentist.

**Injury** is bodily Injury sustained accidentally by external means, including all related conditions and recurrent conditions.

**Inpatient Services for behavioral health** are individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. Room and board charges are Covered Services only when an inpatient stay is authorized by the Claims Administrator or the Claims Administrator’s subcontractor.

**Intensive Outpatient Treatment or Day Treatment** means a structured outpatient mental health or substance abuse treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week. The program may be managed by a licensed mental health professional with a psychiatrist on staff. Therapy is provided by a licensed mental health professional.

**Maximum Allowable Amount** is the amount that the Claims Administrator or the Claims Administrator’s subcontractor determines, on behalf of ABB, is the maximum payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, the Claims Administrator or the Claims Administrator’s subcontractor use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider’s participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Claims Administrator, on behalf of ABB, for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for the plan.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under the plan or any other plan. In the absence of a negotiated amount, the Claims Administrator, on behalf of ABB, shall have discretionary authority to establish the Maximum Allowable Amount for a Non-Network Provider facility. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility’s charge, or an amount determined by the Claims Administrator, after consideration of any one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that the Claims Administrator may have made, or other factors the Claims Administrator, on behalf of ABB, deems appropriate. It is your obligation to pay any Copayments and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with the Claims Administrator.

**Medical Emergency** is medical care and treatment (including treatment of a mental disorder) provided after the sudden onset of a medical condition that manifests itself by acute symptoms, including severe pain. Symptoms are severe enough that, in the judgment of a reasonable person, the lack of immediate medical attention could reasonably be expected to result in any of the following: the patient’s health would be placed in serious jeopardy; bodily function would be seriously impaired; or there would be serious dysfunction of a bodily organ or other part of the body.

**Medically Necessary or Medical Necessity** is an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, Illness, disease or Injury and that is determined by the Claims Administrator, on behalf of ABB, to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member’s condition, Illness, disease or Injury;

- Obtained from a licensed Provider;

- Provided in accordance with applicable medical and/or professional standards;

- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
• The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);

• Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);

• Not Experimental or Investigative;

• Not primarily for the convenience of the Member, the Member’s family or the Provider; and,

• Not otherwise subject to exclusion under the plan provisions in this SPD.

The fact that a Provider has performed, prescribed or recommended a procedure, treatment, services or supplies, or the fact that it may be the only treatment for a particular injury, sickness, mental illness or pregnancy, does not, of itself, make such care, treatment, services or supplies Medically Necessary. The definition of “Medically Necessary” used in this SPD relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define “Medically Necessary.”

**Mental Health Conditions (including Substance Abuse)** are conditions identified as mental disorders in the most current version of the International Classification of Diseases, in the chapter titled “Mental Disorders.”

• Mental Health Condition is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.

• Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Claims Administrator may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

**Negotiated Fee** means the amount the health plan has agreed to pay the Physicians and facilities that contract as part of its network for Covered Services and supplies. The Negotiated Fee will not exceed the Maximum Allowable Amount for a service.

**Network Provider** is a Provider who has entered into a contractual agreement or is otherwise engaged by the Claims Administrator, or with another organization which has an agreement with the Claims Administrator, regarding payment for Covered Services and certain administration functions for the network associated with the plan.

**Network Transplant Facility** is a Hospital that has entered into a contractual agreement or is otherwise engaged by the Claims Administrator, on behalf of ABB, or with another
organization which has an agreement with the Claims Administrator, on behalf of ABB, to provide Covered Services and certain administrative functions to you for the network associated with this Medical Plan. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or,
- All Covered Transplant Procedures.

**Non-Network Provider** is a Provider who has not entered into a contractual agreement with the Claims Administrator, on behalf of ABB, or is not otherwise engaged by the Claims Administrator, on behalf of ABB, for the network associated with this plan. Providers who have not contracted or affiliated with the Claims Administrator’s designated subcontractor(s) for the services they perform under this plan are also considered Non-Network Providers.

**Non-Network Transplant Facility** is any Hospital that has not contracted with the transplant network engaged by the Claims Administrator, on behalf of ABB, to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or,
- All Covered Transplant Procedures.

**Out-of-Pocket Maximum** is the maximum amount an individual or family member will have to pay toward Covered Services during any calendar year. Expenses incurred accumulate separately for meeting the in-network Out-of-Pocket Maximum and out-of-network Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the plan will pay 100% of the Maximum Allowable Amount for most Covered Services for the remainder of that calendar year.

**Outpatient Treatment for behavior health** is office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, marital counseling, and medication evaluation. The service may be provided by a licensed mental health professional (including licensed professional counselors, psychological counselors, and psychological examiners) and is coordinated with the psychiatrist. Two days of Intensive Outpatient Treatment are the equivalent of one day as an inpatient.

**Partial Hospitalization or Day Treatment** is a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least 4 to 6 hours of treatment per day. Patients are expected to participate up to 5 days per week. Two days of Partial Hospitalization treatment are the equivalent of one day as an inpatient.

**Physician** is:

- A legally licensed doctor of medicine, doctor of osteopathy, or optometry; or,
- Any other legally licensed practitioner of the healing arts rendering services which are:
- Covered by the plan;
- Required by law to be covered when rendered by such practitioner; and,
- Within the scope of his or her license.

Physician does not include:

- The Member; or,
- The Member’s spouse/domestic partner, parent, child, sister, brother, or in-law.

**Prescription Drug** means any of the following:

- Federal Legend Drugs. (This is any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled: “Caution—Federal law prohibits dispensing without a prescription.”); or,
- Drugs which require a prescription under state law but not under federal law; or,
- Compound drugs. (A compound drug has more than one ingredient. At least one of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under state law); or,
- Injectable insulin; or,
- Needles and syringes.

**Prostheses** are artificial devices and appliances that replace a limb or body part, or help an impaired limb or body part work.

**Provider** is a duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider.

**Reconstructive Procedure** is a procedure performed to address a physical impairment, which includes surgery or other procedures associated with an Injury, sickness or congenital abnormality. The primary result of the procedure is restored or improved function and not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

**Recovery** is money you receive from another, their insurer or from any “Uninsured Motorist,” “Underinsured Motorist,” “Medical Payments,” “No-Fault,” or “Personal Injury Protection,” or other insurance coverage provision as a result of Injury or Illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the subrogation and reimbursement provisions of this SPD.
Residential Treatment Facility is a facility which provides a program of individualized and intensive treatment for mental health services or substance abuse in a residential setting. It includes observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. It also meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs;
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Abuse Administrator;
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and,
- It provides at least the following basic services in a 24-hour-per-day, structured milieu: room and board; evaluation and diagnosis; counseling; and referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital. Free Standing Residential Treatment Centers are not eligible for coverage.

Skilled Nursing Facility is a Provider constituted, licensed, and operated as set forth in applicable state law, which:

- Mainly provides inpatient care and treatment for persons who are recovering from an Illness or Injury;
- Provides care supervised by a Physician;
- Provides 24-hour-per-day nursing care supervised by a full-time registered nurse;
- Is not a place primarily for care of the aged, custodial or domiciliary care, or treatment of alcohol or drug dependency; and,
- Is not a rest, educational, or custodial provider or similar place.

Totally Disabled means a disability to the extent you are not able to perform the duties of your own occupation or any job for which you may be reasonably qualified based on training, education or experience, regardless of earnings or job openings available; or a dependent is not able to perform the activities of a person in good health and of comparable age.

Transitional Care means mental health services/substance abuse services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living
arrangement may be used as an adjunct to ambulatory treatment, when treatment doesn’t offer the intensity and structure needed to assist the covered person with recovery.

- Supervised living arrangements which are residences, such as transitional living facilities, group homes and supervised apartments, which provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be used as an adjunct to treatment when treatment doesn’t offer the intensity and structure needed to assist the covered person with recovery.

**Urgent Care Center** is a health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for urgent care.
Special Situations for the HRP and HSP

When You Travel Outside of Your Service Area

All ABB plans will pay for your emergency medical expenses while you are traveling, if your care was considered a Medical Emergency and Medically Necessary. In an emergency, get the necessary medical care first. Then, it is recommended that you contact your network Physician and the Claims Administrator within 48 hours to discuss your medical care.

If You Move Outside of the BlueAdvantage Network Service Area

If you move outside of the BlueAdvantage network service area, but move to an area covered by a UnitedHealthcare network service area, then you will be re-enrolled in the same plan, but through UnitedHealthcare. Call the ABB Benefits Service Center at 1-800-354-8069 for information about the plans available to you.

If Your Child Goes to School Away From Home

If a plan network is available in the area where your child goes to school, he or she can choose a network Physician near school to provide health care, or can choose a network Physician near home. You may access BlueAdvantage’s website at www.blueadvantagearkansas.com to locate a Network Provider. Member Services can also let you know whether a specific Physician is a member of the network. For a complete Directory of Providers for the area where your child goes to school, go to www.blueadvantagearkansas.com. You can also contact BlueAdvantage Member Services at 1-866-840-1045.

If the network isn’t available in the school’s area, your child must choose a network Physician in your service area. When your child needs care, he or she should contact that Physician for coordination with the Claims Administrator for approval before going to a Physician at school. If the Claims Administrator approves the medical care, the plan will pay benefits at the same level it pays for Network Providers. If the medical care isn’t approved, benefits will be paid at the out-of-network level.

Emergency care for your child at school will be paid at the network level, as long as it is a true emergency condition.
**Transition Situations**

If you are actively receiving medical care on the day your coverage under the plan goes into effect, special transition of care arrangements can be made if continuity of care is important to the success of your treatment. Transition of care may be available if you are:

- In the third trimester of pregnancy;
- Under active treatment for cancer (surgery or post-surgery, chemotherapy, radiation treatment, etc.);
- Recovering from a heart attack or stroke; or,
- Recuperating from surgery.

If you are eligible for transition of care, you can continue to receive care from your current Physician for a specified period of time, and the plan will pay the same level of benefits it would have paid if you were using a Network Provider. Transition of care benefits are not provided automatically, however. You must apply for them, and BlueAdvantage must approve your eligibility. Call BlueAdvantage at 1-866-840-1045 for an application.
Features and Benefits of the HRP and HSP

Health Care Management

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by assuring the use of appropriate procedures, setting (place of service), and resources through Case Management and through precertification review requirements which may be conducted either prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management, or to determine which services require precertification, call the precertification telephone number on the back of your Medical ID card or refer to the Claims Administrator’s website, www.blueadvantagearkansas.com.

You are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to your precertification request.

Your right to benefits for Covered Services provided under the plan is subject to certain policies, guidelines and limitations, including, but not limited to, the Claims Administrator’s medical policy and clinical guidelines.

A description of each Health Care Management feature, its purpose, requirements and effects on benefits, is provided in this section.

Clinical Guidelines

The Claims Administrator, on behalf of ABB, uses clinical guidelines to assist in the interpretation of Medical Necessity. The clinical guidelines include the Claims Administrator’s corporate medical policy, nationally-recognized utilization review guidelines, Claims Administrator developed medical review/utilization review criteria, Medicare guidelines, and other decision support material. However, this SPD takes precedence over the clinical guidelines. Medical technology and standards of care are constantly changing and the Claims Administrator, on behalf of ABB, reserves the right to review and update the clinical guidelines periodically.
**Precertification**

NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed.

*Precertification* is a Health Care Management feature which requires that an approval be obtained from the Claims Administrator, on behalf of ABB, before incurring expenses for certain Covered Services. The plan’s procedures and timeframes for making decisions for precertification requests differ depending on when the request is received and the type of service that is the subject of the precertification request.

*Urgent Review* means a review of medical care or treatment that, in the opinion of the treating Provider or any Physician with knowledge of the Member’s medical condition could, in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function based on a prudent layperson’s judgment, or, in the opinion of a Physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. Applying the prudent layperson standard, the Claims Administrator, on behalf of ABB, may determine that an urgent review should be conducted. Concurrent reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. **For certain services you will be required to use the Provider designated by the Claims Administrator’s Health Care Management staff.** The care will be covered according to your benefits for the number of days approved unless the Claims Administrator’s concurrent review determines that the number of days should be revised. If a request is denied, the Provider may request reconsideration. The Claims Administrator’s Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Member’s health requires an earlier decision.

Generally, the ordering Provider, facility or attending Physician may call to request a precertification review (“requesting Provider”). The Claims Administrator, on behalf of ABB, will work directly with the requesting Provider for the precertification request. However, you may designate an authorized representative to act on your behalf for a specific precertification request. The authorized representative can be anyone who is 18 years or older. For urgent reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on the plan’s process for designating an authorized representative, call the **precertification telephone number** on the back of your Medical ID card.

**It is your responsibility to obtain precertification for out-of-network services that require precertification.** You should verify that the Provider obtains the required precertification or obtain the required precertification yourself. If you do not obtain any required precertification, you are responsible for all charges for services the Claims Administrator, on behalf of ABB, determines are not Medically Necessary and a **non-compliance penalty of**
$250. If you do not obtain the required precertification, a retrospective review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services the Claims Administrator, on behalf of ABB, determines are not Medically Necessary.

You are responsible for obtaining precertification for the following out-of-network services:

- Inpatient admissions to Hospitals and other covered facilities (Skilled Nursing Facility, rehabilitation facility, Hospice, mental health and substance abuse, organ transplant) except for emergency admissions and maternity admissions which result in childbirth (including admissions of forty-eight (48) hours for normal delivery and ninety-six (96) hours for C-section delivery).
- UPPP (Uvulopalatopharyngoplasty) surgery.
- Plastic/reconstructive surgeries for:
  - Blepharoplasty;
  - Rhinoplasty;
  - Hairplasty;
  - Panniculectomy and Lipectomy/Diatasis Recti Repair;
  - Insertion/Injection of Prosthetic Material Collagen Implants; and,
  - Chin Implant/Mentoplasty/Osteoplasty Mandible.
- Durable Medical Equipment (DME)/prosthetics for:
  - Wheelchairs, special size, motorized or powered, and accessories;
  - Hospital beds, rocking beds, and air beds;
  - Electronic or externally powered prosthetics; and,
  - Custom made and/or custom fitted prefabricated orthotics and braces.
- PET (Positron Emission Tomography).

For inpatient admissions following emergency care, precertification is not required. However, you must notify the Claims Administrator, on behalf of ABB, or verify that your Physician has notified the Claims Administrator, on behalf of ABB, of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Claims Administrator, on behalf of ABB, is contacted, you will be notified whether the inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Claims Administrator, on behalf of ABB, you may avoid financial responsibility for any inpatient care which is determined to be not Medically Necessary under your health benefit plan. If your Provider is not in the BlueAdvantage network, or is not a BlueCard Provider, you
will be financially responsible for any care the Claims Administrator, on behalf of ABB, determines is not Medically Necessary.

For childbirth admissions, precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time. Precertification will be required for any additional time necessary because of complications.

**Precertification Procedures**

*Prospective Review* means a review of a request for precertification that is conducted prior to a Member’s Hospital admission or course of treatment. For prospective reviews, a decision will be made and telephone notice of the decision will be provided to the requesting Provider, as soon as possible, taking into account the medical circumstances, but not later than two business days from the time the request is received by the Claims Administrator, on behalf of ABB.

For *urgent reviews*, telephone notice will be provided to the requesting Provider as soon as possible taking into account the medical urgency of the situation, but not later than two calendar days from the time the request is received by the Claims Administrator, on behalf of ABB.

If additional information is needed to certify benefits for services, the Claims Administrator, on behalf of ABB, will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request. For *urgent reviews*, the Claims Administrator, on behalf of ABB, will notify the requesting Provider of the specific information necessary to complete the review within 24 hours after receipt of the request by the Claims Administrator. Written notice will be sent following the request by telephone.

The requested information must be provided to the Claims Administrator, on behalf of ABB, within 45 calendar days from receipt of the Claims Administrator’s request. **Note:** If the 45th day falls on a weekend or holiday, the timeframe for submission is extended to the next business day. For *urgent reviews*, the requested information must be provided within 48 hours after the Claims Administrator’s receipt of the request for specific information.

A decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, but not later than two business days (two calendar days for urgent reviews) after the Claims Administrator’s receipt of the requested information.

If a response to the Claims Administrator’s request for specific information is not received or is not complete, a decision will be made based upon the information in the Claims Administrator’s possession and telephone notice of the decision will be provided to the requesting Provider not later than two business days (two calendar days for urgent reviews) after the expiration of the period to submit the requested information.
Written notice of prospective review decisions will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

**Concurrent Review**

*Concurrent Review* means a review of a request for precertification that is conducted during a Member’s inpatient Hospital stay or course of treatment. As a result of concurrent review, additional benefits may be approved for care which exceeds the benefit(s) originally authorized by the Claims Administrator’s Health Care Management staff, on behalf of ABB.

If a request for concurrent review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for urgent review, a decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by the Claims Administrator, on behalf of ABB. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting Provider within two calendar days from the time the request is received by the Claims Administrator, on behalf of ABB. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

For concurrent reviews that do not qualify for urgent review, the decision will be made and telephone notice will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Claims Administrator, on behalf of ABB.

If additional information is needed to certify benefits for services for a concurrent review that does not qualify for urgent review, the Claims Administrator, on behalf of ABB, will notify the requesting Provider by telephone and will send written notice to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review within two business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from receipt of the Claims Administrator’s request to provide the information to the Claims Administrator, on behalf of ABB. **Note:** If the 45th day falls on a weekend or holiday, the timeframe for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the requested information is received by the Claims Administrator, on behalf of ABB. If a response to the Claims Administrator’s request for specific information is not received or is not complete, a decision will be made based upon the information in the Claims Administrator’s possession and telephone notice of the decision will be provided to the requesting Provider and written notice of the decision
will be sent to you or your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.

The Claims Administrator, on behalf of ABB, will not reduce or terminate a previously approved ongoing course of treatment until you or your authorized representative receive telephone notice of the Claims Administrator’s decision and have an opportunity to appeal the decision and receive notice of the appeal decision.

Retrospective Review

Retrospective Review means a Medical Necessity review that is conducted after health care services have been provided to a Member. If precertification is required but not obtained prior to the service being rendered, the Claims Administrator, on behalf of ABB, will conduct a retrospective review. Further, if a service is subject to a clinical guideline, but precertification is not required for that service, the Claims Administrator, on behalf of ABB, may conduct a retrospective review.

Retrospective review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For Pre-claim Retrospective Review, a decision will be made and notice will be provided to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Claims Administrator, on behalf of ABB. If additional information is needed to certify benefits for services, the Claims Administrator, on behalf of ABB, will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within two business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from receipt of the Claims Administrator’s request to provide the information to the Claims Administrator, on behalf of ABB. Note: If the 45th day falls on a weekend or holiday, the timeframe for submission is extended to the next business day.

A decision will be made and notice will be provided to you or your authorized representative and the Provider(s) within two business days from the time the requested information is received by the Claims Administrator, on behalf of ABB. If a response to the Claims Administrator’s request for specific information is not received or is not complete, a decision will be made based upon the information in the Claims Administrator’s possession and notice will be provided to you and your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.

For Post-claim Retrospective Review, a decision will be made within 30 calendar days from the time the claim is received by the Claims Administrator, on behalf of ABB. Written notice of the decision will be provided to you or your authorized representative and the Provider(s)
within five business days of the date the decision is rendered, but not later than 30 calendar days from the time the claim is received by the Claims Administrator, on behalf of ABB.

If additional information is needed to certify benefits for services, the Claims Administrator, on behalf of ABB, will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim.

You or your authorized representative and the requesting Provider have a reasonable amount of time taking into account the circumstances, but not less than 45 calendar days from the date of the Claims Administrator’s request to provide the additional information to the Claims Administrator, on behalf of ABB. A decision will be made within 15 calendar days from the time the requested information is received by the Claims Administrator, on behalf of ABB. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information.

**Case Management (includes Discharge Planning)**

Case Management is a Health Care Management feature designed to assure that your care is provided in the most appropriate and cost effective care setting. This feature allows the Claims Administrator, on behalf of ABB, to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Claims Administrator’s Health Care Management staff, on behalf of ABB. In managing your care, the Claims Administrator, on behalf of ABB, has the right to authorize substitution of outpatient services or services in your home to the extent that benefits are still available for inpatient services.

**Surgery Benefits for Mastectomy/Breast Reconstruction**

ABB-sponsored medical plans and other group health plans that provide medical and surgical benefits for mastectomies must also provide coverage for breast reconstruction. Benefits will be provided in a manner determined in consultation with the attending Physician and the patient, and will be paid subject to the plan’s regular Copayments and Deductibles. Coverage is specifically provided for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
- Prostheses and physical complications of all stages of mastectomies, including lymphedemas.
**Maternity Length of Stay**

ABB-sponsored medical plans and other group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The Hospital or other Provider is not required to get prior authorization for a Hospital stay that is not in excess of these time periods.

However, federal law generally does not prohibit the mother’s or newborn’s attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier than the 48-hour period (or 96 hours, if applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
Alternatives to Hospital Care

In some cases, you will be able to get the care you need during an illness or recuperation period using facilities and services in a setting other than a Hospital. The Medical Plans provide coverage for home health care, Hospice care, and Skilled Nursing Facility care. Benefits are based on the medical option you elect, and whether you use network or out-of-network services. You must notify BlueAdvantage in advance before receiving out-of-network services.

Home Health Care

Home health care enables you to recuperate from a serious illness or injury in your home while receiving the necessary medical services and supplies from a certified Home Health Care Agency.

The plan provides home health care coverage for up to 100 visits per calendar year for:

- Part-time or intermittent nursing care furnished or supervised by a registered nurse;
- Physical, occupational, speech and respiratory therapy;
- Medical social services provided by a licensed medical or psychiatric social worker under the supervision of a Physician;
- Part-time or intermittent home health aide services consisting mainly of patient care; and,
- Durable Medical Equipment and other medical and surgical supplies required for treatment.

A visit means up to four hours of covered home health care services given by a home health aide in the same day. Each visit by any other member of the home health care team will count as one visit. Services must be provided through an approved, certified Home Health Care Agency.

A Home Health Care Agency is an agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with applicable licensing and other laws.
- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home;
- It has a full-time administrator;
- It maintains written records of services provided to the patient;
- Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available; and,
- Its employees are bonded and it maintains malpractice insurance.

Home health care benefits are not payable for:

- Custodial Care, meals or housekeepers’ services;
- Services of a member of your immediate family or other individual who normally lives in your home;
- Care for alcoholism, drug addiction, deafness, blindness, senility, mental deficiency or retardation; and,
- Care for mental illness — other than short-term convalescent care in cases in which the prognosis for improvement or recovery is favorable.

**Skilled Nursing Facility Care**

A Skilled Nursing Facility provides you with medical care when you no longer need the full services of a Hospital, but aren’t yet well enough to go home. The plan covers up to 200 days of care for a stay in a Skilled Nursing Facility per calendar year.

A facility that is approved by Medicare as a Skilled Nursing Facility will be covered by this plan.

A Skilled Nursing Facility that is not approved by Medicare must meet the following tests:

- It is operated under applicable licensing and other laws;
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care to sick and injured persons at the patient’s expense during the convalescent stage of an Injury or sickness;
- It maintains a daily medical record of each patient who is under the care of a licensed Physician;
- It is authorized to administer medication to patients on the order of a licensed Physician; and,
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.
A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for purposes of this plan.

The treatment received in the Skilled Nursing Facility must be for the same condition for which you were hospitalized.

Skilled Nursing Facility charges are covered only if care by an approved Home Health Care Agency is not available or home health care is not appropriate.

Skilled Nursing Facility benefits are not payable for:

- Confinements primarily for rest, Custodial Care or educational care;
- Care for chemical dependency, deafness, blindness, senility, mental retardation or deficiency; and,
- Care for mental illness other than short-term convalescent care in which there is a positive prognosis for improvement or recovery.

**Hospice Care**

Hospice care is a coordinated plan of home and inpatient care for a terminally ill patient. It is designed to meet the special needs of the patient, and members of the immediate family who are covered by the plan, during the final stages of terminal illness (life expectancy of six months or less).

The plan covers the usual medical care required by a terminally ill patient and other services provided through an approved program of Hospice care including:

- Services of a medical social worker under a Physician’s direction;
- Dietary and nutritional counseling by a registered dietician;
- Bereavement counseling by a Physician, psychologist, member of the clergy, registered nurse or social worker for members of the patient’s immediate family (covered within 12 months after the person’s death) for up to a maximum of 15 visits;
- Physical, occupational, respiratory and speech therapy;
- Services of homemakers or home health aides, who have completed an approved training program;
- Medical supplies, drugs and medical appliances prescribed by a Physician;
- Psychological, social and spiritual counseling by a Physician, psychologist, member of the clergy, registered nurse or social worker;
- Laboratory services;
• Special transportation to and from the Hospice, when necessary;

• Hospital care of up to five consecutive days per month for the terminally ill patient, to relieve the providers of care; and,

• Part-time or intermittent nursing care by a registered nurse or under a registered nurse’s supervision.

In addition to medical and nursing care, Hospice care also provides counseling services for the patient, a covered spouse/domestic partner and covered dependent children. For more information about Hospice care, see the section of this SPD entitled, “Important Terms.”
Human Organ and Tissue Transplant Services

Covered Transplant Procedures

Services and supplies for Medically Necessary organ or tissue transplant procedures (including but not limited to those listed in this section) are payable under the plans. Prior authorization is required for all Covered Services, and procedures must be performed at a Hospital designated and approved by BlueAdvantage. If you use a Hospital that is not approved by BlueAdvantage, you will be responsible for your out-of-network Deductible and Co-insurance, plus any amount above the Maximum Allowable Amount. These expenses will not apply to the annual Out-of-Pocket Maximum.

Benefits will be provided beginning five (5) working days before the day on which a transplant procedure is performed. Benefits are provided for:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and,
- The transplant procedure.

Covered Expenses

Qualified Transplant Procedures

- Heart transplants;
- Lung transplants;
- Heart/lung transplants;
- Liver transplants;
- Pancreas transplants;
- Liver/kidney transplants;
- Intestinal;
- Simultaneous kidney/pancreas transplants;
- Liver/intestinal; and,
- Bone marrow (either from you or a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. (Not all bone marrow transplants meet the definition of a Covered Service.)
Cornea and kidney transplant benefits are covered under the Medical Plan, subject to prior authorization from BlueAdvantage. Benefits may be paid as inpatient services, outpatient services or Physician office services, depending on where the service is performed. Other features of the “Human Organ and Tissue Transplant Services” described in this section do not apply.

Donor Charges for Organ/Tissue Transplants

- In the case of an organ or tissue transplant, donor charges are considered covered expenses only if the recipient is a covered person under this plan. If the recipient is not a covered person, no benefits will be paid for donor charges.

- No benefits will be provided for procurement of a donor organ or organ tissue that is not used in a transplant procedure, nor for a donor organ or organ tissue that has been sold rather than donated.

- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility.

Medical Care and Treatment

- Pre-transplant diagnostic services and evaluation for one of the procedures listed in this section.

- Organ acquisition and procurement.

- Hospital and Physician fees, including:
  - Semi-private room and board;
  - Services and supplies furnished by the Hospital;
  - Administration of anesthesia; and,
  - Diagnostic services.

- Transplant surgical procedures.

- Services of a Physician who actively assists the operating surgeon in performing the transplant.

- Follow-up care, including home, office and other outpatient medical care visits for examination and treatment, for a period of up to one year after the transplant.

- Rehabilitative and restorative Physician therapy services.

- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for the bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.
Transportation and Lodging

BlueAdvantage will assist the patient, family and donor with travel and lodging arrangements, provided the transplant procedure is being performed at a Hospital designated and approved by BlueAdvantage. Travel and lodging expenses are only available if the transplant recipient or donor resides more than 50 miles from the designated transplant facility. Expenses for travel and lodging for the transplant recipient and a companion (two companions if the transplant recipient is a minor child), as well as the donor, are available under the plans as follows:

- Transportation of the patient and companion(s), as well as the donor, who are traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up care;

- Reasonable and necessary expenses for lodging for the patient (while not confined) and companion(s), as well as the donor. Benefits are paid at a per diem rate of up to $50 per day for the patient/donor or up to $100 per day for the patient/donor plus one companion; or,

- If the patient/donor is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

BlueAdvantage must receive valid receipts for travel and lodging expenses before you will be reimbursed. Examples of eligible travel expenses include:

- Airfare at a coach rate;

- Taxi or ground transportation; or,

- Mileage reimbursement at the IRS rate for the most direct route between the patient’s/donor’s home and the designated treatment facility.

There is a combined overall lifetime maximum benefit of $10,000 per covered person for transportation and lodging expenses* incurred by the transplant recipient, donor and companion(s) that will be reimbursed under this plan in connection with all transplant procedures.

* Please note: Recent IRS regulations prohibit the plan from reimbursing the patient/donor and traveling companion(s) for any expenses related to meals, except as a Hospital inpatient.
Mental Health and Substance Abuse Treatment

The Employee Assistance Program (EAP)
All ABB employees and their family members are automatically enrolled in the Employee Assistance Program (EAP) as part of the ABB TotalHealth program. The EAP is administered by Carebridge Corporation, and is a confidential resource for counseling and support services. It connects you to professional resources that can help you resolve personal issues and problems quickly. The EAP provides up to five visits with a professional counselor any time you need assistance. Each visit is fully paid by ABB — there is no out-of-pocket cost to you or members of your family who use this service. You may reach the EAP 24-hours-a-day, seven-days-a-week. Call 1-800-437-0911 or visit the website at: www.myliferesource.com, Access Code: BNENG.

For more information about the Employee Assistance Program, see the SPD entitled, “Employee Assistance Program (EAP),” which is posted on the ABB HR Portal.

Mental Health/Substance Abuse Services
If you need assistance beyond what the EAP can provide, inpatient and outpatient mental health and substance abuse services will be covered through the Medical Plan. The plan provides benefits for both inpatient and outpatient mental health and substance abuse treatment.

Summary of Your Mental Health/Substance Abuse Treatment Benefits
Covered expenses are paid for Medically Necessary mental/nervous care and substance abuse treatment based on the same schedule as for the Medical Plan. There are no visit or inpatient treatment limits.
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**Limitations on Inpatient Mental Health Benefits**

Subject to $250 penalty if out-of-network inpatient admissions are not precertified as required.

**You must notify BlueAdvantage prior to receiving inpatient and outpatient care. If you or a covered dependent needs mental health or substance abuse treatment, call BlueAdvantage at the number on the back of your Medical ID card **before **any outpatient or inpatient treatment begins. If an inpatient stay is required, it is covered on a semi-private room basis.**

**In an emergency, get the help you need and contact BlueAdvantage within 48 hours of treatment. If you or a covered dependent is hospitalized, BlueAdvantage will work with the Hospital until your condition has stabilized and care can be transferred to an approved Provider, if necessary. If you need follow-up care, contact BlueAdvantage for a referral.**

**If you do not contact BlueAdvantage to notify them for inpatient mental health or substance abuse treatment, and you are confined in an out-of-network facility, benefits will be subject to higher Co-insurance and a $250 penalty.**

**Covered Mental Health and Substance Abuse Services**

Mental health services include those received on an inpatient basis in a Hospital or alternate facility, and those received on an outpatient basis in a Provider’s office or at an alternate facility.

Benefits for mental health services include:

- Mental health evaluations and assessment;
- Diagnosis;
- Treatment planning;
Detoxification (sub-acute/non-medical);

Referral services;

Medication management;

Inpatient services;

Partial hospitalization/Day Treatment;

Intensive Outpatient Treatment;

Services at a Residential Treatment Facility;

Individual, family and group therapeutic services; and,

Crisis intervention.

**Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders**

The plan pays benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric Provider; and,

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

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

Benefits include:

- Diagnostic evaluations and assessment;

- Treatment planning;

- Referral services;

- Medication management;

- Inpatient/24-hour supervisory care;

- Partial Hospitalization/Day Treatment;

- Intensive Outpatient Treatment;
• Services at a Residential Treatment Facility;
• Individual, family, therapeutic group and Provider-based case management services;
• Psychotherapy, consultation and training sessions for parents and paraprofessionals and resource support to family;
• Crisis intervention; and,
• Transitional Care.

For Autism Spectrum Disorder services, remember to notify the Claims Administrator prior to receiving services. Contact BlueAdvantage for more information about these benefits.

**Substance Abuse Services**

Substance abuse services include treatment received on an inpatient basis in a Hospital or an alternate facility and treatment received on an outpatient basis in a Provider’s office or at an alternate facility.

Benefits for substance abuse services include:

• Substance abuse or chemical dependency evaluations and assessment;
• Diagnosis;
• Treatment planning;
• Detoxification (sub-acute/non-medical);
• Inpatient services;
• Partial hospitalization/Day Treatment;
• Intensive Outpatient Treatment;
• Services at a Residential Treatment Facility;
• Referral services;
• Medication management;
• Individual, family and group therapeutic services; and,
• Crisis intervention.

The Claims Administrator must receive notification prior to you receiving these services. If an inpatient stay is required, it is covered on a semi-private room basis.
Non-Covered Mental Health/Substance Abuse Services

Charges for the following mental health/substance abuse services will not be covered under this plan:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

- Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective;

- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Claims Administrator;

- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance abuse that, in the reasonable judgment of the Claims Administrator, are any of the following: (1) not consistent with generally accepted standards of medical practice for the treatment of such conditions; (2) not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered Experimental; (3) typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; (4) not consistent with the Claims Administrator’s level of care guidelines or best practices as modified from time to time; or (5) not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient’s mental illness, substance abuse condition or other disorder based on generally accepted standards of medical practice and benchmarks. The Claims Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

- Mental health services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

- Mental health services as treatment for a primary diagnosis of insomnia or other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;

- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) 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 Claims Administrator;

- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
• 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;

• Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

• Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;

• Substance abuse services for the treatment of nicotine or caffeine use;

• Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders;

• Routine use of psychological testing without specific authorization;

• Pastoral counseling;

• Custodial or domiciliary care;

• Supervised living or half-way houses;

• Biofeedback;

• Free Standing Residential Treatment Centers; and,

• Room and board charges, unless the treatment provided meets the Claims Administrator’s Medical Necessity criteria for an inpatient admission for your condition.

Co-insurance and limits are specified in the “Summary of Your Mental Health/Substance Abuse Treatment Benefits.”
The CVS Caremark Managed Pharmacy Program

Prescription Drug coverage is provided through the CVS Caremark Managed Pharmacy Program.

CVS Caremark is your pharmacy benefit manager. Benefits are provided through CVS Caremark participating retail pharmacies and the mail order plan. However, your plan benefits will differ, based on whether you are enrolled in the HRP or the HSP. If you do not use a CVS Caremark participating pharmacy, you pay the full cost of your prescription. If you are enrolled in the HRP, the cost of your Prescription Drugs will not be counted toward either your Deductible or your Out-of-Pocket Maximum.

The CVS Caremark Managed Pharmacy Program lets you purchase Prescription Drugs for a low cost through a national network of participating retail pharmacies, or by mail. The network includes nationally-recognized chains, as well as many local drugstores.

To fill a prescription at a participating pharmacy, you must show your CVS Caremark ID card, which is separate from your Medical ID card. If you wish to order or refill a prescription at a local pharmacy, you must use a CVS Caremark participating pharmacy.

To help maintain health care quality and manage costs, CVS Caremark encourages the use of Generic-equivalent drugs. It also encourages the use of medications included in its “Formulary,” although the decision as to which medication to prescribe rests solely with your Physician.

The CVS Caremark program uses a three-tier payment schedule. Your costs will vary, depending on whether your prescription is for a Generic or brand name medication, and whether or not your medication is included in the CVS Caremark Formulary.

The Prescription Drug Formulary

The Formulary is a clinically-based drug list that contains FDA-approved Generic and brand name medications. These medications have been reviewed and approved by CVS Caremark’s pharmacists and independent medical directors and Physicians as being appropriate for the treatment of most common medical conditions. The Formulary is reviewed and updated regularly.

All participating pharmacies have a copy of the Formulary, so your pharmacist can determine whether your medication is included before dispensing the prescription. You can also access the Formulary listing on the ABB HR Portal, at the CVS Caremark website (www.caremark.com), or by contacting CVS Caremark Member Services at the number shown on your CVS Caremark ID card.
Specialty Medications

Specialty medications are used to treat complex, chronic conditions, such as multiple sclerosis and rheumatoid arthritis. These medications often require special handling, preparation or refrigeration. CVS Caremark provides access to specialty medications and services and offers:

- 24-hour access to pharmacists and nurses trained in specialty medications and conditions;
- Copayments for each prescription you order;
- Drug safety monitoring; and,
- Refill reminder calls.

Contact CVS Caremark for more information.

How the Plan Works: The HRP

You may fill your prescription at any participating retail pharmacy or by mail order. When you purchase a Generic Drug, you will pay the least in out-of-pocket costs. Here is how the plan works.

Retail Pharmacy

If you purchase a Generic Drug at a retail pharmacy, you will pay a flat dollar Copayment that is payment in full for your prescription. If you purchase a brand name drug, you will pay a Co-insurance percentage toward the cost of the drug. Your out-of-pocket Co-insurance costs will be limited by a minimum and maximum amount. If you purchase a brand name drug when a Generic is available, you will pay your Co-insurance amount plus the difference in cost between the brand and Generic Drug. You can get up to a 30-day supply of your medication at a retail pharmacy.

The Mail Order Plan

The Managed Pharmacy Program also has a mail order Prescription Drug plan, which is available through the mail and also at your local CVS pharmacy. With the mail order plan, you can order up to a 90-day supply of medication — so you get more medication for less cost. You pay a flat dollar Copayment for Generic Drugs or a Co-insurance amount for brand name drugs for each prescription you order by mail. Co-insurance costs are higher when you purchase a brand name drug that is not in the CVS Caremark Formulary.

Generic medication will be used to fill your prescription, unless you or your Physician requests a brand name drug. Your costs are higher when you purchase a brand name drug. If a brand name is requested and a Generic is available, you will pay the brand name Co-insurance amount, plus the difference in cost between the brand name and the Generic equivalent.
The mail order plan is especially valuable to people who need maintenance medication to manage a chronic condition like high blood pressure or diabetes. Prescriptions are mailed directly to your home, and should be delivered within seven to ten days of the date the order is received.

In addition to home delivery for a 90-day supply of maintenance medication, you can also take your prescription to any CVS pharmacy and get it filled over the counter for the same price as mail order.

**Summary of Your Prescription Drug Benefits for the HRP**

Here is a summary of your Prescription Drug benefits:

**Managed Pharmacy Prescription Drug Benefits**

<table>
<thead>
<tr>
<th>Retail Network Pharmacy (30-day supply)</th>
<th>You Pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$10 Copayment per prescription</td>
</tr>
<tr>
<td>Brand name drugs in Formulary</td>
<td>25% Co-insurance (You have a minimum payment of $30 and a maximum payment of $50 per prescription.)*</td>
</tr>
<tr>
<td>Brand name drugs outside Formulary</td>
<td>50% Co-insurance (You have a minimum payment of $70 and a maximum payment of $90 per prescription.)*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order Plan (90-day supply)</th>
<th>You Pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$20 Copayment per prescription</td>
</tr>
<tr>
<td>Brand name drugs in Formulary</td>
<td>25% Co-insurance (You have a minimum payment of $60 and a maximum payment of $100 per prescription.)*</td>
</tr>
<tr>
<td>Brand name drugs outside Formulary</td>
<td>50% Co-insurance (You have a minimum payment of $140 and a maximum payment of $180 per prescription.)*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Drugs (30-day supply)</th>
<th>You Pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$10 Copayment per prescription</td>
</tr>
<tr>
<td>Brand name drugs in Formulary</td>
<td>25% Co-insurance (You have a minimum payment of $30 and a maximum payment of $50 per prescription.)*</td>
</tr>
<tr>
<td>Brand name drugs outside formulary</td>
<td>50% Co-insurance (You have a minimum payment of $70 and a maximum payment of $90 per prescription.)*</td>
</tr>
</tbody>
</table>

* If you request a brand name drug when a Generic is available, you will pay the applicable Formulary or non-Formulary brand name drug Co-insurance/Copayment, plus the difference in cost between the brand and Generic Drug.
Use the Plan to Your Advantage

You pay the least in out-of-pocket costs when you use Generic Drugs and use the mail order plan or a CVS Pharmacy for maintenance medications.

If You Don’t Use a CVS Caremark Participating Pharmacy

If you fill your prescription at a non-participating pharmacy, you will have to pay the full cost of the medication. There is no coverage for Prescription Drugs filled at a non-participating pharmacy.

Whether you fill prescriptions through a retail pharmacy or by mail order, if you or your Physician requests a brand name drug and a Generic is available, you will pay the brand name Co-insurance/Copayment, plus the difference in cost between the brand name and the Generic equivalent.

How the Plan Works: The HSP

You may fill your prescription at any participating retail pharmacy or by mail order. The plan will not pay for any Prescription Drug costs until you have met your applicable Deductible. Covered medical and Prescription Drug costs all count toward your Deductible, provided you use a CVS Caremark participating pharmacy or the mail order plan. Otherwise, you have the flexibility to have prescriptions filled at the out-of-network pharmacy of your choice, but expenses will not count toward your annual Deductible or your Out-of-Pocket Maximum.

Once your Deductible has been met, the plan will pay 90% of your prescription costs if you use a CVS Caremark participating retail pharmacy or the mail order plan. The plan pays 100% of your covered expenses once you have met your annual Out-of-Pocket Maximum.

Even though the plan will not pay for your prescription costs before you meet the Deductible, if you have funded an HSA, you may submit your prescription expenses to the HSA for reimbursement.

Remember that, whether you fill a prescription at a participating retail pharmacy or through mail order, Generic Drugs typically have a lower cost than brand name drugs, so you should consider a Generic Drug each time you fill a prescription.

The Advantage of Mail Order

As an HSP member, you have access to the mail order Prescription Drug plan, either through the mail or at your local CVS pharmacy. With the mail order plan, you can order up to a 90-day supply of medication. Because of the increased efficiency, this may cost you slightly less, but the primary advantage is convenience. Prescriptions are mailed directly to your home, and should be delivered within seven to ten days of the date the order is received. As with the retail pharmacy, Generic medication will cost you less than a brand name drug.
In addition to home delivery for a 90-day supply of maintenance medication, you can also take your prescription to any CVS Pharmacy and get it filled over the counter for the same price as mail order.

**If You Don’t Use a CVS Caremark Participating Pharmacy**

If you fill your prescription at a non-participating pharmacy, the cost of your prescription will not count toward your annual Deductible or Out-of-Pocket Maximum and, once you have met the Deductible, the plan’s Co-insurance will not apply.

If you have funded an HSA, however, you may submit your prescription expenses to the HSA for reimbursement.

**Prescriptions Not Covered**

The CVS Caremark Managed Pharmacy Program will not cover:

- Drugs not considered Medically Necessary;
- Drugs that do not meet generally accepted standards of medical practice in the United States;
- Drugs not considered effective by the Food and Drug Administration;
- Drugs for treatment of tobacco dependency, including over-the-counter smoking cessation products (prescription products such as Zyban are covered up to $325/person/lifetime);
- Drugs for cosmetic purposes, such as Retin A and Accutane for people over age 25;
- Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over-the-counter drug;
- Allergy shots in the Physician’s office (these are covered by the Medical Plan; Epi-pen and emergency allergy kits are covered);
- Therapeutic devices or appliances, including colostomy supplies (insulin syringes are covered);
- Biological sera;
- Progesterone suppositories;
- Immunization agents;
- Anorexient agents;
- Dietary supplements; and,
- Vitamin supplements (prenatal vitamins are covered).
For More Information

For more information about CVS Caremark, call Member Services at the toll-free number shown on your CVS Caremark ID card. Or, visit the CVS Caremark website at www.caremark.com and select Member Services.

To access the Formulary listing, on the main page click on “Understand My Plan and Benefits,” go to “My Personal Plan Details,” then select “Drug List (Formulary)” from the drop down box.
Expenses the Medical Plans Will Not Cover

Some charges are not covered by the BlueAdvantage Medical Plans. These include expenses incurred for services, supplies, medical care or treatment relating to, arising from, or given in connection with the following:

**Administrative**
- Charges for completing forms.
- Charges for failure to keep a scheduled appointment.
- Charges for a telephone consultation with a Provider.
- Stand-by services required of a Physician.
- Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment otherwise qualify as Covered Services.

**Chelation Therapy**
- Chelation therapy, except to treat heavy metal poisoning.

**Cosmetic, Plastic or Reconstructive Surgery**
- Cosmetic, plastic or reconstructive surgery unless:
  - It is required to repair the malfunction of part of the body as a direct result of an accident or Illness; or,
  - To correct a child’s congenital birth defect.
- Examples of excluded expenses include, but are not limited to, breast reduction surgery (unless such surgery meets Health Care Management guidelines), abdominoplasty, and liposuction.
- Cosmetic services and supplies, including wigs or toupees (unless for hair loss due to chemotherapy or radiation therapy), hair transplants, hair weaving or any drug used in connection with baldness.

**Coverage Effective Date/Legal Obligation for Payment**
- Services provided before the effective date of this plan.
- Charges for services and supplies that you are not legally obligated to pay.
- Charges incurred by a dependent if the dependent is covered as an employee for the same services under this plan.
**Custodial Care**

- Charges for Custodial Care, as defined under “Important Terms,” domiciliary care or convalescent care, whether or not recommended or performed by a health care professional.

**Dental Services/Supplies**

- Treatment of the teeth or gums or the fitting of dentures, except oral surgical procedures, required as the result of an accidental Injury (may be covered under the Dental Plan).

- Services and supplies received for care and treatment that are considered covered expenses under the Dental Plan will not be considered as covered expenses under the Medical Plan, except as specifically mentioned in your plan materials (example: oral surgery).

**Disposable Medical Supplies (except urinary catheters)**

**Durable Medical Equipment**

- Charges for the repair and maintenance of Durable Medical Equipment.

**Educational Services and Materials**

- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.

**Experimental/Investigative Services**

- Charges which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Claims Administrator, on behalf of ABB. This exclusion applies even if Experimental/Investigative Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

**Family Planning**

- Charges for procedures that do not diagnose and treat the underlying cause of infertility, beyond what is provided for under “Family Planning” in the “Covered Services” section of this SPD.

- Charges for reversal of sterilization.

**Foreign Claims**

- Claims for health services provided in a foreign country, unless required as emergency health services.
**Government Services**

- Services and supplies that are provided under any government law (other than a government benefit plan for civilian employees and their dependents, Medicare and Medicaid).

- State-mandated benefits that exceed the plan’s level of benefits.

**Health and Fitness**

- Membership costs for health clubs, weight loss clinics or similar programs.

**Holistic or Homeopathic Care**

- Holistic or homeopathic care, including drugs and ecological or environmental medicine, diagnosis or treatment, and herbal medicine.

**Hospital, Specialized Services for Non-acute Care**

- Charges made by a Hospital for confinement in a special area of the Hospital that provides non-acute care, including but not limited to the facilities listed below, will be paid at the benefit level for that facility, and not at the benefit level for the Hospital, if it is covered by these plans:
  - Adult or child day care center;
  - Ambulatory surgery center;
  - Birthing Center;
  - Half-way house;
  - Hospice;
  - Skilled Nursing Facility;
  - Treatment center;
  - Vocational rehabilitation center; and,
  - Any other area of a Hospital which provides services on an inpatient basis for other than acute care of sick, injured or pregnant persons.

**Male Gynecomastia**

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

**Maximum Allowable Amount**

- Charges in excess of the Maximum Allowable Amount.

**Morbid Obesity**

- Not covered unless treatment meets Health Care Management guidelines.
**Non-Covered Services**

- Charges for services and supplies, including confinement or treatment, that are not considered Covered Services, as defined by the health plan. See the section of this SPD entitled, “Important Terms” for a detailed definition of “Covered Services.”

**Not Medically Necessary/Not a Medical Necessity**

- Charges for services and supplies which are determined to be not Medically Necessary or not a Medical Necessity or do not meet the Claims Administrator’s medical policy, clinical coverage guidelines, or benefit policy guidelines.

**Nutritional**

- Treatment for obesity, nutritional care or counseling, nutrients and vitamins, special foods, food supplements, liquid diets, diet plans or any related products, except as approved by Health Care Management.

- Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition, or unless they are specifically created to treat inborn errors of metabolism, such as phenylketonuria (PKU).

- Infant formula available over the counter is always excluded.

**Occupational**

- Charges that result from an occupational Illness or Injury, and that would be covered under Workers’ Compensation or a similar law.

**Orthognathic Surgery**

- Surgical correction or other treatment of malocclusion (jaw), unless required due to one of the following conditions:
  - A jaw deformity resulting from facial trauma or cancer; or,
  - A skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
    - Inability to incise solid foods;
    - Choking on incompletely masticated solid foods;
    - Damage to soft tissue during mastication;
    - Speech impediment determined to be due to the jaw deformity; or,
    - Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.
**Personal Convenience**
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.

**Physician/Dentist**
- Charges for care, service or treatment that is not prescribed, recommended, or approved by your attending Physician or dentist.

**Preventive Care and Screenings**
- Charges for preventive care and screenings, including routine physical exams, well-baby care, well-woman care and well-man care are not covered when performed by a Non-Network Provider under the plan.

**Private Duty Nursing**
- Private duty nursing services which are not Medically Necessary.

**Prosthetic Devices**
- Charges for a prosthetic device that is fully implanted into the body (benefits under this plan are payable for external prosthetic devices only).

**Sensitivity Training, Educational Training Therapy or Treatment for an Education Requirement**

**Service Providers**
- Services provided by a member of your immediate family or someone who resides in your home.
- Services provided by volunteers or persons who do not normally charge for services.
- Services of a member of the clergy in the course of normal duties, including pastoral counseling.

**Sex-change Surgery**

**Temporomandibular Joint Dysfunction (TMJ)**
- Services for the evaluation and treatment of temporomandibular joint dysfunction when the services are considered to be medical or dental in nature, including oral appliances.

**Transplant Procedures**
- 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 this plan and is undergoing a Covered Transplant Procedure.
• An organ or tissue transplant listed as a qualified procedure that is performed at a facility not designated and approved by BlueAdvantage. This includes services and supplies received in connection with the transplant, such as benefits for transportation and lodging for the transplant recipient, donor and traveling companion(s).

**Travel**

• Travel expenses, even if prescribed by a Physician, including air transportation, except as described elsewhere in this SPD.

**Vision Care**

• Eyeglasses or contact lenses, unless required as a result of an accidental Injury or cataract related.

• Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies given in connection with or related to the surgery.

**War, Riot or International Armed Conflict**

• Injury or sickness caused by insurrection, war, declared or undeclared, international armed conflict, participation in a riot, or service in the armed forces in any country. This exclusion does not apply to covered persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
Questions

BlueAdvantage is your toll-free source for answers about the Medical Plans. When you call, you will be greeted by an automated prompting system that will offer you several options. Depending on your selection, you will continue to receive information through the automated system, or you will be connected to a trained representative. Your Member Services Representative can help you:

- Understand more about the plans;
- Find a network Physician;
- Identify network facilities; and,
- Replace a lost Medical ID card.

Call BlueAdvantage at 1-866-840-1045

On-line Help and Information

In addition to toll-free telephone access, you can reach BlueAdvantage through the internet at www.blueadvantagearkansas.com. This site provides all the services available through the automated prompting system, and more. Visit the website to:

- Make real-time inquiries into the status and history of your health claims;
- View your eligibility information;
- Compare Hospitals based on specific procedures by using criteria that you define;
- Order a new or replacement Medical ID card or print a temporary ID card;
- Compare costs for a particular procedure using the Treatment Cost Estimator;
- Search for Physicians or Hospitals available in your plan through the on-line directory (coming soon); and,
- Compare Hospitals using the Hospital Comparison Tool. Review quality of care and patient safety measures (coming soon).

For information on how to file a claim or appeal an adverse decision on a claim, see the section of this SPD entitled, “Filing Claims and Appeals.”

If you have general questions about your medical coverage, contact the ABB Benefits Service Center at 1-800-354-8069. Participant Services Representatives are available Monday through Friday, 8:30 a.m. to 8:00 p.m., Eastern Time, excluding New York Stock Exchange holidays.
Filing Claims and Appeals

This section of the SPD contains information about filing health care claims, how benefits are coordinated and paid if more than one plan is involved, and the claims appeal process and timelines. There are two types of claims: those for health care benefits, as described beginning below, and those where eligibility or the general operation of the plan is at issue, as described in the section of this SPD entitled, “Filing Claims for Eligibility or Plan Operations.” If you are appealing a decision on either type of claim, the appeals process will be different.

ABB has delegated responsibility to a third-party Claims Administrator for administering the health care plans and determining if benefits are payable under those plans. The Claims Administrators for the BlueAdvantage Medical Plan, the CVS Caremark Managed Pharmacy Program and the Employee Assistance Program are shown in the section of this SPD entitled, “Administrative Information.”

ABB, as the Plan Administrator, has the responsibility for determining eligibility for coverage, questions about the operation and administration of the plan, and responding to claims lawsuits.

Filing Claims for Health Care Benefits

Filing complete claims in a timely manner is your responsibility and can help assure that you receive full benefits from the plan. You will have to file a claim for reimbursement when you use Non-Network Providers for Covered Services under both PPO medical options. Claim forms are available from BlueAdvantage at www.blueadvantagearkansas.com.

How to File a Claim for Network Benefits

In most cases, when you receive health care services in-network, claims are filed directly by Network Providers. If you are enrolled in the HRP, charges for network medical services will be reimbursed automatically from your HRA, as long as you have funds in your account.

If you are out of the area or have a Medical Emergency and use a Non-Network Provider, you must pay the bill and submit a claim for reimbursement. In that case:

- If you have contacted your in-network Physician or BlueAdvantage and your care has been approved, your claim will be paid based on the plan’s normal level of reimbursement.
- Once your claim has been processed, you will receive an Explanation of Benefits (EOB) showing the amount paid by the plan and the amount, if any, that you should pay the Provider.
How to File a Claim for Out-of-Network Benefits

- You and your Physician must complete the information requested on the claim form or attach a detailed description of the charges, including a diagnosis. Be sure to attach copies of bills to verify your expenses.

- If the BlueAdvantage Medical Plan is the secondary payer, include a copy of the primary payer’s Explanation of Benefits (EOB) with your itemized bill.

- Follow the steps noted in the section of this SPD entitled, “A Few Reminders” to help expedite claim processing and payment.

- Send completed forms to the Claims Administrator at the address shown on the form. The Claims Administrator is responsible for reviewing each claim for charges that fall within the Maximum Allowable Amount, Medically Necessary services and correct information.

A Few Reminders

Here is how you can help ensure that your claims will be processed as quickly and efficiently as possible:

- If you submit claims for more than one family member in a single envelope, be sure to clearly and separately identify each family member’s bill.

- If you have a question about what your Medical Plan covers, call BlueAdvantage for more information — before you receive treatment.

- Make sure your health care Provider has up-to-date information about your coverage. If your Physician submits claims directly, make sure the Company name and your location are included in the information provided.

- File all claims in a timely manner. Claims should be filed within 90 days following the date in which the service was provided, but in no event more than one year after the service was provided. Claims received after this deadline will not be honored. You should submit claims only for covered expenses.

- Benefits for PPO out-of-network services will be paid to you or to the Provider, as you specify on your claim form. If no one is specified, payment will be made to you. You will receive an Explanation of Benefits (EOB) from BlueAdvantage Administrators of Arkansas.
Using a Health Care Spending Account (HCSA)

An HCSA is a convenient way to budget for health care expenses that are not covered by the Medical Plans. If you enroll in the HRP, you can set aside money in an HCSA on a before-tax basis. Eligible expenses include:

- Your annual individual or family Deductible;
- The Co-insurance you pay toward Covered Services;
- The amounts you spend above Maximum Allowable Amounts; and,
- Prescription Drug Copayments and Co-insurance for prescriptions filled at a network pharmacy or through the Mail Order plan (HRP).

More information about the HCSA is included in “The Flexible Spending Accounts” SPD, which is posted on the ABB HR Portal.

Using a Limited Scope Health Care Spending Account (Limited Scope HCSA)

If you enroll in the HSP, you are not permitted to participate in a traditional HCSA, as described above. You can use your HSA to fund your medical, dental and vision expenses. If your primary goal for your HSA is to save for future medical expenses, you might not want to use the funds in the HSA to pay for dental and vision expenses. A Limited Scope HCSA is a convenient way to budget for those expenses that are not covered by your plan — without having to dip into your HSA to pay for them.

More information about Limited Scope HCSAs is included in “The Flexible Spending Accounts” SPD, which is posted on the ABB HR Portal.

Using an HSA

If you enroll in the HSP, you may also enroll in an HSA, which is offered through HealthSCOPE. The HSA enables you to set aside tax-free money to pay for out-of-pocket medical expenses like the annual Deductible and Co-insurance, or to build a savings account to cover future medical expenses in retirement. Any money you do not use in your account during one calendar year will roll over to the next calendar year, allowing your savings to grow.

You may choose to submit any of the following types of eligible expenses to your HSA. Or, if your primary goal is saving for future health care expenses, you may decide to pay them out of your pocket to allow your account to grow. Eligible expenses include:

- Your annual Deductible;
- The Co-insurance you pay toward Covered Services;
• The amounts you spend above the Maximum Allowable Amount; and,
• Prescription Drug costs.

You own your HSA and you control what expenses are submitted to it. It is your responsibility to ensure that your contributions to the HSA are within the required annual limits. You are also required to make sure that expenses you submit for payment are eligible for reimbursement through an HSA, and to maintain records of such in case the IRS questions the eligibility of the expense. For more information about HSAs, refer to your HealthSCOPE HSA materials or IRS Publication 969.

Proof of Claim

You must provide written notice of a claim within 90 days of the claim or as soon as reasonably possible, but not later than one year from the date of service. Your claim will be considered as long as you provide proof within the time required. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

Benefits will be paid for covered claims when a claim is filed and approved.

If you disagree with a decision concerning your claim, you have a right to appeal the claim decision.

Filing Responsibility

Filing of proper and complete claims is your responsibility and can help assure you of receiving full benefits from the plan. If your claim form is not complete and accurate, you will be required to submit additional information. This will cause payment of your claim to be delayed. Please be aware of the following points when filing a claim:

• You are responsible for filing accurate claims. If someone else, such as your spouse/domestic partner or another family member, files claims on your behalf, you should review the form before you sign it.

• Review the Explanation of Benefits (EOB) statement when it is returned to you to make sure that benefits have been correctly paid.

• Never allow another person to obtain treatment under your name.

• Always complete the “Other Health Care Coverage Information” section of the claim form. If no other health care coverages apply, always check the appropriate boxes.

• Provide complete and accurate information on claim forms. Answer all questions to the best of your knowledge.
How Health Care Benefits Are Paid

The plan shares the cost of your medical expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before the plan begins to pay its share of the balance. Most services are subject to a Deductible and Co-insurance.

Network Providers will seek compensation from the plan for Covered Services. When using a Network Provider you are only responsible for Co-insurance, Deductibles, and non-covered charges. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual charge billed and the Maximum Allowable Amount plus any Deductible, Co-insurance and non-covered charges. Co-insurance is your share of the cost for particular health services, and is generally due at the time you receive the medical service. For Covered Services subject to Co-insurance, you pay a portion of the bill and the plan pays its share of the balance. Refer to the section of this SPD entitled, “Summary of Benefits for the HRP and HSP” to see what Co-insurance is required for each Covered Service.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the section of this SPD entitled, “Summary of Benefits for the HRP and HSP” to see what amount you are required to pay for each service. Claims for Covered Services do not need to be sent to the Claims Administrator in the same order that expenses were incurred.

If you receive Covered Services in a Network Provider facility from a Non-Network Provider, such as an anesthesiologist who is employed by or contracted with that network facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider’s participation agreement for this plan. You may be liable for the difference between the billed charge and the Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Claims Administrator, on behalf of ABB, will deny that portion of any charge which exceeds the Maximum Allowable Amount.
**Notice of Claim**

The plan is not liable, unless the Claims Administrator, on behalf of ABB, receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given. The notice must be given to the Claims Administrator within 90 days of receiving the Covered Services, and must have the data the Claims Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Claims Administrator needs to process the claim, then the necessary data must be submitted to the Claims Administrator within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If the Claims Administrator has not received the information it needs to process a claim, the Claims Administrator will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, the Claims Administrator cannot complete the processing of the claim until the additional information requested has been received. The Claims Administrator generally will make its request for additional information within 30 days of the Claims Administrator’s initial receipt of the claim and will complete its processing of the claim within 15 days after the Claims Administrator’s receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give the Claims Administrator notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year from the date of service, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

**Explanation of Benefits**

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement sent by the Claims Administrator, on behalf of ABB, to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any); and,
- General information about your appeals rights, and for ERISA plans, information regarding the right to bring an action after the appeals process.
BlueCard

When you obtain health care services through BlueCard outside the geographic area the Claims Administrator serves, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services; or,
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes onto the Claims Administrator, on behalf of ABB.

Often this “negotiated price” will consist of a simple discount which reflects the actual price paid by Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any contingent payment arrangements, and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Claims Administrator, on behalf of ABB, would then calculate your liability for any Covered Services in accordance with the applicable state statutes in effect at the time you received your care.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider’s service(s) will be considered non-network care and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your Medical ID card or go to www.blueadvantagearkansas.com for more information about such arrangements.
**Disagreement with Recommended Treatment**

Each Member enrolls in the plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider’s judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Claims Administrator, ABB, nor any Provider, shall have any further responsibility to pay benefits or provide care for the condition under treatment or any complications thereof.

**Circumstances Beyond the Control of the Plan**

The Claims Administrator, on behalf of ABB, shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or ABB, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider’s personnel or similar causes, or the rendering of health care services provided by the plan is delayed or rendered impractical, the Claims Administrator, on behalf of ABB, shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.
BlueAdvantage’s Complaints and Appeals Provision

Claims Denial Notice
If your claim is denied, in whole or in part, you will be given notice in writing or electronically. The notification will include:

- The specific reasons for the denial;
- Information sufficient to identify the claim involved, including the date of the service, the health care Provider and the claim amount (if applicable);
- The specific plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the plan’s standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision;
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary;
- A description of the plan’s internal and external review procedures, information about how to initiate an appeal, the time limits applicable to such procedures, including your right to bring a civil action in federal court following a claims denial on review;
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge;
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding Medical Necessity, Experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge;
- For a claims denial involving an urgent care claim, a description of the expedited internal and external review processes applicable to such claims; and,
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

If you have any questions about a denied claim, you should contact the Claims Administrator.

Complaint and Appeals Procedures
The Claims Administrator’s customer service representatives are specially trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels;
- Specific claims or services you have received;
• Doctors or Hospitals in the network;
• Referral processes or authorizations; and/or,
• Provider directories.

A complaint procedure has been established to provide fair, reasonable, and timely review of complaints that you may have concerning the plan. The Claims Administrator invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by medical Providers in the Claims Administrator’s networks.

**The Complaint Procedure**

If you have a complaint, problem, or claim concerning benefits or services, please contact the Claims Administrator. Please refer to your Medical ID card for the Claims Administrator’s address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claims Administrator of its procedures and contracts. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. If your complaint involves issues of Covered Services, you may be asked to sign a medical records release form so the Claims Administrator can request medical records for its review.

**The Appeals Procedure**

As a Member of the plan, you have the right to appeal decisions to deny or limit the plan benefits. You may also file an appeal to address concerns regarding confidentiality or privacy. Appeals should be filed with the Claims Administrator for review in accordance with the procedures set forth below.

The Patient Protection and Affordable Care Act added an additional Standard External Review process and Expedited External Review process that you can request if you receive an adverse benefit determination from the plan.

**Your Right to Appeal a Denied Claim**

If you disagree with a decision concerning your claim, you have a right to appeal the claim decision, as described below. However, no action at law or in equity shall be brought to recover on the plan until 90 days after proof of claim has been provided. Once you have exhausted all of your administrative appeals rights, if you decide to file a court action on your claim, the court action must be filed within 24 months following the date the cause of action arose.
Appealing a Denied Claim for Health Care Benefits

An appeal is a request from you for the Claims Administrator to change a previous determination made.

You (or your authorized representative) will have 180 days after receiving notice that your claim is denied to appeal the decision in writing to the Claims Administrator (first level of appeal). You may submit written comments, documents, records, and other information relevant to the claim. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Your appeal will be reviewed by a plan fiduciary who had no role in the initial claim denial and the review will be an independent one without giving the original denial any special consideration. If a medical judgment is involved, your appeal will be reviewed by an appropriate Medical Director within BlueAdvantage who has appropriate training and experience in the field of medicine involved in the medical judgment and who had no role in the initial claim denial. If the Medical Director consults with medical or vocational experts, the professionals whose advice was obtained will be identified.

You have the right to designate a representative (e.g., your Physician) to file an appeal on your behalf and to represent you in the appeal. If a representative is seeking an appeal on your behalf, the Claims Administrator must obtain a signed Designation of Representation form from you before the Claims Administrator can begin processing your appeal, unless a Physician is requesting expedited review of a Level 1 appeal on your behalf. If that occurs, the Physician will be deemed to be your representative for the purpose of filing the expedited Level 1 appeal without receipt of a signed form.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

The Patient Protection and Affordable Care Act added an additional Standard External Review process and Expedited External Review process that you can request if you receive an adverse benefit determination from the plan. The Claims Administrator has the exclusive right to interpret and administer the plan, and these decisions are conclusive and binding.

Level 1 Appeals

Level 1 appeals are reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review unless the adverse decision can be overturned based upon prescreening by a nurse or other qualified reviewer. A clinical peer is a Physician or Provider who has the same license and is in the same field of medicine as the Provider who will perform or has performed the service.
If your Level 1 appeal concerns an adverse precertification decision, your appeal may be initiated by letter or over the phone. The Claims Administrator requires its Members to submit all other requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to the following address, or to the address (or phone number for adverse precertification decisions) provided for filing an appeal on any written notice of an adverse decision that you receive from the Claims Administrator:

**FOR MEDICAL CLAIMS:**
Attention: Appeals
BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203-1460

**FOR PRESCRIPTION CLAIMS:**
CVS Caremark
Appeals Department
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

If you are appealing an adverse precertification decision (i.e., an adverse Prospective, Concurrent or Retrospective review decision) or the denial of any prior approval required by the plan, the Claims Administrator will provide you with a written response indicating the decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date the Claims Administrator receives your Level 1 appeal request. If more information is needed to make a decision on your appeal, the Claims Administrator will send a written request for the information after receipt of the appeal. No extensions of time for additional information may be taken on these Level 1 appeals without the permission of the Member. Therefore, the Claims Administrator will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision and sufficient information is available to decide the appeal, the Claims Administrator will resolve your Level 1 appeal within a reasonable period of time but not later than 60 calendar days from receipt of the Level 1 appeal request. If more information is needed to make a decision on your appeal, the Claims Administrator shall send a written request for the information after receipt of the appeal. After the Level 1 appeal decision is made, you will be notified within five business days in writing by the Claims Administrator of the decision concerning your Level 1 appeal.
Level 2 Appeals

If you are dissatisfied with the Level 1 appeal decision, you may request a Level 2 appeal. At Level 2, the appeal is reviewed by a panel of the Claims Administrator’s staff members. Level 2 appeals concerning adverse precertification decisions or the denial of any prior approval required by the plan will be resolved by the panel no later than 30 calendar days from the date your Level 2 appeal request was received by the Claims Administrator. All other Level 2 appeals will be resolved by the panel no later than 60 calendar days from the date your Level 2 appeal request was received by the Claims Administrator. After the appeal panel makes a decision, you will be notified within five business days in writing by the Claims Administrator of the decision concerning your Level 2 appeal.

Standard External Appeals

If you receive an adverse benefit determination or a final adverse benefit determination based upon a medical judgment, you may file a request for an external review within four months (or by the first day of the fifth month if there is no corresponding date) after the date of the denial. Within five days of receipt of your request, the Claims Administrator must conduct a preliminary review to determine:

- If you were covered under the plan at the time the service was provided;
- If you had exhausted all internal review processes, if required; and,
- Whether you had provided all the information and forms necessary to process the claim.

The Claims Administrator will notify you of your eligibility for an external appeal within one business day of completing the review. If you are not eligible, the Claims Administrator will explain the reasons why and provide contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-3272). If the request is not complete, the Claims Administrator must notify you of what is needed and allow you to respond with the additional information within the four-month filing period or within the 48-hour period following notification, whichever is later.

If eligible, the Claims Administrator will assign your case to an accredited independent review organization (IRO) to conduct a full independent review of your claim. The Plan will be bound by the determination of the IRO. The IRO will notify you in writing that you are eligible for the external review, and allow you to submit any additional documentation about your claim within ten calendar days. The IRO must provide written notice of the final decision on your claim within 45 calendar days. The notice will include:

- A general description of the reason for the request for external review, including the date or dates of service, the health care Provider, and the claim amount (if applicable);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
• References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

• A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; and,

• A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the plan, such as judicial review, and including current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PHS Act section 2793.

Upon receipt of a notice of a final external review decision to reverse the adverse benefit determination, the Claims Administrator immediately must provide coverage or payment (including immediately authorizing or paying benefits) for the claim.

**Expedited Reviews**

Any level of appeal can be expedited if:

- The service at issue has not been performed;

- The service at issue has been denied as Experimental/Investigative or as not Medically Necessary; and

- Your Physician believes that the standard appeal timeframes could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

The Claims Administrator, by applying a prudent layperson standard, may also determine that an appeal may be expedited.

**Expedited Medical Claims:** The Claims Administrator will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation but not later than seventy-two hours (72 hours) after the Claims Administrator receives the Level 1 appeal request and will communicate the decision by telephone to your attending Physician or the ordering Provider. The Claims Administrator will also provide written notice of the determination to you, your attending Physician or ordering Provider, and the facility rendering the service. The Claims Administrator will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and panel administration permits.

**Expedited Clinical Prescription Claims:** For an Expedited Appeal, CVS Caremark will process both the Level 1 and Level 2 internal appeals for clinical claims in a single step within 72 hours. If the denial is upheld, the member will then be eligible for an External review.

The decision will be communicated by telephone to your attending Physician or the ordering Provider. The Claims Administrator will also provide written notice of the determination to you, your attending Physician or ordering Provider, and to the facility rendering the service.
An expedited external review of an appeal must be conducted as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external appeal. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Claims Administrator within 48 hours.

**Appeals Filing Time Limit**

You are encouraged to file Level 1 appeals on a timely basis. The Claims Administrator will not review a Level 1 appeal if it is later than 180 calendar days after you are notified of the denial or rescission. Level 2 medical claim appeals must be filed within 60 days of receipt of notice of the Level 1 appeal determination. Level 2 clinical prescription claim appeals must be filed within 180 days of receipt of notice of the Level 1 appeal determination. External appeals must be filed within four months of notice of an adverse benefit determination.

**Appeals by Members of ERISA Plans**

If you are covered under an ABB plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Level 1 appeal prior to bringing a civil action under 29 U.S.C. 1132 §502(a). Level 2 appeals, if available, are voluntary levels of review you can obtain and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be temporarily suspended while a Level 2 appeal is pending. You will be notified of your right to file for Level 2 review if the response to your current appeal level (i.e., Level 1) is adverse. Upon your request, the Claims Administrator will also provide you with detailed information concerning Level 2 appeals and, if available, including how Level 2 panelists are selected.

**Filing Claims for Eligibility or Plan Operations**

An eligibility claim is a claim to participate in a health care option, to change an election to participate in an option during the year, or it could be related to enrollment for a certain option. For example, you may feel a mistake was made during the enrollment process resulting in your being assigned to incorrect coverage or an incorrect coverage tier. To initiate a claim concerning eligibility or plan operations, contact the ABB Benefits Service Center at 1-800-354-8069. Participant Services Representatives are available Monday through Friday, 8:30 a.m. to 8:00 p.m., Eastern Time, excluding New York Stock Exchange holidays. If you disagree with the information provided in response to your concern, you can file an appeal with ABB, the Plan Administrator, at the address shown below.
Appealing a Claim for Eligibility or Plan Operations

If your eligibility claim, or claim regarding plan operations, is denied in whole or in part, you can appeal the denial. Your appeal must be presented to the Plan Administrator in writing within 180 days of receipt of the notice of denial. You may submit your appeal via email to MYHRSMART@us.abb.com or mail it to the Plan Administrator at the following address:

ABB INC.
EMPLOYEE BENEFITS DEPARTMENT – APPEALS
12040 REGENCY PARKWAY
SUITE 200
CARY, NC 27518

The Plan Administrator will review your appeal considering the terms of the plan, the information you have presented and any other documentation that is relevant to your claim.

You will be notified of the decision on your appeal within a reasonable time period, generally within 30 calendar days, but not later than 60 calendar days after the plan receives your request for review. The Plan Administrator has the final authority for deciding all claims regarding eligibility/plan operations.

Please note that eligibility/plan operation claims are subject to the same limitations for filing a lawsuit as health care claims.

Health Care Fraud

Health care fraud is a felony that can be prosecuted. If you willfully and knowingly engage in any activity intended to defraud the ABB plans, that act can result in disciplinary action up to and including termination of employment. If you receive money from the plan to which you are not entitled, you will be required to fully reimburse the plan.

When You Are Covered By More Than One Plan
(Coordination of Benefits)

Many people are covered by more than one group medical plan. If this applies to you or your covered dependents, you must provide the Claims Administrator with the name of the other Provider when you file a claim.

The Medical Plan, like most plans, has a coordination of benefits (COB) provision designed to prevent duplication of benefits. The provision coordinates benefits from all group medical plans — including employer and government-sponsored plans — covering you and your covered dependents. Coordination of benefits also applies when benefits are paid by no-fault automobile insurance.
If you, your spouse/domestic partner or your eligible dependents have coverage under an ABB plan and that plan is the secondary payer (for example, if your spouse/domestic partner has medical coverage elsewhere, the other plan will pay first for your spouse/domestic partner’s medical expenses and the ABB plan will pay second), benefits from the ABB plan will be offset by benefits from the other plan.

This means that if the other plan pays less than the option you have chosen under the ABB plan, the ABB plan will pay the difference — but only up to what would have been paid if the ABB plan had been the primary payer. The ABB plan will not duplicate any benefits paid by another plan. (You must satisfy any applicable Deductible under the ABB plan, even if you or a covered dependent has primary coverage under another plan. In this instance, no benefits will be paid under this plan until you pay any required Deductible.)

The ABB Medical Plan will always be secondary to medical payment coverage or personal injury protection (PIP) coverage under any auto liability or no-fault insurance policy.

**Coordination of Benefits Under the HRP**

Let’s look at how benefits would be coordinated under the in-network benefits of the HRP.

For example, let’s assume your spouse/domestic partner is covered under both the HRP and his/her employer’s medical plan, which pays benefits based on 70% of the Maximum Allowable Amount. Your spouse/domestic partner has $100 of medical expenses. Your spouse/domestic partner’s network personal care Physician provided all care and the expenses equaled the network Negotiated Fee. Your spouse/domestic partner’s employer’s plan is the primary payer and, after all Deductibles are met, pays $70. Your spouse/domestic partner can then submit a claim to the HRP for payment of the remaining $30. Under the HRP, your spouse/domestic partner would have paid 20% of in-network charges, and the HRP would have paid the remaining 80%, or $80. Because your spouse/domestic partner’s plan has already paid $70, the HRP will reimburse your spouse/domestic partner $10 ($80 – $70 = $10).

**Coordination of Benefits Under the HSP**

If you or you and your spouse/domestic partner are enrolled in the HSP and also participate in the HSA, coordination of benefits does not apply because you may not be covered by any plan other than the HSP. If you are covered under the ABB HSP and your spouse/domestic partner is covered under another high deductible health plan at his/her employer, benefits would be coordinated as described above for the HRP, but at the 80% level in-network.

**Which Plan Pays Benefits First**

If there are two group plans providing coverage, the Claims Administrator is responsible for determining how the plans coordinate benefits and which plan pays first. Here are some general guidelines for determining which plan pays first.

- If you (the employee) are the patient, the ABB plan will pay first in most cases.
- If your spouse/domestic partner is the patient, your spouse/domestic partner’s plan generally will pay first.

- If a dependent child is the patient, usually the plan covering the parent whose birthday comes earlier in the calendar year will pay first (the birthday rule).
  - If not otherwise specified by a court decree, benefits for children of divorced or legally separated parents will be determined first by the plan covering the child as a dependent of the parent with custody. (If the parent with custody remarries/enters into a new domestic partnership, the plan covering the child as a dependent of the stepparent pays second. The plan of the parent without custody pays last.)
  - If the other plan provides for the father’s plan to pay before the mother’s plan when a dependent child is the patient (gender rule), the ABB plan will default and follow the gender rule.
  - If the other plan does not have a coordination of benefits provision, that plan will pay first for your covered dependents, in all cases.

- If payment responsibilities still are unresolved, the plan that covered the patient for the longer period of time pays first.

- If one of your eligible dependents is covered by an HMO sponsored by the dependent’s employer, medical benefits payable under the ABB Medical Plans will be reduced to the extent that coverage is available from the HMO — whether or not the dependent actually applies for, or receives, treatment from the HMO.

**Right to Release and Obtain Necessary Information**

The Claims Administrator may, without the consent of or notice to any person, release to or obtain from any other person any information that it deems necessary to determine whether the coordination of benefits provision or other general claim administration provisions apply. The Claims Administrator may implement its terms or the terms of any provision of similar purpose of any other plan as well. You must provide the Claims Administrator with information needed to implement the coordination of benefits provision or other general claim administration provisions.

**Facility of Payment**

If payments that should have been made under the terms of this plan’s coordination of benefits provision or other general claim administration provisions are made under other plans, the Claims Administrator may pay the appropriate amount to any person who made such payment. To the extent of such payments, the Claims Administrator and the Company will be discharged from liability under this plan.
Subrogation and Right of Reimbursement

These provisions apply when plan benefits are paid as a result of Injury or Illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Claims Administrator, on behalf of ABB, has the right to recover plan payments made on your behalf from any party responsible for compensating you for your Injuries. The following apply:

- The Claims Administrator, on behalf of ABB, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and Injuries.

- You and your legal representative must do whatever is necessary to enable the Claims Administrator, on behalf of ABB, to exercise their rights and do nothing to prejudice them.

- The Claims Administrator, on behalf of ABB, has the right to take whatever legal action they see fit against any party or entity to recover the benefits paid under the plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Claims Administrator’s subrogation claim and any claim still held by you, the Claims Administrator’s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

The Claims Administrator, on behalf of ABB, is not responsible for any attorney fees, other expenses or costs, without its prior written consent. The Claims Administrator, on behalf of ABB, further agrees that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Claims Administrator, on behalf of ABB.

Reimbursement

If you obtain a Recovery and the Claims Administrator, on behalf of ABB, has not been repaid for the benefits the Claims Administrator, on behalf of ABB, paid on your behalf, the Claims Administrator, on behalf of ABB, shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse the Claims Administrator, on behalf of ABB, to the extent of plan benefits the Claims Administrator, on behalf of ABB, paid on your behalf from any Recovery.

- Notwithstanding any allocation made in a settlement agreement or court order, the Claims Administrator, on behalf of ABB, shall have a right of Recovery, in first priority, against any Recovery.
• You and your legal representative must hold in trust for the Claims Administrator, on behalf of ABB, the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Claims Administrator, on behalf of ABB, immediately upon your receipt of the Recovery. You must reimburse ABB, in first priority and without any offset or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Claims Administrator, on behalf of ABB.

• If you fail to repay the Claims Administrator, on behalf of ABB, the Claims Administrator, on behalf of ABB, shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Claims Administrator, on behalf of ABB, has paid or the amount of your Recovery, whichever is less, from any future benefit under the plan if:
  - The amount the Claims Administrator, on behalf of ABB, paid on your behalf is not repaid or otherwise recovered by the Claims Administrator, on behalf of ABB; or,
  - You fail to cooperate.

• In the event that you fail to disclose to the Claims Administrator and/or ABB the amount of your settlement, the Claims Administrator, on behalf of ABB, shall be entitled to deduct the amount of their lien from any future benefit under the plan.

• The Claims Administrator, on behalf of ABB, shall also be entitled to recover any of the unsatisfied portion of the amount they have paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Claims Administrator, on behalf of ABB, has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Claims Administrator, on behalf of ABB, would not have any obligation to pay the Provider.

The Claims Administrator, on behalf of ABB, is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

**Your Duties**

• You must notify the Claims Administrator, on behalf of ABB, promptly of how, when and where an accident or incident resulting in personal Injury or Illness to you occurred and all information regarding the parties involved.

• You must cooperate with the Claims Administrator, on behalf of ABB, in the investigation, settlement and protection of ABB’s rights of the Claims Administrator.

• You must not do anything to prejudice the rights of the Claims Administrator, on behalf of ABB.
• You must send the Claims Administrator, on behalf of ABB, copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or Illness to you.

• You must promptly notify the Claims Administrator, on behalf of ABB, if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, the Claims Administrator, on behalf of ABB, will have the right to recover such payment from you or, if applicable, the Provider. The Claims Administrator, on behalf of ABB, reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

The Claims Administrator, on behalf of ABB, has oversight responsibility for compliance with Provider, vendor and subcontractor contracts. The Claims Administrator, on behalf of ABB, may enter into a settlement or compromise regarding enforcement of these contracts and may retain any Recoveries made from a Provider, vendor or subcontractor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator, on behalf of ABB, has established Recovery policies to determine which Recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. The Claims Administrator, on behalf of ABB, will not pursue Recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator, on behalf of ABB, may not provide you with notice of overpayments made by the plan or you if the Recovery method makes providing such notice administratively burdensome.
General Information About the Health Care Program

BlueAdvantage Note

ABB, on behalf of itself and its participants, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this SPD) constitutes a contract solely between ABB and BlueAdvantage Administrators of Arkansas (BlueAdvantage), and that BlueAdvantage is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Arkansas. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, BlueAdvantage is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of BlueAdvantage other than those obligations created under other provisions of the Administrative Services Agreement or this SPD.

Reservation of Discretionary Authority

BlueAdvantage shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the plan and interpretation of this SPD. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the plan, to resolve Member Complaints and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the plan. A specific limitation or exclusion will override more general benefit language. BlueAdvantage has complete discretion to interpret this SPD. BlueAdvantage’s determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the plan’s Maximum Allowable Amount. A Member may utilize all applicable Complaint and Appeals procedures.

Your Right to Privacy

The Department of Health and Human Services has issued comprehensive federal regulations that give individuals broad protections over the privacy of their health records. These regulations are part of the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Provision, which in part governs the transmission of health care transactions, privacy, and security. The purpose of this law is to standardize and safeguard the transmission of protected health information, protect the privacy of your health information (including genetic information), and allow you access to your medical records.
HIPAA protection applies to the medical, dental, vision, Prescription Drug, Employee Assistance Program (EAP), and health care spending account programs.

By providing privacy protections at a federal level, all employees, no matter which state they live in, will be covered by a national base of privacy. Compliance with state law and other federal laws will be included as part of our total compliance program.

These regulations apply to your health care Providers, such as Physicians and Hospitals, as well as to the ABB Inc. Flexible Benefits Plan. These rules became effective April 14, 2003.

**What Are My Rights Under the HIPAA Regulations?**

The privacy regulations affect every individual who receives medical care and treatment. You will have the following rights and protections:

- Assurance that your medical information is kept private.

- Assurance that your medical information is not used for unrelated purposes, such as making employment or financial decisions, unless specifically authorized by you. This authorization may be limited or revoked at a later time.

- Access to your medical records. You have the right to see and obtain a copy of certain designated medical records, and to request changes to those records. It's possible that the plan may not have these kinds of records.

- The right to request in writing an accounting of any uses and disclosures of your protected health information.

- The right to request a restriction or limitation on how the plan can use or disclose your private medical information for purposes of treatment, payment or health care operations. We are not required to agree to your request.

- The right to request confidential communications, so that we communicate with you about medical matters in a certain way or at a certain location.

- Assurance that the plan will follow the privacy guidelines described in this SPD, and will inform you of any changes to its privacy policies.

- Access to a complaint resolution process, and to the Department of Health and Human Services, if you believe the privacy of your protected health information has been violated.

**What Type of Health Information Is Protected by HIPAA?**

HIPAA safeguards Protected Health Information (PHI). PHI is individually identifiable health information that is created or received by an ABB Inc. Human Resources Representative or other authorized individual, such as ABB Benefits Service Center representatives, as part of administering the plan. PHI has an identifier such as your name, social security number, or
date of admission that when attached to the record makes it clear that the record concerns your health information.

The plan may use or disclose health information for purposes of payment, treatment or health care operations. Information may also be disclosed in order to comply with federal, state, or local law and to avert a safety threat to you or the public.

However, every effort is made to ensure the confidentiality of all health information received by the plan and the plan sponsor. Even when protected information is released for the purposes of payment, treatment, or health care operations, only the minimum amount of information determined necessary to achieve the goal will be released.

To ensure that the plan is in compliance with HIPAA privacy requirements, ABB Inc. has appointed a “Privacy Officer” who is responsible for developing, communicating and enforcing the necessary procedures for ensuring the privacy of protected health information within the organization.

The Privacy Officer is the contact person if you have a complaint about the handling of your protected health information, or for more information about HIPAA.

**What if there Is a Breach of My Protected Health Information?**

If there is a breach of your unsecured protected health information (PHI), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the plan notify you without unreasonable delay but no later than 60 days after the plan’s discovery of the breach. The notice must be written in plain language and contain the following information, to the extent possible:

- A brief description of what happened, including the date of the breach and the date of discovery;

- The types of PHI involved (name, SSN, date of birth, diagnosis, etc.);

- Any steps you should take to protect yourself from potential harm resulting from the breach;

- A brief description of the steps the plan is taking to investigate, mitigate losses, and protect against further breaches; and,

- Contact information for you to ask questions, including a toll-free number, email address, website or postal address.

If a breach of your unsecured PHI occurs, a notice will be sent by first-class mail to your last known address, or if you agree to electronic notice, by email.
What if I Have a Complaint About the Handling of My Protected Health Information?

You may file a written complaint with the plan, or with the Department of Health and Human Services, if you believe your privacy rights have been violated. The Privacy Officer is the plan’s first point of contact for handling your complaint or grievance. The Privacy Officer will investigate the details of your complaint, and get back to you within ten business days concerning the results of the investigation. You will not be penalized or otherwise retaliated against for filing a complaint.

If you are not satisfied that your complaint has been resolved satisfactorily, you may file a request for additional review. The Privacy Officer will provide the background information concerning the complaint and results of the investigation to ABB Inc.’s General Counsel. You will have an opportunity to present your concerns as part of the Company’s formal Grievance Procedure. The Grievance Procedure was effective as of April 14, 2003.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act prohibits health coverage discrimination and employment discrimination against employees based on their (or their family members’) genetic information.

Genetic information includes:

- Genetic tests;
- The request for, or receipt of, genetic counseling or other genetic services; and,
- The manifestation of a disease or disorder in an individual’s family member.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history, such as through a Health Risk Assessment (HRA), will be treated as confidential, as required by HIPAA and GINA.

Documentation of Health Coverage

If coverage under a health plan ends, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to receive a certificate of prior health coverage. The ABB Benefits Service Center will issue a Certification of Coverage form to you if your coverage in the plan ends and, if applicable, at the end of any continuous period (such as coverage under COBRA). You will need to provide this Certification of Coverage form if your new plan imposes pre-existing condition exclusions. It provides all the necessary information another health plan will need to determine if your prior coverage should be credited to reduce or eliminate any waiting period for benefits. The ABB Benefits Service Center will also issue the
Certification of Coverage form if you request an additional copy any time within the first 24 months after your ABB coverage terminates.

**When You Become Eligible for Medicare**

Medical coverage through Medicare is available when you and/or your covered dependent spouse/domestic partner reaches age 65. If you remain an active employee beyond age 65, you and your dependent spouse/domestic partner will continue to be covered by the Company-sponsored medical program.

**W-2 Reporting**

The Patient Protection and Affordable Care Act requires employers to report the aggregate dollar value of the health insurance coverage provided under the ABB Medical Plan option you choose on your W-2 Earnings Statement. This amount will be shown on your W-2 in Box 12 Code “DD.” The amount shown is for informational purposes only and is not included as part of your taxable wages.

**Continuation of Benefits**

In general, if you leave active employment with the Company, coverage for you and your enrolled dependents ends on your last day of work. The Company extends medical coverage for a limited period of time under certain circumstances. After your Company-provided coverage ends, you and your covered dependents can continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You are eligible to continue coverage only if you had medical coverage on your last day of work.

In general, COBRA allows you to continue coverage for up to 18 months under certain circumstances and up to 36 months for your dependents in the event of death, divorce or loss of dependent status. Generally, you are not covered for any medical services or supplies furnished after the date your coverage stops.

**Cost of Coverage**

Under the law, COBRA must be offered to eligible individuals at group rates. These rates are subject to change annually, based on plan experience. The monthly cost of continuing coverage under COBRA is 100% of the actual cost plus a 2% administrative fee. If you are receiving continuation coverage and you were disabled at the time continuation coverage began, you may be required to pay up to 150% of the full cost of coverage.
Continuation Coverage under Federal Law (COBRA)

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

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

- An employee or retiree;
- An employee’s enrolled dependent, including with respect to the employee’s children, a child born to or placed for adoption with the employee during a period of continuation coverage under federal law; or,
- An employee’s spouse/domestic partner or former spouse/domestic partner (in the case of divorce or legal separation or termination of a domestic partnership). Note: While not required by law, ABB extends COBRA coverage to domestic partners.

Qualifying Events for Continuation Coverage under COBRA

If the health care coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is eligible for COBRA continuation coverage. The Qualified Beneficiary may elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee or retiree who is a Qualified Beneficiary are:

- Termination of employment with us, for any reason other than gross misconduct (applicable only to employees); or,
- Reduction in the employee’s hours of employment (applicable only to employees); or,
- Loss of coverage within one year before or after the plan sponsor’s commencement of a bankruptcy proceeding under Title 11 of the United States Code (applicable only to retirees).

With respect to an employee’s or retiree’s spouse/domestic partner or dependent child who is a Qualified Beneficiary, the qualifying events are:

- Termination of the employee’s employment (for reasons other than the employee’s gross misconduct); or,
- Reduction in the employee’s hours of employment; or,
- Death of the employee or retiree; or,
• Divorce, legal separation or termination of a domestic partnership of the employee or retiree; or,

• Loss of eligibility by an enrolled dependent who is a child (applicable only to the affected child); or,

• Entitlement of the employee/surviving spouse/domestic partner to Medicare benefits; or,

• The plan sponsor’s commencement of a bankruptcy proceeding, under Title 11, United States Code. This is also a qualifying event for any retired employee and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under COBRA

Notification Requirements for Qualifying Event

The employee or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the latest of the date of the employee’s divorce, legal separation or termination of a domestic partnership; an enrolled dependent’s loss of eligibility as an enrolled dependent; or the date the Qualified Beneficiary would lose coverage under the plan. An employee or other Qualified Beneficiary must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If the employee or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60-day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If an employee is continuing coverage under federal law, the employee must notify the Plan Administrator within 60 days of the birth or adoption of a child in order to obtain coverage for that child.

Notification Requirements for Disability Determination and Change in Disability Status

The employee or other Qualified Beneficiary must notify the Plan Administrator as described in the section of this SPD entitled, “COBRA Terminating Events.”

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address shown in the section of this SPD entitled, “Administrative Information.” The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

None of the notice requirements will be enforced if the employee or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.
Individual Rights

Each Qualified Beneficiary has the right to make his or her own election of COBRA coverage. For example, you may choose to continue coverage for yourself, and your spouse may waive coverage. However, you may elect COBRA coverage for your spouse, and you or your spouse may elect coverage for your children.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or ‘alternative trade adjustment assistance’ under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost, but begins on the first day of the special second election period.

Individuals who are receiving retirement benefits payable by the Pension Benefit Guaranty Corporation (PBGC) may retain COBRA for the remainder of their lives and their surviving spouse/domestic partner and dependent children will be eligible for an additional 24 months of coverage following the death of the individual receiving retirement benefits from the PBGC. All other individuals covered by TAA may retain COBRA coverage for the duration of their TAA eligibility.

How to Elect Continuation Coverage

To elect continuation coverage under COBRA, you and/or your covered dependents must act within 60 days from the later of:

- The date the coverage ends; or,

- The date the Company has provided notification of continuation rights.

It is your responsibility to notify the Company within 60 days if a covered dependent no longer meets the plan definition of dependent. The Company then will contact the dependent within 14 days regarding his or her continuation rights. If your employment terminates, you are laid off or your hours are reduced, the Company will notify you and/or your covered dependents regarding continuation rights.
**Coverage during the Election Period**

On the date your coverage is terminated, you and your dependents will not have any coverage until COBRA continuation coverage is properly elected and the required premiums have been paid. This means no benefits or expenses will be paid during the election period. To receive uninterrupted coverage, it is important to elect continuation coverage and make the required premium payments as soon as possible after receiving notice of your COBRA rights. When a completed election form is received and all required premiums are paid, COBRA coverage becomes retroactive to the date coverage was terminated.

**Payment of Premiums for COBRA Coverage**

The Qualified Beneficiary’s initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation coverage.

All continuation coverage payments will be made on an after-tax basis — except coverage for a former spouse/domestic partner which can be paid on a pre-tax basis as long as you are still working for the Company.

After the initial 45-day grace period, the Qualified Beneficiary must pay the monthly premiums for the cost of COBRA coverage. If payment is not received within 30 days of the monthly payment date, coverage will be terminated and the Qualified Beneficiary will have no further rights to continuation coverage. Even if continuation coverage is elected, benefits will not be paid until all payments due have been paid, without regard to a grace period.

**Second Qualifying Events**

If a second qualifying event occurs during the initial 18 months of COBRA continuation coverage following a termination of employment or reduction in hours of the covered employee (for example, the second event may be a divorce, legal separation, the covered employee’s death or a child losing eligibility status), the 18 months of COBRA coverage can be extended to 36 months from the date of the original qualifying event, but only for the individual whose coverage would have ended as a result of the second qualifying event, had the first event not occurred. In no event will COBRA continuation coverage last longer than 36 months after the date the original qualifying event occurs.

**Conversion Options**

If your group health plan gives participants and beneficiaries the option to convert from group health coverage to an individual policy when employment terminates, the plan must give you the same option when your maximum period of continuation (COBRA) coverage ends. The conversion option must be offered not later than 180 days before your continuation coverage ends. The premium for an individual conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. You are not entitled to the conversion option, however, if your continuation coverage is terminated before the end of the maximum period for which it is available.
COBRA Notice of Unavailability of Continuous Coverage

Group health plans may sometimes deny a request for continuation coverage or for an extension of continuation coverage. If you or any member of your family requests continuation coverage and the plan determines that you or your family member is not entitled to coverage for any reason, the plan must give the person who requested it a notice of unavailability of continuation coverage. The notice must be provided within 14 days after the request is received and it must explain the reason for denying the request.

COBRA Terminating Events

COBRA continuation coverage under the plan will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary’s coverage would have ended because the employee’s employment was terminated or hours were reduced (i.e., qualifying event A. or B.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A., then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following conditions:

i. Notice of such disability must be provided within the latest of 60 days after (a) the determination of the disability; (b) the date of the qualifying event; (c) the date the Qualified Beneficiary would lose coverage under the plan, and in no event later than the end of the first 18 months of continuation coverage;

ii. The Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and,

iii. If the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided to the Plan Administrator within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the employee; divorce, legal separation or termination of a domestic partnership of the employee; or loss of eligibility by an enrolled dependent who is a child (i.e., qualifying events C., D., or E.).

C. With respect to Qualified Beneficiaries who are not the employee, and to the extent that the employee was entitled to Medicare prior to a qualifying event that is a
termination of employment or reduction in hours (qualifying event A. or B.), the later of the following:

i. Eighteen months from the date of the employee’s termination of employment or reduction in hours; or,

ii. Thirty-six months from the date of the employee’s Medicare entitlement.

D. With respect to Qualified Beneficiaries, and to the extent that the employee became entitled to Medicare subsequent to the qualifying event:

i. Thirty-six months from the date of the employee’s termination of employment or work hours being reduced (first qualifying event), if:

   a. The employee’s Medicare entitlement occurs within the 18-month continuation period; and,

   b. If absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the plan for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the plan sponsor filed for bankruptcy (i.e., qualifying event G.). If the Qualified Beneficiary was entitled to continuation coverage because the plan sponsor filed for bankruptcy (i.e., qualifying event G.), and the retired employee dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the employee’s death.

H. The date the entire plan ends.
If You Leave the Company

If your employment ends for reasons other than gross misconduct, or your work hours are reduced to a point where you are no longer eligible for coverage, you and your covered dependents can continue medical coverage under COBRA. You can continue coverage for up to 18 months by paying the full cost of coverage (the actual cost plus a 2% administrative fee), or 29 months if you or your covered dependent was determined to be disabled before or during the first 60 days of continuation coverage, by paying the full cost of coverage (the actual cost plus 50% for the additional 11 months).

If you leave ABB and elect COBRA continuation coverage, you will remain eligible to participate in the ABB TotalHealth program while on COBRA; however, you will not be eligible to earn additional TotalHealth Rewards, nor will ABB provide any further “seed” contributions to your HSA.

If You Are Laid Off

If you are laid off, your medical coverage will be continued at Company expense for a period of time. The ABB Benefits Service Center will let you know the length of this continuation.

If you are eligible for retiree medical coverage when you are laid off, however, you may either continue coverage under COBRA, as described above, or enroll for retiree medical coverage. If you elect retiree medical coverage, you will receive whatever subsidy to which you are entitled based on your years of service. You will be responsible for the premium above the subsidy amount.

If You Are On An Approved Leave of Absence

If you are on an approved Leave of Absence for qualified Military Service, you have the right to continue health care coverage. See the section of this SPD entitled, “Uniformed Services Employment and Reemployment Rights Act” or contact your local HR representative for more information.

If you are on an approved Family Medical Leave of Absence [FMLA], your health care coverage will continue for up to 12 weeks in the applicable 12-month period (or 26 weeks in a single 12-month period for military caregiver leave), as long as you continue to pay your share of the cost of coverage. See the section of this SPD entitled, “The Family and Medical Leave Act (FMLA)” for more information.

If you are on an approved leave of absence for any other reason, your health care coverage will continue for one month, if you pay your share of the cost of coverage. Once your one month of regular coverage ends, you and your covered dependents may continue medical coverage under COBRA for up to an additional 17 months by paying the full cost of coverage (the actual cost plus a 2% administrative fee) or 28 months if the disability provision applies by paying the full cost of coverage (the actual cost plus 50% for the additional 11 months).
The Family and Medical Leave Act (FMLA)

Any provisions of the plan that provide for continuation of coverage during a leave of absence, and reinstatement of coverage following a return to active service, are modified by the following provisions of the federal Family and Medical Leave Act of 1993 (the FMLA), where applicable.

Continuation of Health Coverage during a Leave

Your health coverage will be continued during a leave of absence for up to 12 weeks in the applicable 12-month period (or 26 weeks in a single 12-month period for military caregiver leave), if:

- That leave qualifies as a leave of absence under the FMLA (Act) and any applicable amendments to the Act; and,
- You are an eligible employee under the terms of the Act.

You are responsible for paying the regular employee portion of the cost of your health coverage during such leave. At your election:

- You may prepay the entire cost of coverage before you go out on leave; or,
- You may pay premiums each month during the course of your leave.

If you do not pay for your portion of the cost of health coverage during your leave, coverage will terminate. At the end of the initial 12-week FMLA leave period (if leave continues) (or 26-week FMLA leave period for military caregiver leave), or when your employment otherwise terminates, whichever comes first, you (and your covered dependents) may be eligible for continuation coverage under COBRA.

Reinstatement of Canceled Coverage Following Leave

Upon your return to active service following your FMLA leave, any canceled health care coverage or other benefits suspended during the term of your leave will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any pre-existing condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Upon request, the Company will give you detailed information about the FMLA and its effect on your benefits.
Uniformed Services Employment and Reemployment Rights Act

If you take a military leave, whether for active duty or for training, you and your dependents are entitled to continue medical, dental and vision coverage for up to 24 months, as long as you give the Company advance notice (with certain exceptions) of the leave. The first six months of a military leave of absence is covered under your active employment benefits and contributions continue unchanged, as long as you pay the direct bill premiums.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires employers to offer COBRA continuation coverage to persons in the armed services if the absence for military duty would result in loss of coverage as a result of active duty. The maximum length of COBRA continuation coverage required under USERRA is the lesser of 24 months, beginning on the day that the uniformed service leave begins, or a period beginning on the day that the service leave begins and ending on the day after the employee fails to return to, or reapply for, employment within the time allowed by USERRA. The six months of continued active employment benefits and contributions discussed above will offset the 24 months of USERRA continued coverage. This means that, in total, you are entitled to up to 24 months of health care coverage.

If the entire length of the service leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the plan premium (COBRA) after the first six months (to a maximum of 24 months) that benefits are continued under the active employee benefit program.

You and your eligible dependents will have your ABB coverage reinstated effective on the date of your return to work. There will be no waiting period required. However, the plan will not cover Injuries or Illnesses (as defined by the plan) that are attributable to military service; those will be covered by the uniformed service.

Benefits other than health care coverage will be offered to employees upon return from service leave on the same basis they are provided to other employees actively employed at ABB.

If You Are Hospitalized or Disabled

If you are hospitalized, or a covered dependent is hospitalized, at the time when your coverage would otherwise end for any reason, medical coverage continues until the end of the Hospital confinement, for that patient and that condition only.

If you or one of your covered dependents is Totally Disabled at the time coverage would otherwise end, health care benefits will continue to be paid for covered expenses related to that disability. Health care coverage is continued until the end of the calendar year following the calendar year during which coverage would otherwise end, or until the individual becomes covered under a similar group medical plan, if sooner.
If you are receiving benefits through the Company’s Short-term Disability (STD) Plan, your health care coverage will continue for you and your enrolled family members. Contact the ABB Benefits Service Center for more information.

If you go on long-term disability (LTD), your medical coverage will be transferred to the Medical Plan for Employees on Long Term Disability. This is a PPO plan with no attached health accounts, so contributions to the HRA and HSA will stop. Depending on the date when your STD benefits begin, you may be responsible for making contributions, as follows:

- If your date of disability (when STD benefits began) is on or after January 1, 2006, you are required to pay a share of the cost of your medical coverage, based on your salary band. See “The Managed Disability Program” SPD for information.

- If your date of disability (when STD benefits began) is prior to January 1, 2006, medical benefits are currently paid by the Company for as long as you are eligible for coverage under the LTD plan.

If you are eligible for Social Security Disability Income Benefits, you will become eligible for Medicare after 29 months of disability. Once you become eligible for Medicare, Medicare will become the primary payer and the ABB Medical Plan the secondary payer for your covered medical expenses. The ABB Medical Plan will pay benefits as if Medicare coverage had been elected, regardless of whether you made such election. There is no change in coverage for your enrolled dependents.

If you provide proof that you were eligible for federal Social Security benefits for disability at the time you lost coverage under the plan, or within the first 60 days of COBRA continuation coverage (due to your termination or other similar event), coverage may be continued under COBRA for up to 29 months from the date coverage under your ABB plan would otherwise end, or until one of the events in the section of this SPD entitled, “COBRA Terminating Events” occurs.

**When You Retire**

Contact the ABB Benefits Service Center for more information about available coverage when you retire.

**If You Become Divorced, Legally Separated or Terminate a Domestic Partnership**

If you become divorced or legally separated, or you terminate a domestic partnership, your covered spouse/domestic partner and affected covered dependents can continue medical coverage under COBRA for up to 36 months by paying the full cost of coverage (the actual cost plus a 2% administrative fee).
When Your Child Is No Longer a Dependent

If your covered dependent child no longer meets the plan’s definition of “dependent,” your child may continue medical coverage under COBRA for up to 36 months by paying the full cost of coverage (the actual cost plus a 2% administrative fee).

If You Die While Actively Employed

If you die while actively employed, your covered dependents may continue medical coverage at Company expense for up to 12 months from your date of death, if your dependents remain eligible during this period. (If your spouse/domestic partner remarries/enters into a new domestic partnership or becomes covered under another plan, or if your dependents reach the limiting age or become covered under another plan, coverage provided at Company expense ends.) After your Company-provided benefits end, your covered dependents may continue coverage for a combined Company/COBRA continuation total of up to 36 months, if they pay the full cost of coverage (the actual cost plus a 2% administrative fee) after the period of Company-provided benefits ends.

If you met the eligibility requirements for the Retiree Medical Plan at the time of your death, your surviving spouse/domestic partner and covered dependents may continue coverage under COBRA, as described above, or they may elect coverage under the Retiree Medical Plan instead. In that case, coverage will be provided at whatever subsidy to which you were entitled based on your years of service. Your surviving spouse/domestic partner would pay the balance of the premium above the subsidy amount. Your surviving spouse/domestic partner should contact the ABB Benefits Service Center for details.

Circumstances That May Result in Denial, Loss or Forfeiture of Benefits

Under certain circumstances, plan benefits may be denied or reduced from those described in this SPD. For instance:

- Rescission of coverage may be permitted in limited circumstances such as fraud or the intentional misrepresentation of a material fact. If coverage is subject to rescission, all affected participants must be provided with written notice at least 30 days prior to the date of rescission.

- Coverage may also be terminated retroactively for you (and/or your dependents) for failure to pay the required contributions on a timely basis, or in certain other limited circumstances without ABB having to provide 30 days written notice.
Termination of Benefits Coverage

In general, you and your dependents’ benefits coverage will terminate on the earliest of the following dates:

- The date your employment ends;
- The date the plan is terminated;
- The date the plan is amended to terminate the benefits coverage of a class of employees of which you are a member; or,
- With respect to any coverage for which you cease to be a member of the class or classes of employees eligible for such coverage, the end of the month during which cessation of such membership occurs.

In addition, dependents’ coverage will terminate on the earlier of:

- The date your dependent begins active duty in the Armed Forces of any state; or,
- The date you become ineligible to have dependents covered under the plan.

Qualified Medical Child Support Order

In divorce and other domestic relations proceedings, certain court orders (and orders issued through a state-approved administrative process) may require health care coverage for your child. This is known as a Qualified Medical Child Support Order (QMCSO), and it could affect the cost of your benefits. For a medical child support order to be considered “qualified” under the plan, the plan’s procedures must be followed and the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) must be met. As soon as you become aware of any court proceedings that involve or affect your children’s health care coverage, contact the Plan Administrator for a copy of the administrative policy and plan requirements.

Plan Continuation and Reservation of Rights

The Company presently intends to continue the plans described in this Summary Plan Description, but reserves the right to amend, suspend, discontinue, or terminate any or all of the plans at any time.

The Company’s decision to amend, suspend, discontinue or terminate any of the plans may be due to changes in federal or state laws governing welfare or pension benefits, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974, as amended, (ERISA), the provision of a contract or policy involving an insurance company, Company policy, or any other reason.
The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to take any other actions with respect to questions arising in connection with the operation of the plans. The Claims Administrator has sole discretionary authority to determine the amount of benefits payable based on the terms of the plans, and to pay and adjudicate benefit claims. All decisions, determinations and interpretations of the Plan Administrator and/or the Claims Administrator are conclusive and binding on all persons.

If the Medical Plan described in this SPD is terminated, you will not have any further rights other than payment of expenses or other claims incurred before the plan was terminated. After all benefits have been paid and other requirements of law have been met, any remaining plan assets will be, at the discretion of the Company, either used to purchase benefits or distributed to plan participants in accordance with the requirements of law.

**Plan Documents**

This SPD describes the highlights of the ABB HRP and HSP, and does not attempt to cover all the details. The contents of this SPD are an integral part of the official plan documents.

Additional details may be provided in the plan documents and insurance and/or service contracts, which legally govern the plans. The additional documents may be seen in the Plan Administrator’s office during normal working hours. These documents include any documents filed with the Internal Revenue Service, the annual financial reports and the plan descriptions that are filed with the U.S. Department of Labor, and may include contracts and other documents used by the Claims Administrator. You may obtain copies of these documents by sending a written request to the Plan Administrator. There will be a charge to cover copying costs.

In the event of any discrepancy between this SPD and the other controlling documents, the controlling documents will prevail.
Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended, (ERISA). ERISA provides that all plan participants shall be entitled to:

**Receive Information about Your Plan and Benefits**

- Examine, without charge, through the Plan Administrator’s office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Coverage**

- Continue health care coverage for yourself, your spouse or dependents, if there is a loss of coverage under the plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan for the rules governing your COBRA continuation of coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage; or,
Your COBRA continuation coverage ceases, if you request it before losing coverage or you request it within 24 months after losing coverage.

Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called “fiduciaries,” have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Company, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a plan participant.

If your claim for a welfare 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 plan documents or the latest annual report from the plan and you do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. But if you lose, the court may order you to pay all costs and fees if, for example, it finds your claim is frivolous.
If You Have Questions

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications concerning your rights and responsibilities under ERISA by calling the publications Hotline of the Employee Benefits Security Administration at 1-866-444-EBSA (3272).
# Administrative Information

## The Medical Plans Administered by BlueAdvantage

<table>
<thead>
<tr>
<th>Legal Name of Plan</th>
<th>The ABB Inc. Flexible Benefits Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Type</td>
<td>Health Care Plan</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 – December 31</td>
</tr>
<tr>
<td>Type of Financing/Administration</td>
<td>Self-insured</td>
</tr>
</tbody>
</table>
| Plan Administrator and Agent for Service of Legal Process | ABB Inc.  
12040 Regency Parkway  
Suite 200  
Cary, NC 27518  
(919) 856-2360  
The Plan Administrator has the final authority to:  
- Interpret plan provisions  
- Make the final determination of an eligibility or plan operations appeal  
- Exercise discretion in the interpretation and administration of the plan |
| Claims Administrators       | The Claims Administrator has the final authority to:  
The Claims Administrators for the plans are shown below:  

### The Preferred Provider Organization (PPO) Medical Plans  
**BlueAdvantage Administrator of Arkansas**  
P.O. Box 1460  
Little Rock, AR 72203-1460  

### Managed Pharmacy Program  
**CVS Caremark**  
P.O. Box 659541  
San Antonio, TX 78265-9541  

### The Employee Assistance Program (EAP)  
**Carebridge Corporation**  
40 Lloyd Avenue  
Malvern, PA 19382  

### Employer Identification Number  
36-3100018  

### Plan Number  
576