Summary Plan Description

The Lubrizol Corporation Employee Benefits Plan
Lubrizol CDHP (Consumer-Driven Health Plan)
Core, Standard, and Plus Plans

Effective: January 1, 2022
Group Number: 730140

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health Care/Substance-Related and Addictive Disorders Administrator: 1-877-706-1735;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

The Lubrizol Corporation is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Lubrizol CDHP* of The Lubrizol Corporation Employee Benefits Plan (Plan). It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for the Lubrizol CDHP.

*The Lubrizol CDHP consists of the Core, Standard, and Plus Plans.

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 15, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Lubrizol CDHP.

The Lubrizol Corporation intends to continue the Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan document, your rights shall be determined under the Plan document and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare administers claims on behalf of the Lubrizol CDHP. Although UnitedHealthcare will assist you in many

ways, it does not guarantee any Benefits. The Lubrizol Corporation is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Lubrizol CDHP work. If you have questions, contact the Lubrizol Benefits Center (1-844-747-1641), your local benefits representative, or call 1-877-706-1735.

How to Use This SPD

- Read the entire SPD and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections of this SPD. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at http://benefits.lubrizol.com/ or request printed copies by contacting your local benefits representative.
- Capitalized words in the SPD have special meanings and are defined in Section 15, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 15, *Glossary*.
- The Lubrizol Corporation is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Lubrizol CDHP;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Lubrizol CDHP.

Eligibility

As a regular Employee of Lubrizol or of its participating subsidiaries or affiliates, who is reasonably anticipated to work at least an average of 20 hours per week or is participating in a phased-in retirement program, you and your Dependents are eligible for coverage under the Lubrizol CDHP. This includes Employees on an Employer-approved salary continuation leave of absence; Employees on an Employer-approved personal leave of absence; Employees on an Employer-approved military leave of absence; Employees on an Employer-approved family and medical leave of absence; and Employees of foreign affiliates of Lubrizol who are on an Employer-approved temporary U.S. assignment. A regular Employee generally does not include any person employed solely to work during the summer or as a seasonal employee (meaning that the Employee's customary period of annual employment is six months or less); any person who renders service solely as a director, independent contractor, or temporary worker who provides services through an agreement with a third party or otherwise; a person employed as a student intern or in connection with a cooperative educational program with any college, university, or other post-secondary school (although he or she may be eligible to participate in the Lubrizol CDHP, as described above); any person employed as a vo-education student employee; and any other person working in a category that Lubrizol has determined is not a regular Employee category. However, you and your Dependents are eligible for coverage under the Plan if you are an Employee employed as a student intern or in connection with a cooperative educational program with any college, university, or other post-secondary school, if you are reasonably anticipated to work at least an average of 20 hours per week over a bi-weekly period during your periods of active employment.

If you are a regular Employee of Lubrizol but are not reasonably anticipated to work an average of 20 hours or more per week or have variable hours, you may be still eligible to participate in the Lubrizol CDHP under rules adopted under the Affordable Care Act. Under those rules, if you actually work an average of at least 30 hours per week during an applicable "measurement period," you will be eligible to participate in the Lubrizol CDHP for the following "stability period."

For ongoing employees, the standard measurement period is the 12-month period starting on October 15 and ending on the following October 14. The stability period is the calendar year, January 1 through December 31.

Illustration: Your normal weekly work schedule is 15 hours. During the standard measurement period starting October 15, 2017 and ending October 14, 2018, you actually work an average of 30.5 hours per week. Because you worked an average of at least 30 hours per week during the standard measurement period, you will be eligible to participate in the Lubrizol CDHP for the next stability period starting January 1, 2019 and ending December 31, 2019.

For newly hired and rehired Employees, an initial measurement period will also apply. The initial measurement period is the 12-month period starting with the Employee's date of hire or rehire. The stability period that corresponds to the initial measurement period is the 12-month period starting the first day of the full month following the initial measurement period.

Illustration: You are hired as a regular Employee on June 1, 2017, with a normal work schedule of 15 hours per week. Your initial measurement period will run from June 1, 2017 to May 31, 2018. The related stability period will start June 1, 2018, and end May 31, 2019.

A newly hired or rehired employee's first standard measurement period will start on the first October 15 of his or her employment or reemployment, and will end on the following October 14.

Illustration: You are hired as a regular Employee on June 1, 2018, with a normal work schedule of 15 hours per week. Your first standard measurement period will run from October 15, 2018 through October 14, 2019.

This means that, at certain times during the employee's first year of employment or reemployment, the initial and the first standard measurement periods will be running at the same time.

Illustration: You are hired as a regular Employee on June 1, 2018, with a normal work schedule of 15 hours per week. Your initial measurement period will run from June 1, 2018 to May 31, 2019. Your first standard measurement period will run from October 15, 2018 through October 14, 2019. Therefore, from October 15, 2018 to May 31, 2019, your initial and standard measurement periods will overlap.

The following illustration explains how eligibility to participate in the Lubrizol CDHP for a new or rehired employee is determined by looking at hours worked during the initial measurement period and standard measurement periods.

Illustration: As a new Employee hired June 1, 2018 and scheduled to work 15 hours per week, you actually worked an average of 30.5 hours per week during your initial measurement period, which ran from June 1, 2018 to May 31, 2019. You will be eligible to participate in the Lubrizol CDHP for the stability period starting June 1, 2019 and ending June 30, 2020.

After June 30, 2020, your continued eligibility to participate in the Lubrizol CDHP for the rest of 2020 will depend upon whether you actually worked an average of at least 30 hours per week during your first standard measurement period (October 15, 2018 through October 14, 2019). If your weekly hours during that standard measurement period averaged at least 30 hours, you will be eligible to participate in the Lubrizol CDHP for the related stability period (January 1, 2020 through December 31, 2020). This means that you may continue to participate in the plan after June 30, 2020 for the remainder of 2019. If your average weekly hours during the standard measurement period fell short of 30 hours, however, your eligibility to participate in the Lubrizol CDHP will end on June 30, 2020.

The next time your eligibility to participate in the Lubrizol CDHP will be considered is for the stability period running January 1, 2021 through December 1, 2021. In other words, you will be treated in the same way as other ongoing employees who are regular Employees who are not reasonably expected to work an average of 20 hours per week over a biweekly period. Your eligibility to participate for the stability period starting January 1, 2021 will depend on whether your average weekly hours for the immediately preceding standard measurement period (October 15, 2019 through October 14, 2020) equaled or exceeded 30 hours. A similar analysis will apply for all subsequent standard measurement periods and related stability periods.

The rules regarding eligibility to participate in the Lubrizol CDHP are complex, and eligibility will also depend upon the facts in an individual case. Lubrizol, as Plan Administrator, has the authority to determine an individual's eligibility to participate in the Lubrizol CDHP. If you have any questions about eligibility to participate in the Lubrizol CDHP, please contact your local benefits representative.

If you and your Spouse or Domestic Partner are both covered under Lubrizol medical coverage, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse or Domestic Partner are both covered under Lubrizol medical coverage, only one parent may enroll your child.

Your eligible Dependents may also participate in the Lubrizol CDHP. An eligible Dependent is considered to be:

- your lawful Spouse, as defined in Section 15, *Glossary;*
- your Domestic Partner, as defined in Section 15, *Glossary;*
- the following children under the age of 26: your natural or legally adopted child, a child lawfully placed with you for legal adoption, your stepchild, your eligible foster child, your Domestic Partner's child or a child who is placed with you by an authorized placement agency or by court order; or
- any other unmarried child for whom you are the sole legal guardian or sole legal custodian/conservator, or for whom you are legally responsible to provide health care coverage, or for whom you with your Spouse, if applicable, are the sole legal guardian or sole legal custodian/conservator, or for whom you, with the child's natural parents, are a joint legal guardian or joint legal custodian and who lives with you in a normal parent-child relationship, provided both of the following are true:

- the child is a tax Dependent for whom you claim as an exemption on your income tax return or for whom you are legally responsible to provide health care under a Qualified Medical Child Support Order or other court or administrative order, as described in Section 14, *Other Important Information*; and
- the child is under the age of 26 unless the child has a disability (as defined under the Plan) in existence at the time the child would otherwise have ceased to qualify for coverage under the Plan. Documentation may be required.

Note: Your Dependents may not enroll in the Lubrizol CDHP unless you are also enrolled.

Cost of Coverage

You and The Lubrizol Corporation share in the cost of the Lubrizol CDHP. Your contribution amount depends on the medical coverage you select (Core, Standard, or Plus) and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of The Lubrizol Corporation's cost in covering a Domestic Partner will be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children will be paid using after-tax payroll deductions.

Your contributions are subject to review and The Lubrizol Corporation reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Lubrizol Benefits Center or by going to http://benefits.lubrizol.com.

How to Enroll

Enrollment may be done online at https://lubrizol.benefitsnow.com (or through a link on The Channel) or by calling the Lubrizol Benefits Center at 1-844-747-1641 within 30 days of the date you first become eligible for medical coverage. If you do not enroll within 30 days, you will need to wait until the next Annual Enrollment to make your benefit elections.

Special Enrollments

1. You may enroll yourself or you and your Dependents within 30 days of acquiring a new Dependent. Coverage will begin on the date the Dependent first becomes eligible for coverage (e.g., date of birth or marriage). You have 60 days to enroll a newborn or newly adopted child. No claims will be paid until enrollment occurs.

2. You may also enroll yourself and/or your Dependent(s) for coverage within 30 days of the loss of other coverage unless the loss is due to failure to pay premiums or for cause.

Satisfactory proof of the loss of other coverage must be provided. Coverage will be effective on the date of the loss of other coverage.

3. If you transfer to another work location, which results in a change in the medical and/or dental plan(s) to which you are eligible, you may enroll yourself and your Dependents within 30 days of the transfer. Coverage will begin on the date of transfer.

4. If you or your Dependents become ineligible for Medicaid or CHIP and lose coverage or if you or your Dependents become eligible for a state's premium assistance program, you have 60 days from the event to request enrollment in your Employer's plan. If you enroll within the 60 days, you or your Dependents will be covered under the Plan retroactive to the date of the triggering event. If these special circumstances apply to you, please contact your local benefit representative for further assistance.

If you or your Dependents do not enroll within the time limits described above, you will be able to enroll for coverage in the ***same Plan year*** of eligibility effective on the first day of the month following enrollment. You should promptly notify the Lubrizol Benefits Center at 1-844-747-1641 or view the Life Events link at http://benefits.lubrizol.com for any change that may affect your coverage or the coverage of a Dependent, such as:

- marriage;
- birth of a child;
- divorce/annulment;
- adoption of a child;
- death of a Dependent;
- transfer to another location;
- legal separation;
- Dependent becomes eligible;
- Dependent ceases to be eligible; and
- loss of Domestic Partner eligibility.

The Lubrizol CDHP may ask for proof of dependency to establish that a person is a Dependent eligible to enroll in the Lubrizol CDHP. Failure to timely provide the requested proof may result in delayed or denied enrollment.

Each year during Annual Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Annual Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth (60 days for a newborn or adoption), obtaining guardianship of a child, adoption of a child, or other family status change, you must contact the Lubrizol Benefits Center at 1-844-747-1641 within 30 days of the event. If you or your Dependents do not enroll within the time limits described above, you will be able to enroll for coverage in the ***same Plan year*** of eligibility effective on the first day of the month following enrollment. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

Once you have properly completed enrollment, coverage will begin on your date of hire or effective date of special enrollment. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for Spouse or Domestic Partner or Dependent children/stepchild acquired through marriage, birth, guardianship or adoption is effective the date of the family status change, provided you notify the Lubrizol Benefits Center within 30 days of the marriage, birth, adoption, or the beginning of legal guardianship (60 days for a newborn or adoption).

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Lubrizol CDHP:

- your marriage, divorce, legal separation or annulment;
- a Domestic Partner becomes eligible or loses eligibility;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse or Domestic Partner's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;

- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse or Domestic Partner's position or work schedule that impacts eligibility for health coverage;
- a change under another employer plan that has a period of coverage that differs from the Lubrizol CDHP's period of coverage;
- you experience a significant premium cost change upon changing employment status from full time to part time or from part time to full time;
- you were enrolled in a CDHP, no longer live and work in the Lubrizol CDHP service area, and the Lubrizol CDHP is no longer available to you;
- benefits are no longer offered by the Lubrizol CDHP to a class of individuals that includes you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Lubrizol Benefits Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Lubrizol Benefits Center within 60 days of determination of subsidy eligibility); or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you can make the change online at www.lubrizolbenefits.com or contact the Lubrizol Benefits Center within 30 days of the change in family status. If you or your Dependents do not enroll within the time limits described above, you will be able to enroll for coverage in the *same Plan year* of eligibility effective on the first day of the month following enrollment. Otherwise, you will need to wait until the next Annual Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At Annual Enrollment, she elects not to participate in Lubrizol medical coverage, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under The Lubrizol Corporation's medical coverage outside of Annual Enrollment.

SECTION 3 - HOW THE LUBRIZOL CDHP WORKS

What this section includes:

- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

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

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

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

Designated Network Benefits (known as Center of Excellence (COE)) apply to Covered Health Services that are provided by a Network Physician or Network Provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Lubrizol CDHP Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

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

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

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

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

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

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

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider.

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

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at 1-877-706-1735 or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of The Lubrizol Corporation or UnitedHealthcare.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the telephone number on your ID card to request a copy. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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

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

Designated Providers

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

Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

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

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

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

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you.

In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

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

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
    - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.

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

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

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

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

Non-Network Benefits

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

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.

- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

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

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

- **For Emergency Health Services provided by an non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

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

- **For Air Ambulance transportation provided by an non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and an non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expense are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are

responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

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

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There is a combined Network and Non-Network Annual Deductible for the Lubrizol CDHP. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Eligible Expenses charged by both Network and non-Network providers apply towards the Annual Deductible.

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

The Annual Deductible applies to all Covered Health Services under the Lubrizol CDHP, including prescription drugs as covered in the *Prescription Drug Attachment*, as administered by Caremark.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example
Let's assume that you receive Benefits for outpatient surgery from a Network provider. Since the Lubrizol CDHP pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

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

Eligible Expenses charged by both Network and non-Network providers apply towards the annual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Lubrizol CDHP, including prescription drugs as covered in the *Prescription Drug Attachment*, as administered by Caremark. Amounts applied to the Annual Deductible also apply to Out-of-Pocket Maximum.

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

The Lubrizol CDHP Features	Applies to the Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes
Coinsurance payments, including those for prescription drugs as covered in the *Prescription Drug Attachment*	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services which require prior authorization.

Care Management

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

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

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls 1-877-706-1735 regarding an upcoming treatment or service.

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

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

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call 1-877-706-1735 for support.
- **Inpatient care management** - If you are hospitalized, Personal Health Support Nurses will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or

follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call 1-877-706-1735.

Prior Authorization

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

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling 1-877-706-1735.

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

To obtain prior authorization, call 1-877-706-1735. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

Covered Health Services Which Require Prior Authorization

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

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

The services that require prior authorization from the Claims Administrator are:

- Ambulance - non-Emergency;
- Cellular and Gene Therapy;
- Clinical Trials;
- Congenital Heart Disease surgery;
- Diabetes Services;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Gender Dysphoria treatment as described under *Gender Dysphoria* in Section 6, *Additional Coverage Details*;
- Home health care including nutritional foods;
- Hospice care - inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics – Outpatient - Genetic Testing and sleep studies;
- Mental Health Care and Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including services at a Residential Treatment facility); intensive outpatient program treatment; psychological testing; outpatient electro-convulsive treatment; transcranial magnetic stimulation; extended outpatient treatment visits with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA);*
- Prosthetic Devices for items that will cost more than $1,000 to purchase or rent;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;

- Surgery - Outpatient - blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgeries, cochlear implant and orthognathic surgeries;
- Therapeutics Treatments – Outpatient - dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound; and
- Transplants.

Note: Certain services do not require you to obtain prior authorization, but do require you to provide notification to the Claims Administrator:

- Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.
- For obesity surgery services to be considered Covered Health Services, you must notify Bariatric Resource Services before the time a pre-surgical evaluation is performed.
- For infertility services to be considered Covered Health Services, participation in Fertility Solutions is required for member to have coverage.

For notification and prior authorization timeframes, and reductions in Benefits that apply if you do not provide notification or obtain prior authorization from the Claims Administrator or contact Personal Health Support, see Section 6, *Additional Coverage Details*.

Contacting the Claims Administrator or Personal Health Support is easy.
Simply call 1-877-706-1735.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Lubrizol CDHP, you are not required to obtain prior authorization before receiving Covered Health Services. Since Medicare pays benefits first, the Lubrizol CDHP will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

Chemotherapy Prior Authorization Program

The Chemotherapy Prior Authorization program helps ensure appropriate utilization of chemotherapy cancer treatments. UnitedHealthcare determines coverage for chemotherapy cancer treatments using the *National Comprehensive Cancer Center Compendium*®. With the prior authorization program, Network providers will be responsible for obtaining chemotherapy authorizations prior to Covered Persons receiving these services. Requests that meet NCCN guidelines receive immediate approval. Requests that require additional clinical review can take up to three business days for approval.

Please note this program does not require Covered Persons to obtain prior authorization. However, if a Covered Persons goes to a non-Network provider, the claim will still be subject to a review to ensure the request is in compliance with the UnitedHealthcare medical policy. If the claim is denied, the Covered Person will be held liable.

Women's Health and Cancer Rights
In compliance with the Women's Health and Cancer Rights Act of 1998, if you are receiving Benefits in connection with a mastectomy, the Plan will provide coverage in a manner determined in consultation with the attending Physician and patient, for: a) all stages of reconstruction of the breast on which a mastectomy has been performed, b) surgery or reconstruction of the other breast to produce a symmetrical appearance and, c) prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. The amount you must pay for such Covered Health Services (including Coinsurance and any Annual Deductible) is the same as is required for any other Covered Health Service.

Newborns' and Mothers' Health
In compliance with the Newborns' and Mothers' Health Protection Act of 1996, the Plan:

■ provides Benefits for a Hospital length of stay in connection with childbirth for the mother or newborn child of no less than 48 hours following a vaginal delivery, or no less than 96 hours following a delivery by cesarean section. The Plan may pay for a shorter stay if the attending Physician or other provider, after consultation with the mother, discharges the mother or newborn earlier.

■ does not require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

SECTION 5 - THE LUBRIZOL CDHP HIGHLIGHTS

Payment Terms and Features

The table below outlines the Annual Deductibles and Out-of-Pocket Maximums for the Core, Standard, and Plus Plans.

Plan Features	Network / Non-Network		
	Core	**Standard**	**Plus**
Annual Deductible[1] ■ Individual[2] ■ Employee Plus One[2] ■ Employee Plus Family[2] **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	 $4,250 $6,375 $8,500	 $3,250 $4,875 $6,500	 $2,250 $3,375 $4,500
Annual Out-of-Pocket Maximum[1] ■ Individual[3,4] ■ Employee Plus One[3,4] ■ Employee Plus Family[3,4] **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.	 $5,750 $7,875 $10,000	 $4,750 $6,375 $8,000	 $3,750 $4,875 $6,000
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay during the entire period you are enrolled in the Lubrizol CDHP.	Unlimited		

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[2]For the Core plan only, the annual out-of-pocket maximum for Employee Plus One and Employee Plus Family has an individual annual cap of $5,750. Once any one family member reaches the individual cap of $5,750, the Plan starts paying 100% of that person's covered expenses for the rest fo the Plan year. For the Standard, and Plus plan the Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the Employee plus one or Employee plus family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, if two people in a family are covered, the Employee plus one Deductible applies, and no one in the family is eligible to receive Benefits until the Employee plus one Deductible is satisfied. If three or more people in a family are covered, the Employee plus family Deductible applies, and no one in the family is eligible to receive Benefits until the Employee plus family Deductible is satisfied.

[3]The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Employee plus one or Employee plus family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, if two people in a family are covered, the Employee plus one Out-of-Pocket Maximum applies. If three or more people in a family are covered, the Employee plus family Out-of-Pocket Maximum applies.

[4]For the Core plan only, The Plan does require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Employee plus one or Employee plus family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does apply.

Schedule of Benefits

This table provides an overview of the Lubrizol CDHP's coverage levels (applies to Core, Standard, and Plus). For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 15, *Glossary*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
Acupuncture Services (in lieu of anesthesia only)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services		
■ Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Lubrizol CDHP Works*.		
Bariatric Resource Services (BRS) (Obesity Surgery) ***For obesity surgery services to be considered Covered Health Services, you must contact Bariatric Resource Services (BRS) (1-877-706-1735) before the time a pre-surgical evaluation is performed. Services must be rendered by a BRS Designated Provider. If services are not rendered by a BRS Designated Provider, no Benefits will be paid.***		
■ Physician's Office Services	*Designated Network Benefits (COE):* 90% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
■ Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	Not Covered
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	Not Covered
■ Lab and X-ray Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.	90% after you meet the Annual Deductible	Not Covered
Cellular and Gene Therapy For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	Designated Network Benefits (COE) – 90% after you meet the Annual Deductible Network Benefits – 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	Designated Network Benefits (COE) – 90% after you meet the Annual Deductible Network Benefits – 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
Dental Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetes Services		
■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
■ Diabetes Self-Management Items		
- diabetes equipment: insulin pumps	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
- diabetes supplies	Benefits for diabetes supplies are not covered under the Lubrizol CDHP. Coverage may be available under the prescription drug coverage.	
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Room Services - Outpatient		
■ Emergency Services	80% after you meet the Annual Deductible	
■ Non-Emergency Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Lubrizol CDHP Works*.		
Fertility Preservation for Iatrogenic Infertility	*Enrolled in Fertility Solutions Program,* 90% after you meet the Annual Deductible *If not enrolled in Fertility Solutions,* Not Covered	Not Covered
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Genetic Testing and Counseling	Depending upon where the Covered Health Service is provided, Benefits for Genetic Testing will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
Hearing Exam and Appliances Any combination of Network Benefits and Non-Network Benefits for hearing aid exams and hearing aids, including fitting, acquisition and dispensing fees, is limited to $500 every two calendar years.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care Up to 120 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Infertility Services For Network Benefits, Infertility services must be received from a Designated Provider.	*Enrolled in Fertility Solutions Program,* 90% after you meet the Annual Deductible *If not enrolled in Fertility Solutions,* Not Covered	Not Covered
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Care and Substance-Related and Addictive Disorders Services ■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Nutritional Counseling	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Lubrizol CDHP Works*, under *Eligible Expenses*.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy - Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
Preimplantation Genetic Testing (PGT) and Related Services	*Enrolled in Fertility Solutions Program,* 90% after you meet the Annual Deductible *If not enrolled in Fertility Solutions,* Not Covered	Not Covered
Preventive Care Services		
■ Physician Office Services	100% Annual Deductible does not apply	100% Annual Deductible does not apply
■ Lab, X-ray or Other Preventive Tests	100% Annual Deductible does not apply	100% Annual Deductible does not apply
■ Breast Pumps	100% Annual Deductible does not apply	100% Annual Deductible does not apply
Prosthetic Devices Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures		
■ Physician's Office Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
■ Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Including Chiropractic) Up to 20 visits per calendar year for spinal manipulation or chiropractic treatment	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Second Opinion	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 120 days per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spine and Joint - Orthopedic Surgeries Non-Network Benefits under this section include only the spine and joint surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, implant fees, durable medical equipment and supplies and non-surgical management of spine and joint will be the same as those stated under each Covered Health Service category in this section. See Section 6, *Additional Coverage Details*, for limits.	Designated Network Benefits (COE) – 90% after you meet the Annual Deductible Network Benefits – 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
Temporomandibular Joint (TMJ) Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services	Designated Network Benefits (COE) – 90% after you meet the Annual Deductible Network Benefits – 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Not Covered
Vision Examinations Only examinations due to a medical diagnosis	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Lubrizol CDHP:	
	Designated Network and Network Benefits	**Non-Network**
Wigs Up to $500 per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]Please obtain prior authorization before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Lubrizol CDHP pays Benefits; and
- Covered Health Services that require you to obtain prior authorization or prior advance notification before you receive them, and any reduction in Benefits that may apply if you do not obtain authorization.

This section supplements the second table in Section 5, *Lubrizol CDHP Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

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

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to," the intent is not to limit the description to that specific list. When the Lubrizol CDHP does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Acupuncture Services

The Lubrizol CDHP pays for acupuncture services given in lieu of anesthesia by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

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

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Lubrizol CDHP covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Room Services. See Section 15, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Room Services.

The Lubrizol CDHP also covers transportation provided by a licensed professional ambulance (either ground or Air Ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

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

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. Please remember for Non-Network Benefits, if you are requesting non-Emergency ambulance services, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) as soon as possible prior to the transport. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Bariatric Resource Services (BRS) (Obesity Surgery)

The Lubrizol CDHP covers surgical treatment of obesity provided by or under the direction of a Physician when either of the following is 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 treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- you have enrolled in the Bariatric Resource Services (BRS) program;
- you have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present;
- you are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4;
- you have a 3-month physician or other health care provider supervised diet documented within the last 2 years;
- you have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation; and

- you are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 15, *Glossary* and are not Experimental or Investigational or Unproven Services.

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

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 15, *Glossary*, for obesity surgery services. See *Bariatric Resource Services (BRS) Program* in Section 7, *Clinical Programs and Resources* for more information on the BRS program.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. All services must be rendered at a BRS program Designated Provider in order to be covered. You can contact Bariatric Resource Services by calling toll-free 1-877-706-1735.

Note: The services described under *Travel and Lodging Assistance Program* in Section 7*, Clinical Programs and Resources* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

For obesity surgery services to be considered Covered Health Services, you must contact Bariatric Resource Services (BRS) (1-877-706-1735) before the time a pre-surgical evaluation is performed. If you do not notify BRS prior to receiving services no Benefits will be paid, and you will be responsible for paying all charges. This is true even if you receive services at a BRS Designated Provider.

Your notification to BRS (1-877-706-1735) regarding your intention to have obesity surgery will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Cellular and Gene Therapy

The Lubrizol CDHP pays Benefits for Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

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

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

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

Clinical Trials

The Lubrizol CDHP pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip, and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; or
  - other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH) (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs;
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

    - comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    - ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Congenital Heart Disease (CHD) Services

The Lubrizol CDHP pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program facility. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

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

To receive Benefits under the CHD program, you must contact CHD Resource Services (1-888-936-7246) prior to obtaining Covered Health Services. The Lubrizol CDHP will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Lubrizol CDHP pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury;*
- *Physician Fees for Surgical and Medical Services;*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic;*
- *Therapeutic Treatments - Outpatient;*
- *Hospital - Inpatient Stay; and*
- *Surgery – Outpatient.*

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program facility.

Prior Authorization Requirement
Please remember for Non-Network Benefits you must obtain prior authorization from the Claims Administrator (1-877-706-1735) as soon as CHD is suspected or diagnosed. If you fail to obtain prior authorization as required, Benefits for Covered Health Services will be subject to a $500 reduction.

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

Dental Services

Dental services are covered by the Lubrizol CDHP when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury).

The Lubrizol CDHP also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Lubrizol CDHP, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within twelve months of the accident, or if not a Covered Person at the time of the accident, within the first twelve months of coverage under the Lubrizol CDHP.

The Lubrizol CDHP pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

The Lubrizol CDHP pays Benefits for the Covered Health Services identified below.

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

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

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs including:

- Insulin pumps that are subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies.
- Blood glucose meters including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

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

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed $1,000. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Durable Medical Equipment (DME)

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

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

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Lubrizol CDHP. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- speech generating devices. Speech generating devices (SGDs) are speech aids that provide individuals with severe speech impairment the ability to meet their functional speaking needs. Digitized speech devices, sometimes referred to as devices with "whole message" speech output, use words or phrases that have been recorded by an individual other than the SGD user for playback upon command of the SGD user. Speech

generating devices require formal written evaluation of cognitive and communication abilities by a speech-language pathologist. The formal, written evaluation must include, at a minimum, all of the following elements:

- a description of the functional communication goals expected to be achieved and treatment options; and
- a treatment plan that includes a training schedule for the selected device; and
- an assessment of whether the Covered Person's daily communication needs could be met using other natural modes of communication; and
- demonstration that the Covered Person possesses the cognitive and physical abilities to effectively use the selected device and any accessories to communicate; and
- evaluation of current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment; and
- for a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the Covered Person of the upgrade compared to the initially provided SGD; and
- rationale for selection of a specific device and accessories.

Accessories and upgrades for the SGD are considered a Covered Health Service if the medical necessity for each accessory is clearly documented in the formal evaluation. Only one speech generating device or speech generating software program per Covered Person at a time is considered medically necessary. Laptop computers, desktop computers, personal digital assistants (PDAs), or other devices must be dedicated SGDs. Software that enables a laptop computer, desktop computer, or PDA to function as a SGD is considered an SGD; however, installation of the program or technical support is not covered.

- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage;
- compression stockings/tights are covered (OTC and custom-made surgical support stockings) with a limit of up to 2 pairs per calendar year;
- cranial orthotic devices that are reconstructive and only when medically necessary for treating infants with the following conditions:
  - Craniofacial asymmetry with severe (non-synostotic) positional plagiocephaly when all the following criteria are present:
    - Infant is between 3-18 months of age;
    - Severe plagiocephaly* is present with or without torticollis;
    - There is documentation of a trial of conservative therapy of at least 2 months duration with cranial repositioning, with or without stretching therapy;
  - Craniosynostosis (i.e., synostotic plagiocephaly) following surgical correction;
    - Severe plagiocephaly is defined as an asymmetry of 10 mm or more in one of the following anthropometric measures: cranial vault, skull base, or orbitotragial depth; OR a cephalic index at least 2 standard deviations above or below the

mean for the appropriate gender/age. Clinical evidence demonstrates improved surgical outcomes with use of the orthotic;

- foot orthotics; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits are limited as stated below. Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Lubrizol CDHP.

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

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Any combination of Network Benefits and Non-Network Benefits for foot orthotics is limited to one pair per calendar year.

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

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Emergency Room Services - Outpatient

The Lubrizol CDHP's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician

determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

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

Fertility Preservation for Iatrogenic Infertility

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

- collection of sperm;
- cryo-preservation of sperm;
- ovarian stimulation, retrieval of eggs and fertilization;
- oocyte cryo-preservation; and
- embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Pharmaceutical Products - Outpatient*.

Benefits are not available for embryo transfer.

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

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

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in the section.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation of vagina)
  - Vulvectomy (removal of vulva)

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

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

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

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

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

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

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits you must obtain prior authorization (1-877-706-1735) as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises.

If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

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

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

Prior Authorization Requirement for Non-Surgical Treatment:
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.

Genetic Testing and Counseling

Benefits under this section include Genetic Testing and Genetic Counseling, when ordered by your Physician and approved by UnitedHealthcare. Not all Genetic Testing is a Covered Health Service.

Genetic Testing includes a wide range of evaluations used for the following, but not limited to, major categories:

- diagnosis of disease;
- prediction of future disease (disease recurrence, response to treatment); or
- prediction of drug reactions.

If you or your Physician have questions or would like additional information, please call UnitedHealthcare at 1-877-706-1735.

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) as soon as reasonably possible before BRCA Genetic Testing. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for non-urgent BRCA Genetic Testing services typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior

authorization. If you receive non-Network BRCA Genetic Testing services before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

Hearing Exams and Appliances

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

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

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

Any combination of Network Benefits and Non-Network Benefits for hearing aid exams and hearing aids, including fitting, acquisition and dispensing fees, is limited to $500 every two calendar years. For Covered Persons under age 21, routine hearing care is covered as described under *Preventive Care Services* in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by an agency or organization which is approved as a Home Health Agency under Medicare;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 15, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 15, *Glossary* for the definition of Skilled Care.

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

Any combination of Network Benefits and Non-Network Benefits is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior Authorization Requirement
Please remember for Non-Network home health care Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) five business days before receiving services, including nutritional foods, or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for non-urgent home health care services typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior authorization. If you receive non-Network home health care services before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
Please remember for inpatient, Non-Network hospice care Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) five business days before receiving services or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for non-urgent hospice care services typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior authorization. If you receive non-Network hospice care services before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

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

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for anesthesiologists, Emergency room Physicians, pathologists and radiologists.

The Lubrizol CDHP will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice, when a Semi-private Room is not available, or when treatment in a special care unit is necessary.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Room Services - Outpatient* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic Services*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Non-Network Benefits:

- for a scheduled admission: you must obtain prior authorization from the Claims Administrator (1-877-706-1735) five business days before admission or as soon as reasonably possible;
- for a non-scheduled admission (including Emergency admissions): you must notify the Claims Administrator (1-877-706-1735) within 48 hours after admission or on the same day of admission if reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for a scheduled admission typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior authorization. If you are admitted as scheduled to a non-Network Hospital before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

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

What is Coinsurance?
Coinsurance is the amount you pay for a Covered Health Service, not including the Deductible.

For example, if the Lubrizol CDHP pays 80% of Eligible Expenses for care received from a Network provider, your Coinsurance is 20%.

Infertility Services

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

- Assisted Reproductive Technologies (ART).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- ICSI - (intracytoplasmic sperm injection).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).

- Embryo transportation related network disruption.
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structual Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the SPD. Benefits for diagnostic tests are described under, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits*.

Benefits for certain Pharmaceutical Products, including specialty Pharmaceutical Products, for the treatment of Infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under *Pharmaceutical Products*.

Enhanced Benefit Coverage

Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Additional Benefit Coverage

Fertility Preservation for Non-Medical Reasons - when you would like to delay Pregnancy for non-medical reasons. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Criteria to be eligible for Benefits

To be eligible for the Infertility services Benefit you are not required to have a diagnosis of infertility. The below requirements do apply:

- You are a female under age 44 and using own oocytes (eggs).
- You are a female under age 50 and using donor oocytes (eggs). For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Child Dependents are eligible for Fertility Preservation when planned cancer or other medical treatment is likely to produce infertility/sterility.

Certain criteria to be eligible for Benefits may be waived for Fertility Preservation for medical and/or non-medical reasons.

Any combination of Network Benefits and Non-Network Benefits are limited to $25,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Physician office visits for the treatment of Infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.

There is a separate limit of $15,000 under the Outpatient Prescription Drug plan administered by Caremark.

Only charges for the following apply toward the infertility lifetime maximum:

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

For infertility services to be considered Covered Health Services, you must enroll in the Fertility Solutions Program (1-888-936-7246). If you do not notify the Fertility Solutions Program prior to receiving services no Benefits will be paid, and you will be responsible for paying all charges. This is true even if you receive services at a Fertility Solutions Program Designated Provider.

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists, and radiologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Limited to 18 Presumptive Drug Tests per year.

Limited to 18 Definitive Drug Tests per year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described below.

Prior Authorization Requirement
Please remember for Non-Network Benefits for Genetic Testing and sleep studies, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) five business days before scheduled services are received or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for a non-urgent sleep study typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior authorization. If you receive non-Network sleep study services before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office are covered.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists, and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Care and Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

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

- Intensive Outpatient Treatment.
- Outpatient treatment.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies (*Applied Behavioral Analysis)* that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

  These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

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

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

Prior Authorization Requirement
For Non-Network Benefits for:

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

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Mental Health Care/Substance-Related and Addictive Disorders Administrator (1-877-706-1735) as required, Benefits will be subject to a $500 reduction.

Nutritional Counseling

The Lubrizol CDHP will pay for Covered Health Services for nutritional counseling provided in a Physician's office by an appropriately licensed or healthcare professional when:

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

Some examples of such medical conditions include:

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

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

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Lubrizol CDHP pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's

home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits under this section do not include medications for the treatment of infertility.

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

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

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

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

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

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays and other

diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Please Note
Your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Lubrizol CDHP will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to the Lubrizol CDHP. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If you fail to obtain prior authorization as required, Benefits for the extended stay will be subject to a $500 reduction.

Healthy moms and babies
The Lubrizol CDHP provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

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

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

- PGT must be ordered by a Physician after Genetic Counseling;

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

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

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. This Benefit limit also includes services as described under *Fertility Preservation for Iatrogenic Infertility*.

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

Preventive Care Services

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

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

If not covered in the above guidelines, this preventive care benefit includes:

- mammography (film and digital) screening for all adult women;
- computed tomographic colonography (virtual colonoscopy) for screening for colon cancer;

- osteoporosis screening for all women age 50 and over (regardless of risk);
- cervical cancer screening or PAP test every three years for women ages 21-65 or co-testing (PAP/HPV) every five years for women ages 30-65;
- prostate cancer screening for all men age 40 and over; and
- routine physical examinations for adults.

Breast Pumps

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

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

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

- which pump is the most cost effective;
- whether the pump should be purchased or rented;
- duration of a rental; and
- timing of an acquisition.

For questions about your preventive care Benefits under this Plan call 1-877-706-1735.

Prosthetic Devices

Benefits are paid by the Lubrizol CDHP for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

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 Lubrizol CDHP may pay only the amount that would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

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

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

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Lubrizol CDHP if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at 1-877-706-1735 for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Lubrizol CDHP does not provide Benefits for Cosmetic Procedures, as defined in Section 15, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) five business days before undergoing a Reconstructive Procedure or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for non-urgent Reconstructive Procedure services typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior authorization. If you receive non-Network Reconstructive Procedure services before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

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

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Including Chiropractic)

The Lubrizol CDHP provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment (including Chiropractic);
- speech therapy;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke;
- pulmonary rehabilitation;
- cardiac rehabilitation;

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

The Lubrizol CDHP will pay Benefits for speech and language problems that result from identifiable organic or physiologic medical conditions and for diagnosable congenital etiology such as cleft lip, cleft palate, cerebral palsy and dento-facial abnormalities. Speech therapy is also covered when provided to address autism spectrum disorders. Speech therapy is not covered for treatment of symptoms that result from other non-curable developmental disorders such as developmental delay, mental retardation, Down's syndrome or for non-

organic/functional speech and language disorders such as lisping, stuttering, stammering and dysfunctions that are self-correcting. Maintenance therapy is not covered.

Benefits for physical and occupational therapy include services provided to address autism spectrum disorders.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Any combination of Network Benefits and Non-Network Benefits is limited to 20 visits per calendar year for Manipulative Treatment (including Chiropractic) and is only available to Covered Persons over the age of 13 with a musculoskeletal-related diagnosis from a Physician. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment (including Chiropractic) or if treatment goals have previously been met. Benefits under this section are not available for maintenance/ preventive Manipulative Treatment (including Chiropractic).

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Lubrizol CDHP pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Second Opinion

The Lubrizol CDHP will pay for an evaluation by a Physician not affiliated with the Covered Person's Physician to determine the need for surgery or other treatment which has been recommended by their Physician. This benefit will include up to but no more than two such evaluations. A second opinion is not a required service to obtain Benefits.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Lubrizol CDHP. Benefits include:

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

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Lubrizol CDHP does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 15, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits:

- for a scheduled admission: you must obtain prior authorization from the Claims Administrator (1-877-706-1735) five business days before admission or as soon as reasonably possible;
- for a non-scheduled admission (including Emergency admissions): you must notify the Claims Administrator (1-877-706-1735) within 48 hours after admission or on the same day of admission if reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for a scheduled admission typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior authorization. If you are admitted as scheduled to a non-Network facility before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

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

Spine and Joint - Orthopedic Surgeries

Benefits for certain inpatient and outpatient orthopedic surgeries which are ordered by a Physician. Orthopedic surgical procedures including but not limited to the following:

- Spine Fusion and disc surgery;
- Total joint replacement and joint revision surgeries; and
- Scopic procedures for joints.

Designated Network Benefits include Physician fees, the facility charge and the charge for supplies and equipment.

For all other Benefits, Physician fees are described under *Physician Fees for Surgical and Medical Services.*

Enhanced benefits are offered to members who enroll in the Orthopedic Health Support (OHS) Program and utilize an OHS Designated Provider (COE) for their surgery. These benefits include:

- 90% after deductible.
- A maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses per episode of care to and from a Designated Provider (COE). Travel expenses are available if the recipient lives more than 50 miles from facility.

You are not required to visit a Designated Provider. For members who do not enroll in the OHS program or use a Designated Provider, Lubrizol pays Benefits as described under

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

Outpatient services and treatment do not apply.

To enroll in the Orthopedic Health Support program: You or your doctor may call the toll-free number on your ID Card. When you enroll in the OHS program and use a Designated Provider you receive the highest level of Benefits available under the Plan.

Resources
As a program participant you can contact your Orthopedic Nurse team with any questions or concerns you might have, call toll-free at 1-888-936-7246 or email optumspineandjoint@optum.com.

Surgery - Outpatient

The Lubrizol CDHP pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for anesthesiologists, pathologists, and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For Non-Network Benefits for blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgeries, cochlear implant and orthognathic surgeries you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you are admitted as scheduled to a non-Network facility before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

Temporomandibular Joint (TMJ) Services

The Lubrizol CDHP covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a

Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

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

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

Therapeutic Treatments - Outpatient

The Lubrizol CDHP pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

Prior Authorization Requirement
Please remember for Non-Network Benefits for all outpatient therapeutic treatments, you must obtain prior authorization from the Claims Administrator (1-877-706-1735) five business days or as soon as reasonably possible before scheduled services are received or, for non-scheduled services, within 48 hours or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction. Keep in mind that the prior authorization process for non-urgent outpatient therapeutic treatment services typically takes five business days. Your non-Network provider may postpone or refuse to provide these services without prior authorization. If you receive non-Network outpatient therapeutic treatment services before obtaining prior authorization and authorization is not granted, the $500 reduction in Benefits will apply.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. Benefits are available to the donor and the recipient when the recipient is covered under the Lubrizol CDHP. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- CAR-T cell therapy for malignancies;
- pancreas;
- intestinal; and
- bone marrow (either from you or from 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 Health Service.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Lubrizol CDHP.

The Lubrizol CDHP has specific guidelines regarding Benefits for transplant services. Contact Optum at 1-888-936-7246 or the Claims Administrator at 1-877-706-1735 for information about these guidelines.

Note: The services described under *Travel and Lodging Assistance Program* in Section 7*, Clinical Programs and Resources* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
Please remember for Non-Network Benefits you must obtain prior authorization from the Claims Administrator (1-877-706-1735) as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

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

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Lubrizol CDHP provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 15, *Glossary*. When Urgent Care services are provided in a Physician's office, the Lubrizol CDHP pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

Virtual Care Services

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

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

Benefits are available for the following:

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

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

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

Vision Examinations

The Lubrizol CDHP pays Benefits for vision exams, including refraction, when the eye exam is due to a medical diagnosis.

Wigs

The Lubrizol CDHP pays Benefits for wigs and other scalp hair prosthesis for temporary loss of hair resulting from treatment of a malignancy.

Any combination of Network Benefits and Non-Network Benefits is limited to $500 per calendar year.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

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

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

The Lubrizol Corporation believes in giving you the tools you need to be an educated health care consumer. To that end, The Lubrizol Corporation has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and The Lubrizol Corporation are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Employee Assistance Program (EAP)

UnitedHealthcare offers free counseling and referral services nationwide through the Employee Assistance Program (EAP). Using a solution focused approach to care, they tailor their interventions to meet your individual needs. The program can help you and your immediate family members cope with issues such as:

- family or relationship problems;
- parenting difficulties;
- work-related problems;
- financial and legal issues;
- substance-related and addictive disorders or abuse;
- grief and loss; and

- anxiety.

Call 1-866-248-4094 to speak to a specially trained, master's-level specialist who will recommend the right resources for your specific life concern. Services are available any time, 24 hours a day, seven days per week and are strictly confidential in accordance with state and federal laws.

Health Survey

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

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

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

Reminder Programs

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

- mammograms for women;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees.

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

Decision Support

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

This program offers:

- access to health care information;
- support by a nurse to help you make more informed decisions in your treatment and care;
- expectations of treatment; and
- information on providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call 1-877-706-1735.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.

With **www.myuhc.com** you can:

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

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

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

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Coinsurance and Annual Deductibles;

- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card, or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease Management Services

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

These programs offer:

- educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call 1-877-706-1735.

Complex Medical Conditions Programs and Services

Bariatric Resource Services (BRS) Program

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

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

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Bariatric Resource Services (BRS) (Obesity Surgery)* in Section 6, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with travel and lodging assistance. Refer to *Travel and Lodging Assistance Program*.

Cancer Resource Services (CRS) Program

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

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

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

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Cancer Support Program

UnitedHealthcare provides a program that identifies and supports a Covered Person who has cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies treatment options.

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

For information regarding specific Benefits for cancer treatment within the Plan, see *Cancer Resource Services (CRS) Program*.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and

education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

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

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

Comprehensive Kidney Solution (CKS) program

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

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

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

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

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

Kidney Resource Services program (KRS) program
End-Stage Renal Disease (ESRD)

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

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have

been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

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

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

Orthopedic Health Support Program

Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond.

This program offers:

- Early intervention and appropriate care.
- Coaching to support behavior change.
- Shared decision-making.
- Pre- and post-surgical counseling.
- Support in choosing treatment options.
- Education on back-related information and self-care strategies.
- Long-term support.
- Access to Designated Providers.

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

If you are considering surgery you must contact an Orthopedic nurse prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

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

Transplant Resource Services (TRS) Program

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

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

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

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

Travel and Lodging Assistance Program

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

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease, transplant, and orthopedic health support programs offer a maximum of $10,000 per Covered Person per episode of care for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

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

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.

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

  Examples of items that are not covered:

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

Transportation

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

Women's Health/Reproductive

Maternity Support Program

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

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.

- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

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

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

Fertility Solutions

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

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

The Plan pays Benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions program provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.

Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact an Fertility Solutions case manager to determine a Network Provider prior to starting treatment. For infertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

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

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

SECTION 8 - EXCLUSIONS: WHAT THE LUBRIZOL CDHP WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Lubrizol CDHP Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Lubrizol CDHP Highlights*. Please review all limits carefully, as the Lubrizol CDHP will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "included but not limited to," the intent is not to limit the description to that specific list. When the Lubrizol CDHP does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;

2. aromatherapy;

3. hypnotism;

4. massage therapy;

5. Rolfing (holistic tissue massage); and

6. art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health* (*NCCIH*) of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment (including Chiropractic) and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services* in Section 6, *Additional Coverage Details*.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded;

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

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*;

3. dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*;

4. dental braces (orthodontics);

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

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Lubrizol CDHP, as identified in *Dental Services in* Section 6, *Additional Coverage Details*; and

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

Devices, Appliances and Prosthetics

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

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria or as described under *Durable Medical Equipmen*t in Section 6, *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include but are not limited to any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease;

3. the following items are excluded, even if prescribed by a Physician:

- blood pressure cuff/monitor;
- enuresis alarm;
- non-wearable external defibrillator;
- trusses; and
- ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for dedicated speech generating devices (SGDs), speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*;

7. oral appliances for snoring; and

8. powered and non-powered exoskeleton devices.

Drugs

(The excluded drugs listed below may be covered under the Prescription Drug Benefits as described in Attachment II.)

1. prescription drugs for outpatient use that are filled by a prescription order or refill;

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

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office;

5. over the counter drugs and treatments;

6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed;

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

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

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

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

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Lubrizol CDHP has agreed to cover them as defined in Section 15, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet; and
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes;

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. shoe inserts;

6. arch supports; and

7. shoes (standard or custom), lifts and wedges.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
   - Voice modification surgery.
   - Voice lessons and voice therapy.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:

   - ace bandages;
   - diabetic strips; and
   - syringes.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*;
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or

- urinary catheters for which Benefits are provided as described under *Urinary Catheters* in Section 6, *Additional Coverage Details;*

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health Care and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases, Mental and Behavioural Disorders section,* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

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

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service; and

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - electric scooters;

- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 15, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - sclerotherapy treatment of veins;
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. wigs except as described in Section 6, *Additional Coverage Details*; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Manipulative Treatment (including Chiropractic) to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition;

6. speech therapy, except as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Including Chiropractic)* in Section 6, *Additional Coverage Details*;

7. rehabilitation services and other treatments for autism;

   This exclusion does not apply to screenings or tests intended to diagnose autism spectrum disorders or to outpatient physical, occupational or speech therapy identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Including Chiropractic)* in Section 6, *Additional Coverage Details*;

8. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

9. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

10. psychosurgery (lobotomy);

11. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

12. chelation therapy, except to treat heavy metal poisoning;

13. Manipulative Treatment (including Chiropractic) for Covered Persons age 13 or under. For Covered Persons over the age of 13, Manipulative Treatment (including Chiropractic) unless there is a musculoskeletal-related diagnosis from a Physician, or provided to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

14. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

15. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Bariatric Resource Services (BRS)* in Section 6, *Additional Coverage Details*;

16. medical and surgical treatment of hyperhidrosis (excessive sweating);

17. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations;

18. breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which UnitedHealthcare determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*; and

19. intracellular micronutrient testing.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse or Domestic Partner, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

5. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

6. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

7. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

    - prior to ordering the service; or
    - after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. The following treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

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

   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
   - IVF for a traditional Surrogate.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

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

   - Donor eggs - The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under *Infertility Services* including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
   - Donor sperm - The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under *Infertility Services* including thawing and insemination.

4. The reversal of voluntary sterilization.

5. Infertility services not received from a Designated Provider.

6. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.

7. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

8. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

9. Infertility treatment following unsuccessful reversal of voluntary sterilization.
10. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. or is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

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

3. while on active military duty;

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible;

5. expenses that are incurred in a Hospital owned or operated by the United States Government, or for which the patient is eligible for reimbursement or indemnification through any charitable or governmental program; or

6. for Injury or Sickness for which there is non-group coverage (except individual health insurance plans) providing medical payments or medical expense coverage. If Benefits subject to this provision are paid or provided by the Plan, the Plan reserves all rights to recover the reasonable value of such Benefits as provided in Section 11, *Subrogation and Reimbursement*.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. health services for transplants involving animal organs; and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless they are necessary and are Covered Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging Assistance Program* in Section 7, *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Lubrizol CDHP's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 15, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 15, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

2. purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. eye exercise or vision therapy;

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

5. bone anchored hearing aids (BAHA) except when the Covered Person has either of the following:

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

If the Covered Person meets the above coverage criteria, Benefits are limited to one BAHA during the entire period of time the Covered Person is enrolled in the Plan. In addition, repairs and/or replacement for a BAHA for Covered Persons who meet the above coverage are not covered, unless the BAHA malfunctions.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:
   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing;

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:
   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:
   - that do not meet the definition of a Covered Health Service in Section 15, *Glossary*;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that arise out of, or in the course of, any employment for wage or profit (not limited to employment with The Lubrizol Corporation), or for which he or she is entitled to or eligible for benefits under any workers' compensation act or similar legislation;
   - that are received after the date your coverage under the Lubrizol CDHP ends, including health services for medical conditions which began before the date your coverage under the Lubrizol CDHP ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Lubrizol CDHP;
   - that exceed Eligible Expenses or any specified limitation in this SPD; or
   - for which a non-Network provider waives the Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be

Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization; and

9. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - required solely for purposes of education, sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration (this exclusion does not include immunizations for travel);
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders; or
   - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

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

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling 1-877-706-1735 or contacting the Lubrizol Benefits Center. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service; and
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Lubrizol CDHP allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Lubrizol CDHP paid.

Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260) or* the consent of UnitedHealthcare or Lubrizol, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Otherwise, nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

Unless UniredHealthcare or Lubrizol has provided its consent, the Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

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

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

Any such payment to a provider:

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

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

recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 10: Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call 1-877-706-1735 to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 15, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Lubrizol CDHP will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740816
Atlanta, GA 30374-0816

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at 1-877-706-1735 to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Urgent Appeals that Require Immediate Action

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

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Lubrizol CDHP offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 90 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a denied pre-service request for benefits and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling 1-877-706-1735 or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review, within five days of the external review request, to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process, unless the individual. is not required to do so; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

If UnitedHealthcare determines that your request for external review was not complete, UnitedHealthcare will issue a notice to you describing the information or materials need to make the request complete, and you will have until the later of the expiration of the four-month filing period, or 48 hours following receipt of the notification, to submit the materials or information.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO's request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

Upon receipt of a *Final External Review Decision* reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.

- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at 1-877-706-1735 for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 15, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Lubrizol CDHP must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**72 hours**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**48 hours** after the earlier of (i) receiving the additional information from you or (ii) the end of the period for providing the additional information
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal
You must appeal the first level appeal (file a second level appeal) within:	**90 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**72 hours** after receiving the second level appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days** (UnitedHealthcare may request a 15-day extension under certain conditions)
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days** (or if extension is requested, prior to the expiration of extension period)
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**90 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

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

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days** (UnitedHealthcare may request a 15-day extension under certain conditions)
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Post-Service Claims	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**90 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Plan, The Lubrizol Corporation or the Claims Administrator to recover reimbursement until you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against The Lubrizol Corporation or the Claims Administrator, you must do so within the shorter of (i) one year from the date of the final appeal denial (or the final denial by an Independent Review Organization, if applicable) or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

You cannot bring any legal action against the Plan, The Lubrizol Corporation or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section, or else you lose any rights to bring such an action against the Plan, The Lubrizol Corporation or the Claims Administrator.

Any legal action you bring against the Plan, The Lubrizol Corporation, or any officer, employee, committee, or affiliate of The Lubrizol Corporation must be brought in the U.S. District Court for the Southern District of Texas. By accepting Benefits under the plan, you consent to the exercise of personal jurisdiction over you in the U.S. District Court for the Southern District of Texas, and you waive the argument that that forum is not convenient for you. In the unlikely event that the U.S. District Court for the Southern District of Texas does not have jurisdiction over the legal action, the legal action must be brought in the U.S. District Court for the Northern District of Ohio, to which, by accepting Benefits under the Plan, you also consent to the exercise of personal jurisdiction over you, or if such court also lacks jurisdiction over the legal action, you may bring the legal action in any United States federal or state court that does have jurisdiction.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under the Lubrizol CDHP coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Lubrizol CDHP overpays Benefits.

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

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

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

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call 1-877-706-1735 to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

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

- the Lubrizol CDHP will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a Dependent;

- your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child;
- plans covering an active employee (or that employee's Dependent) pay before plans covering a laid-off or Retired Employee (or that person's Dependent);
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Lubrizol CDHP will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, the Lubrizol CDHP will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Lubrizol CDHP determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under the Lubrizol CDHP, and as a Dependent under your Spouse's plan, the Lubrizol CDHP will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. The Lubrizol CDHP will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When the Lubrizol CDHP is Secondary

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

- From the primary plan's allowable expense the Lubrizol CDHP subtracts the primary plan's benefit payment amount.
- To the remaining amount, the Covered Person's Deductible and Coinsurance, if any, are applied.

The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense When the Lubrizol CDHP is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under the Lubrizol CDHP.

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

- Employees with active current employment status and their Spouse or Domestic Partners who also are Medicare eligible; and
- individuals with end-stage renal disease, for a limited period of time; and
- individuals in the long term disability status who are still employed Lubrizol.

Medicare becomes primary when employment terminates for a Medicare-eligible Employee who is in long term disability status with Lubrizol, including that Employee's Medicare-eligible Dependents.

Determining the Allowable Expense When the Lubrizol CDHP is Secondary

If the Lubrizol CDHP is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an

"explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

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

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

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare in its sole discretion will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If This Plan is Secondary to Medicare

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

- The Lubrizol CDHP determines the amount it would have paid based Medicare's allowable expense.
- If the Lubrizol CDHP would have paid less than Medicare paid, the Lubrizol CDHP pays no Benefits.
- If the Lubrizol CDHP would have paid more than Medicare paid, the Lubrizol CDHP will pay the difference.

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

Medicare Crossover Program

The Lubrizol CDHP offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Lubrizol CDHP to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Lubrizol CDHP is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Lubrizol CDHP.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

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

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

Overpayment and Underpayment of Benefits

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

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

If the Lubrizol CDHP overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If The Lubrizol Corporation pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to The Lubrizol Corporation if:

- The Lubrizol Corporation's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

- all or some of the payment The Lubrizol Corporation made exceeded the Benefits under the Lubrizol CDHP; or
- all or some of the payment was made in error.

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, The Lubrizol Corporation may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Lubrizol CDHP. If the refund is due from a person or organization other than the Covered Person, The Lubrizol Corporation may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Lubrizol CDHP. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to The Lubrizol Corporation. The Lubrizol Corporation may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

If a Covered Person ultimately fails to provide information or payments owed to The Lubrizol Corporation, the Employee through whom the Covered Person is covered and such Employee's Dependents will be permanently terminated from coverage under Lubrizol CDHP.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

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

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

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

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

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

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- The Lubrizol Corporation in a workers' compensation case or other matter alleging liability; or
- any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators;

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

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to 1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and 2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or

- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 – NOTICE REGARDING PRIVACY OF PROTECTED HEALTH INFORMATION

Notice Regarding Privacy of Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require that the Plan provide you with this Notice Regarding Privacy of Protected Health Information. This notice describes (1) how the Plan may use and disclose your protected health information, (2) your rights to access and control your protected health information and (3) the Plan's duties and contact information.

Protected Health Information

"Protected health information" is health information created or received by the Plan that contains information that may be used to identify you, such as your name or address. It includes written or verbal health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present or future payment for health care.

The Use and Disclosure of Protected Health Information in Payment and Health Care Operations

Your protected health information may be used and disclosed by the Plan in the course of providing payment for treatment and conducting medical, prescription, vision and dental claims operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The Plan may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The Plan may use or disclose your protected health information in connection with your treatment, which includes the provision, coordination or management of health care and related services. For example, the Plan may disclose information to a treating specialist the name of your regular doctor so that the specialist may request the transfer of your test results from your doctor.

Payment. The Plan may use or disclose your protected health information to provide payment to you or your health care providers for services rendered to you by your health care providers. These uses or disclosures may include disclosures to your health care provider or to another group health care plan or insurer to obtain the information needed to process your claim for benefits.

Operations. The Plan may use or disclose your protected health information when needed for the Plan's medical, prescription, and dental claims operations for the purposes of management and administration of the Plan. For example, the Plan may use your information for claims operations may include: utilization management; disease management program activities; administration of the Plan's subrogation provisions; coordination of

benefits; claims management; reviewing provider performance and Plan performance; activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; conducting or arranging for medical review, legal services, actuarial services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; systems maintenance; and management activities.

Other Uses and Disclosures. The Plan may also use or disclose your protected health information to provide appointment reminders; to describe or recommend treatment alternatives or to provide information about other health-related benefits and services that may be of interest to you.

The Plan may use or disclose protected health information for underwriting purposes as permitted by law, but the Plan cannot use or disclose your genetic information for that purpose. Underwriting purposes include eligibility rules or determinations, including eligibility for enrollment or continued enrollment and for benefits under the plan; calculating premium or contribution amounts under the plan; applying pre-existing condition exclusions, if any; or activities related to creating, renewing or replacing any health insurance contract or health benefits.

The Plan may also disclose protected health information to The Lubrizol Corporation, the sponsor of the Plan. Any disclosure to The Lubrizol Corporation will be in accordance with the HIPAA privacy regulations.

Additional Uses and Disclosures Permitted without Authorization or An Opportunity to Object

In addition to payment and health care operations, the Plan may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The Plan will comply with any federal, state or local law that requires it to disclose your protected health information.

For Judicial and Administrative Proceedings. The Plan may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by the order or a signed authorization is provided.

For Workers' Compensation. The Plan may disclose your protected health information to comply with workers' compensation laws or similar Programs.

Uses and Disclosures Permitted with an Opportunity to Object

Subject to your objection, the Plan may disclose your protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. The Plan will inform you orally or in writing of these uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not respond to these disclosures, the Plan is able to infer from the circumstances that you do not object, or the Plan determines

that it is in your best interests for the Plan to disclose information that is directly relevant to the person's involvement with your care, then the Plan may disclose your protected health information. If you are incapacitated or in an emergency situation, the Plan may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You

Other than the circumstances described above, the Plan will not disclose your health information unless you provide written authorization. In particular the Plan will not, without your authorization, use or disclose your health information that consists of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by you or as otherwise permitted by law. The Plan must also obtain your authorization to use or disclose your information for most marketing purposes or to sell your information. You may revoke your authorization in writing at any time except to the extent that the Plan has taken action in reliance upon the authorization.

Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the Plan holds your protected health information, you may inspect and obtain a copy of the information included in a designated record set. A "designated record set" contains enrollment, payment, claims adjudication and case or medical management records systems maintained by or for the Plan, as well as any other records the Plan uses to make decisions regarding health care benefits provided to you. The Plan may deny your request to inspect or copy your protected health information if the Plan determines that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:

(1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and

(2) protected health information that is subject to a law that prohibits access to protected health information. You have the right to have a decision to deny access reviewed in some situations.

You must submit a written request to the Plan's Privacy Officer to inspect and copy your health information. The Plan may charge you a fee for the costs of copying, mailing, or other costs incurred by the Plan in complying with your request. Please contact the Privacy Officer at the number given at the end of this notice if you have any questions about access to your medical information.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the Plan not use or disclose specific sections of your protected health information for the purposes of payment or health care operations. Additionally, you may request that the Plan not disclose your health information to family members or friends who may be involved in your care or for notification purposes described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for whom you want the restriction to apply. Your request should be directed to the Privacy Officer.

The Plan may choose to deny your request for a restriction, in which case the Plan will notify you of its decision. Once the Plan agrees to the requested restriction, the Plan may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The Plan may terminate the agreement to a restriction in some cases.

The right to request to receive confidential communications from the Plan by alternative means or at an alternative location. You have the right to request to receive communications of protected health information from the Plan through alternative means or at an alternative location if you clearly state that the disclosure of all or part of that information could endanger you. The Plan will make every effort to comply with reasonable requests. However, the Plan may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact.

You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information. During the time that the Plan holds your protected health information, you may request an amendment of your information in a designated record set. The Plan may deny your request in some instances. However, should the Plan deny your request for amendment, you have the right to file a statement of disagreement with the Plan. In turn, the Plan may develop a rebuttal to your statement. If it does so, the Plan will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the Plan's disclosures of your protected health information made for the purposes other than payment or health care operations as described in this notice. The Plan is not required to account for disclosures (1) you requested, (2) you authorized by signing an authorization form, (3) to friends or family members involved in your care and (4) certain other disclosures the Plan is permitted to make without your authorization. The request for an accounting must be made in writing to the Privacy Officer and should state the time period that you wish the accounting to include, up to a six year period. The Plan is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The Plan will not charge you for the first accounting you request in any 12-month period. Subsequent accountings may require a fee based on the Plan's reasonable costs for compliance of the request.

The right to receive a paper copy of this notice. The Plan will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Plan's Duties

The Plan is required by law to ensure the privacy of your protected health information, to provide you with this notice of your rights and the Plan's legal duties and privacy practices, and to notify you in the event of a breach of your unsecured protected health information. The Plan must abide by the terms of this notice, as may be amended periodically. The Plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the Plan collects and maintains. If the Plan alters its notice, the Plan will provide a copy of the revised notice through regular mail or in person.

Complaints

If you believe that your privacy rights have been violated, you have the right to relay complaints to the Plan and to the Secretary of the Department of Health and Human Services. You may provide complaints to the Plan verbally or in writing. These complaints should be directed to the Privacy Officer. The Plan encourages you to relay any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Plan's contact person regarding the Plan's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the Plan should be directed to the Privacy Officer at the following address:

HR Director– Employee Benefits
The Lubrizol Corporation
29400 Lakeland Boulevard
Wickliffe, OH 44092

The Privacy Officer can be contacted by telephone at 440-347-5151.

SECTION 13 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, The Lubrizol Corporation will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Lubrizol CDHP will end on the earliest of:

- the last day of the month your employment with the Company ends;
- the date the Lubrizol CDHP ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from The Lubrizol Corporation to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire under the Plan, unless specific coverage is available for retired persons and you are eligible for that coverage.

Failure to Cooperate: If you (or your Dependents) are covered by another plan or you (or your Dependents) incur a claim for which this plan may have subrogation rights, the claim will not be paid until you provide the appropriate information.

If this Plan has already paid the claim despite the fact that you did not provide the appropriate information, or if the Plan pays a claim in error or in excess of the correct amount and you do not reimburse the Plan the difference, your (or your Dependents') future claims may be offset by the amount of the claim paid in error until you provide the information or reimburse the Plan. If you ultimately fail to provide the appropriate information or reimburse the Plan for claims paid in error, you and your Dependents will permanently lose coverage under the Plan.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;

- the last day of the month UnitedHealthcare receives written notice from The Lubrizol Corporation to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under the Lubrizol CDHP.

Other Events Ending Your Coverage

The Lubrizol CDHP will provide prior at least thirty days' written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and The Lubrizol Corporation find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact The Lubrizol Corporation has the right to demand that you pay back all Benefits The Lubrizol Corporation paid to you, or paid in your name, during the time you were incorrectly covered under the Lubrizol CDHP.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Lubrizol CDHP will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to The Lubrizol Corporation proof of the child's incapacity and dependency within 30 days of the date coverage would have otherwise ended because the child reached a certain age;
- you provide proof that the child is claimed as a Dependent on your tax return; and
- you provide proof, upon The Lubrizol Corporation's request, that the child continues to meet these conditions.

The proof might include medical examinations at The Lubrizol Corporation's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 30 days, the Lubrizol CDHP will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Lubrizol CDHP.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 15, *Glossary*.

Continuation coverage under COBRA is available only to plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if The Lubrizol Corporation is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

- an Employee;
- an Employee's enrolled Dependent, including 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 former Spouse or Domestic Partner.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse or Domestic Partner	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months[3]	36 months[3]

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse or Domestic Partner	For Your Child(ren)
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
The Lubrizol Corporation files for bankruptcy under Title 11, United States Code.2	36 months	36 months	36 months

[1]Subject to the following conditions: (i) notice of the 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 Lubrizol CDHP, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is 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.

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Lubrizol CDHP	36 months

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

Getting Started

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

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

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

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

- during Annual Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Lubrizol CDHP; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail 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 you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Plan Administrator with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. 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.

Trade Act of 2002

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.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- the date the entire Lubrizol CDHP ends; or
- the date coverage would otherwise terminate under the Lubrizol CDHP as described in the beginning of this section.

Note: If you selected continuation coverage under a prior coverage which was then replaced by coverage under the Lubrizol CDHP, continuation coverage will end as scheduled under the prior coverage or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Lubrizol CDHP coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Lubrizol CDHP by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Lubrizol CDHP coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or

- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

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

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 14 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and The Lubrizol Corporation;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

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

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

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

Your Relationship with UnitedHealthcare and The Lubrizol Corporation

In order to make choices about your health care coverage and treatment, The Lubrizol Corporation believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you decisions about whether the Lubrizol CDHP will cover or pay for the health care that you may receive (the Lubrizol CDHP pays for Covered Health Services, which are more fully described in this SPD); and

- the Lubrizol CDHP may not pay for all treatments you or your Physician may believe are necessary. If the Lubrizol CDHP does not pay, you will be responsible for the cost.

The Lubrizol Corporation and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Lubrizol Corporation and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Lubrizol Corporation and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between The Lubrizol Corporation, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not The Lubrizol Corporation's agents or Employees, nor are they agents or employees of UnitedHealthcare. The Lubrizol Corporation and any of its Employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employee's agents or employees of Network providers.

The Lubrizol Corporation and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, The Lubrizol Corporation and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not The Lubrizol Corporation's Employees nor are they employees of UnitedHealthcare. The Lubrizol Corporation and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. The Lubrizol Corporation and UnitedHealthcare are not liable for any act or omission of any provider.

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

The Lubrizol Corporation and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Lubrizol CDHP.

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The Lubrizol Corporation and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- interpret Benefits under the Lubrizol CDHP;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments; and
- make factual determinations related to the Lubrizol CDHP and its Benefits.

The Lubrizol Corporation and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Lubrizol CDHP. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, The Lubrizol Corporation may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that The Lubrizol Corporation does so in any particular case shall not in any way be deemed to require The Lubrizol Corporation to do so in other similar cases.

Information and Records

The Lubrizol Corporation and UnitedHealthcare may use your individually identifiable health information to administer the Lubrizol CDHP and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Lubrizol Corporation and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The Lubrizol Corporation and UnitedHealthcare will keep this information confidential. The Lubrizol Corporation and UnitedHealthcare may

also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Lubrizol CDHP, you authorize and direct any person or institution that has provided services to you to furnish The Lubrizol Corporation and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Lubrizol Corporation and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. The Lubrizol Corporation and UnitedHealthcare agree that such information and records will be considered confidential.

The Lubrizol Corporation and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Lubrizol CDHP, for appropriate medical review or quality assessment, or as The Lubrizol Corporation is required to do by law or regulation. During and after the term of the Lubrizol CDHP, The Lubrizol Corporation and UnitedHealthcare and its related entities may use and transfer the information gathered under the Lubrizol CDHP in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements The Lubrizol Corporation recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, The Lubrizol Corporation and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of

providing or arranging to provide the Covered Person's health care is less than or more than the payment.

- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Coinsurance as described in your *Schedule of Benefits*.

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

Rebates and Other Payments

The Lubrizol Corporation and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Lubrizol Corporation and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays and/or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Lubrizol CDHP do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If the Lubrizol CDHP is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Lubrizol CDHP is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Lubrizol CDHP and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official Plan document, the Plan document will govern. A copy of the Plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

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

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

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

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 15 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Lubrizol CDHP is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Lubrizol CDHP.

Addendum – any attached written description of additional or revised provisions to the Lubrizol CDHP. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

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

- surgical services;
- Emergency Room Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

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

Amendment – any attached written description of additional or alternative provisions to the Lubrizol CDHP. Amendments are subject to all conditions, limitations and exclusions of the Lubrizol CDHP, except for those that the amendment is specifically changing.

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

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

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Lubrizol CDHP will begin paying Benefits in that

calendar year. The Deductible is shown in the first table in Section 5, *Lubrizol CDHP Highlights*.

Annual Enrollment – the period of time, determined by The Lubrizol Corporation, during which eligible Employees may enroll themselves and their Dependents in the Plan options. The Lubrizol Corporation determines the period of time that is the Annual Enrollment period.

Bariatric Resource Services (BRS) – a program administered by UnitedHealthcare or its affiliates made available to you by The Lubrizol Corporation. The BRS program provides:

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

Benefits – Lubrizol CDHP payments for Covered Health Services, subject to the terms and conditions of the Lubrizol CDHP and any Addendums and/or Amendments.

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

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by The Lubrizol Corporation. The CRS program provides:

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

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

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Lubrizol CDHP.

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

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Lubrizol CDHP Works*.

Company – The Lubrizol Corporation.

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

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

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by UnitedHealthcare. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

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

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Lubrizol CDHP determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms;
- Medically Necessary;
- described as a Covered Health Service in this SPD under Sections 5 and 6, *Lubrizol CDHP Highlights* and *Additional Coverage Details*;
- provided to a Covered Person who meets the Lubrizol CDHP's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not otherwise excluded in this SPD under Section 8, *Exclusions*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Lubrizol CDHP. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

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

Dependent – an individual who meets the eligibility requirements specified in the Lubrizol CDHP, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be enrolled as a Dependent of more than one Employee.

Designated Network Benefits (known as Center of Excellence (COE)) – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Lubrizol CDHP Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or facility that:

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

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

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider – a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on

UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent.

The Employee and Domestic Partner must jointly sign and file with the Company an affidavit of domestic partnership available in the forms section of the Lubrizol benefits website: http://benefits.lubrizol.com.

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

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

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

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Lubrizol CDHP Works*.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following

evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

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

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

Emergency Health Services – with respect to an Emergency:

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

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

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

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

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

e. any other conditions as specified by the Secretary.

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

Employee – a regular Employee of the Employer who meets the eligibility requirements specified in the Lubrizol CDHP, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – The Lubrizol Corporation.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or

- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6*, Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6*, Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Lubrizol CDHP; and
- the reason(s) why the service or supply was not covered by the Lubrizol CDHP.

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

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

Genetic Counseling – counseling by a qualified clinician that includes:

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

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

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

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital – an institution, operated as required by law, which is:

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

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

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

Independent Freestanding Emergency Department – a health care facility that:

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

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

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

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

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

Intensive Behavioral Therapy (Applied Behavioral Analysis) – outpatient behavioral services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders.

Intensive Outpatient Treatment – a structured outpatient treatment program.

- for Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week; and
- for Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

Intermittent Care – skilled nursing care that is provided or needed either:

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

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

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

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

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

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

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available,

observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

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

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

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

Mental Health Care/Substance-Related and Addictive Disorders Administrator – the organization or individual designated by The Lubrizol Corporation who provides or arranges Mental Health Care and Substance-Related and Addictive Disorders Services under the Lubrizol CDHP.

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

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

with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits – description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Lubrizol CDHP Highlights* for details about how Network Benefits apply.

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

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

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Non-Network Benefits – description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Lubrizol CDHP Highlights* for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Lubrizol CDHP Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Lubrizol CDHP Works* for a description of how the Out-of-Pocket Maximum works.

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

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

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

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

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Lubrizol CDHP.

Plan – The Lubrizol Corporation Employee Benefits Plan.

Plan Administrator – The Lubrizol Corporation or its designee.

Plan Sponsor – The Lubrizol Corporation.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT) - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-A – for aneuploidy (formerly PGS);
- PGT-M - for monogenic disorder (formerly single-gene PGD); and
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

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

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

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

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

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

The amount is based on either:

1) an *All Payer Model Agreement* if adopted,
2) state law, or
3) the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

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

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

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

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

- it is established and operated in accordance with applicable state law for Residential Treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health Care/Substance-Related and Addictive Disorders 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.

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

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

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

Spouse – an individual to whom you are legally married.

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

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

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

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

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

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

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

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

Please note:

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

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

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

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

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Lubrizol CDHP administrative information, including your rights under ERISA.

This section includes information on the administration of the Lubrizol CDHP, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 15, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

The Lubrizol Corporation is the Plan Sponsor and Plan Administrator of The Lubrizol Corporation Employee Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Employee Benefits Administrative Committee
c/o Human Resources Director – Employee Benefits
The Lubrizol Corporation
29400 Lakeland Blvd
Wickliffe, OH 44092
(440) 943-4200

Claims Administrator

UnitedHealthcare is the Lubrizol CDHP's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Lubrizol CDHP's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
185 Asylum Street
Hartford, CT 06103-3408

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service for Legal Process is:

The Lubrizol Corporation
29400 Lakeland Blvd
Wickliffe, OH 44092
(440) 943-4200

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Lubrizol CDHP is administered as required by ERISA.

Type of Administration

The Lubrizol Corporation Employee Benefits Plan is a self-funded and insured welfare plan and the administration is provided through one or more third party administrators. The plan administered by UnitedHealthcare is self-funded.

Plan Name:	The Lubrizol Corporation Employee Benefits Plan
Plan Number:	501
Employer ID:	34-0367600
Plan Type:	Welfare Benefits Plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured & Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Lubrizol CDHP, you are entitled to certain rights and protections under ERISA. ERISA provides that all Lubrizol CDHP participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all Plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration of the U.S. Department of Labor; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Domestic Partner or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan are called "fiduciaries" of the Plan and have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

The Plan's Benefits are administered by The Lubrizol Corporation, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and The Lubrizol Corporation are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare and The Lubrizol Corporation are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at 1-877-706-1735.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at 1-877-706-1735.

ATTACHMENT II - PRESCRIPTION DRUGS

The Pharmacy Benefits described on the following pages are NOT administered by UnitedHealthcare. The administrator for the Pharmacy Benefits is CVS Caremark.

Participants in all of Lubrizol's medical options will receive their prescription coverage through CVS Caremark. The prescription drug benefit offers coverage at network retail pharmacies or through the mail service pharmacy for covered drugs prescribed to treat illness or injury. All covered prescription expenses will be applied to the Annual Deductible and annual Out-of-Pocket Maximums. Once the Annual Deductible is satisfied, a portion of the prescription benefit will be paid by the participant based on the applicable coinsurance percentage amount as described in the chart below. This will continue until the appropriate annual Out-of-Pocket Maximum is met.

Summary of Prescription Drug Benefits	
Retail Prescriptions	**Coinsurance Percentage**
Preventive Maintenance[1]	0%
Generic	10%
Brand Formulary	20%
Brand Non-formulary	30%
Lifestyle	50%
Mail Prescriptions	**Coinsurance Percentage**
Generic	10%
Brand Formulary	20%
Brand Non-formulary	30%
Biotech/Specialty	35%
Preventive Services Drugs*	0%

[1] Drugs considered "Preventive Maintenance" are included on CVS Caremark's "High Deductible Health Plan (HDHP) – Health Savings Account (HSA) Generics Only Preventive Therapy Drug List." Visit www.caremark.com or call 1-844-742-5087 for the current list.

*** The following categories of drugs are covered at 100% based on The U.S. Preventive Services Task Force (USPTF) guidelines and the Health Resources and Services Administration Health Plan Coverage Guidelines:**

Aspirin to prevent cardiovascular disease	**For men 45-79 years old and women 55-79 years old**
Iron Supplementation in Children	**Children 6 to 12 months**
Oral Fluorides	**Children less than 6 years old**
Folic Acid	**Women to age 55**
Tobacco Cessation	**Annual limit 2 cycles of treatment (12 weeks per cycle)**
Immunizations	**Children birth to age 18**
Contraceptive method	**Women with reproductive capacity**

Certain drugs used for Medication Assisted Treatment will be available with no member cost-sharing:

Drug Name	Strength
buprenorphine sublingual tab	2 mg
	8 mg
buprenorphine-naloxone sublingual tab	2 mg-0.5 mg
	8 mg-2 mg
naltrexone tablet	50 mg

Enrollment

Prescription coverage is provided with your Lubrizol medical benefit. If you choose to waive Lubrizol medical coverage, you will not have the option to enroll in prescription only coverage.

Administrator

The prescription benefit is administered by CVS Caremark. Most retail pharmacies, including all the large discount chains like CVS, Target, Wal-Mart and Walgreen's, and many small, independent pharmacies, are part of the CVS Caremark network. The prescription benefit also offers mail service and mail at retail features. After you enroll in the program, you will receive a brochure describing the program, an identification card and a form to use the mail pharmacy service.

The prescription drug benefit is administered by:

CVS Caremark 800 Biermann Court Mount Prospect, IL 60056-2173	
Mail Service Program:	CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467
Paper Claims:	CVS Caremark Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196
CVS Caremark Customer Care (Participants):	1-800-776-1355
CVS Caremark Customer Care (Pharmacists):	1-800-421-2342

Prescription Program

The prescription program is included in your Lubrizol medical coverage and features four tiers of payment for retail pharmacies and the mail service pharmacy program. There are different levels of coinsurance amounts for generic drugs, brand formulary (Primary Drug List), brand non-formulary, and biotech/specialty. Using brand formulary medications may save you money when generic drugs are not available.

Under the prescription program, you and the Plan each pay a percentage (coinsurance) of the cost of your prescriptions. All covered expenses including prescription drug, medical, behavioral health, and substance abuse will be applied to the annual general deductible and annual out-of-pocket maximums. When the annual out-of-pocket maximum has been reached, the Plan will pay 100% of the cost of covered prescriptions obtained through network providers for the remainder of the calendar year.

Prescription Program Features

Retail Pharmacy Benefit

Use a participating Caremark network retail pharmacy for short-term prescriptions of 30 days or less (with one refill). You will pay your coinsurance amount (after your deductible is met) directly to the pharmacy. The Plan will pay the remainder of the cost

Mail Service Pharmacy Benefit

The mail service pharmacy benefit allows you to obtain up to a 90-day supply* of maintenance or long-term prescription drugs. The program is easy and convenient. When your physician prescribes a new maintenance medication, ask him or her to write two prescriptions:

1. The first for up to a 90-day* supply plus refills, to be ordered through the mail service program; and

2. The second to be filled immediately at a Caremark participating retail pharmacy for use until you receive your prescription order from the mail service program.

*Please note: By law, Caremark must fill your prescription for the exact quantity prescribed, up to the 90-day limit. A prescription written for "30 days plus two refills" will be filled with one 30-day supply at a time; it does not equal a prescription written for "90 days." Lower limits may apply for certain categories of drugs.

Maintenance Choice - CVS Mail at Retail Pharmacy Program

Caremark has a special program which allows you to purchase a 90-day prescription at a CVS retail pharmacy for the same coinsurance as the 90-day mail order cost. This is a convenient option and provides access to a neighborhood pharmacist to discuss any concerns about your medications.

Not all drugs are eligible for this program. There are a limited number of drugs that are only available through the mail order pharmacy. Examples of drugs not eligible for Maintenance Choice include biotech and specialty drugs.

Generic Substitution

The prescription program requires generic drugs (A-rated only) to be substituted for brand name drugs, when available. Ifyou request or your physician requires brand name drugs to be dispensed, you will pay the difference between the cost of the brand name drug and the generic drug in addition to any applicable deductible or coinsurance.

Biotech and Specialty Drugs

Biotech drugs are those produced from living sources like microorganisms, and often are administered intravenously. They are used for the treatment of genetic diseases, autoimmune diseases, infectious diseases, chronic diseases and cancers. Among the drugs included in these categories are Rebif and Avonex (multiple sclerosis), Herceptin (cancer), Remicade and Enbrel (arthritis), human growth hormones, Rebetrol (severe infections) and other oncology therapies.

Specialty drugs are those used to treat specific, low-incidence chronic and/or genetic conditions. These products are typically very expensive and may require member-specific dosing, medical devices to administer the medication, and/or special handling and delivery.

Biotech and specialty drugs carry a coinsurance of 35% for mail service program and are only available through CVS Caremark Specialty Pharmacy.

CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides these products directly to you, along with the supplies, equipment and any care coordination needed.

Other Programs – Contact CVS/Caremark at 1-844-742-5087

Pharmacy Advisor

The Pharmacy Advisor program provides comprehensive support for participants with diabetic and cardiovascular chronic conditions. Pharmacists offer timely, personalized counseling by phone for participants that use CVS/Caremark Mail Service and face to face at CVS/Pharmacies. Employees eligible for the program will also receive Web-based tools and education materials.

Specialty Guideline Management (SGM)

The Specialty Guideline Management program helps ensure appropriate utilization of specialty medications. This program will only impact participants with a specialty prescription (includes biotech). Specialty drugs are typically used for the treatment of genetic diseases, autoimmune diseases, infectious diseases, oncological diseases and chronic diseases. These medications are typically very expensive and often require specific dosing, medical devices to administer the medication, and/or special handling and delivery. For continued treatment, a clinical review is required. Caremark will obtain the necessary clinical information from impacted participants' doctor's office and conduct the review. No action is required from impacted participants at this time.

Generic Copay Incentive

The Generic Copay Incentive program is being implemented to encourage the use of generic drugs over more costly brand drugs. Select brand drugs have been identified and impacted participants will receive a targeted communication explaining they are eligible for one free fill of the appropriate generic alternative to their brand drug. Please note, not all brand drugs are eligible for the Generic Copay Incentive program.

Generic Step Therapy

Members will be required to try a cost-effective generic before non-preferred single source brands are covered. Certain drug classes will require members to try more than one cost-effective generic before the non-preferred single source brands are covered.

Advanced Control Specialty Formulary™

The formulary includes both specialty generics and clinically effective brand therapies. The formulary also has drug exclusions in several classes where multiple, therapeutically equivalent products exist (similar safety and efficacy).

Transform Diabetes™

This opt-in program emphasizes tailored support for members with diabetes and incorporates both clinical care and cost management solutions (improving medication adherence, A1c control, and lifestyle management). As part of the diabetes program, members may receive:

- highly personalized support and coaching through CVS Health consumer touch points;
- comprehensive diabetes visits at Minute Clinic locations at no out-of-pocket cost, including A1c checks;

- a connected glucometer, which will share their blood glucose levels with a pharmacist-led team via a health cloud, enabling the team to identify potential issues and intervene with one-on-one coaching; and
- access to digital tools within the CVS Pharmacy mobile app, such as medication refill reminders and the ability to refill a prescription via two-way text messaging, to help reduce the complexity of daily disease management.

Limitations and Exclusions

The prescription program generally covers any FDA-approved A-rated generic or FDA-approved non-generic drug, and any of a select list of FDA-unapproved, legally marketed drugs identified as clinically appropriate by the plan's pharmacy benefit manager, prescribed in writing by a physician and which is an appropriate treatment of the participant's diagnosed injury or illness and which is not otherwise covered under another schedule of the Plan.

However, in addition to the limitations described elsewhere in this SPD, the following apply:

Preauthorization is required for any compounded prescription drug for which the ingredient cost exceeds $300. Authorization will be given only if any individual ingredient component being requested is FDA approved in the same finished dosage form of the compound. Coverage will be limited to one compounded drug per 25-day period per individual.

Certain categories and types of drugs require prior authorization to be eligible for coverage, based on information given by your physician to the Caremark pharmacy benefit representative. These include (but are not limited to): anabolic steroids, androgens (Androgel), medication for the treatment of hypoactive sexual desire disorder and testosterone.

Acne medications such as Retin A, Tretinoin, and Avita are covered for participants under age 26 by mail order only. Retinoids and other drugs in this category are not covered for participants who are 26 or older regardless of diagnosis.

Drugs that do not, by U.S. federal law, require a doctor's prescription, and are dispensed by a pharmacy or organization licensed to dispense drugs, are not covered.

Drugs with the sole purpose of promoting hair growth (e.g., Rogaine, Propecia) or those used for cosmetic purposes only (Renova) are not covered.

Erectile dysfunction drugs are only covered with a prescription from a physician and in the amount of up to six doses per month.

Experimental drugs or procedures are not covered. The term "experimental drugs" is defined as follows:

- the drug cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug is furnished; or
- the *drug required the patient to sign an informed consent document utilized with the drug,* which was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- the drug is considered by any governmental agency or subdivision as experimental or investigational, not reasonable and necessary, or any similar finding; or
- the drug is not covered under the Medicare reimbursement laws, regulations, or interpretations; or
- *reliable evidence shows that the drug is the subject of ongoing phase I or phase II clinical trials*; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- *reliable evidence shows that the prevailing opinion among experts regarding the drug is that further studies or clinical trials* are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug; or the written informed consent used by the treating facility or by another facility studying substantially the same drug.

Infertility drugs are limited to $15,000 benefit in a lifetime.

Lidocaine Quantity Limit and Post-Limit Prior Authorization – FDA-approved products that are lidocaine or lidocaine-containing formulations will be subject to a quantity limit with a post-limit prior authorization requirement (Emla (30gm), Lidocaine 2% gel (30gm), Lidocaine 4% gel (30gm), Lidocaine 5% ointment (50gm), Lidocaine 4% solution (50ml), Pliaglis 7-7% cream (30gm), Synera 70-70mg patch (2)).

Mail Service Pharmacy only – Certain categories and types of drugs are available only through the mail service pharmacy. These include anabolic steroids, androgens, and growth hormones. *Nutrition and dietary supplements* are not covered. Biotech and Specialty Drugs are only available through mail-order.

Opioid Management Program – The opioid management program contains the following limitations:

- The length of the first fill will be limited to seven days for immediate release, new, acute prescriptions for plan members with no history of prior opioid use. A physician can submit a prior authorization (PA) request if it is medically necessary to exceed the seven-day limit.

- The quantity of opioid products prescribed (including those that are combined with acetaminophen, ibuprofen or aspirin) will be limited up to 90 MME per day (based on a 30-day supply). Prescribers who believe their patient should exceed CDC Guideline recommendations can submit a PA request for up to 200 MME per day. Quantities higher than 200 MME per day would require an appeal.
- Opioid products containing acetaminophen, aspirin, or ibuprofen will be limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day.
- Use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation, unless the member has a previous claim for an IR or ER product, or the prescriber submits a PA.
- Opioid-naïve patients aged 19 years and younger are limited to no more than a three-day supply of short acting opioids. The strategy will include immediate release (IR) and immediate release combination opioid products. For patients whose clinical diagnosis may require a longer day supply for ongoing therapy, prescribers may apply for prior authorization on a case-by-case basis. Opioid prescriptions for cancer, sickle cell disease, hospice or palliative care are exempt from this three-day limit.

Other items not required to treat illness or injury are not covered.

Over-the-counter drugs, medications, and vitamins are not covered.

Smoking cessation medications that require a prescription are available up to two 12-week supplies per calendar year.

Smoking cessation over-the-counter products are not covered.

Topical Analgesics (patches/lotions/creams) containing ingredients (alone or in combination) in strengths typically used in over-the-counter analgesics for temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness are excluded.

Drugs taken for cosmetic purposes are not covered. This category includes drugs such as depigmenting, hair growth and hair removal agents.

Diabetic supplies including test strips, needles and glucometers are covered.

Certain drugs having limited clinical value and clinically appropriate, lower cost alternatives are not covered.

Important Notice from The Lubrizol Corporation About Your Prescription Drug Coverage and Medicare

If you or your family members are not currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice does not apply to you.

Please read this notice carefully. This notice has information about your current prescription drug coverage with The Lubrizol Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Lubrizol Corporation has determined that the prescription drug coverage offered by CVS Caremark is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you or your Dependent(s) decide to join a Medicare drug plan, your Lubrizol prescription drug coverage will be affected. For those individuals who enroll in a Medicare Part D plan, coverage under the Lubrizol prescription drug Plan will end for the individual and all covered Dependents.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with The Lubrizol Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage Contact your local benefits representative for additional information or call the Lubrizol Benefits Center at 1-844-747-1641.

NOTE: You'll get this notice each year and if the Lubrizol Prescription Drug Program has any changes which affect Medicare Part D. You also may request a copy of this notice at any time.

More Information About Your Options Under Medicare Prescription Drug Coverage More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Appeal Procedures

An appeal may be filed if:

- an Adverse Benefit Determination has been rendered on a Claim, or
- you believe that the benefits to which you are entitled to have not been provided under the Plan.

You have the right to request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. Your request must be made in writing to the Claims Administrator.

An appeal of an Adverse Benefit Determination must be made in writing (or orally by the attending physician, in the case of an Adverse Benefit Determination rendered on an Urgent Care Claim) and submitted to the Claims Administrator. An appeal of an Adverse Benefit

Determination must be made within 180 days after you receive notification of the Claims Administrator's Adverse Benefit Determination.

Submitting an Appeal

All appeals must be submitted to the Claims Administrator in writing. In the case of an appeal of an Adverse Benefit Determination rendered on an Urgent Care Claim, the attending physician may also call the Claims Administrator to submit an appeal.

Your appeal should include the following:

- Name of the person the appeal is for
- CVS Caremark Identification Number
- Date of Birth
- Written statement of the issue(s)
- Drug name(s) being appealed
- Documents, records or other information relating to the Claim

Your written appeal and supporting documentation may be mailed or faxed to the Claims Administrator:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician only toll-free number: 1-866-443-1183.

Claims Administrator's Review

The Claims Administrator will review the appeal of an Adverse Benefit Determination. The period of time that applies to when the participant will receive written notice (or oral notification to the attending physician for an Urgent Care Claim, if applicable, followed by written notification) of the Claims Administrator's decision on a Claim that has been appealed depends on the nature of the Claim, for example, a Post-Service Claim.

The Claims Administrator's decision will be communicated in writing to the participant. In the event that the Claims Administrator renders an Adverse Benefit Determination on appeal, the Claims Administrator will provide written notification, which will include:

- the specific reason or reasons for the Adverse Benefit Determination;
- specific reference to pertinent Plan provision on which the Adverse Benefit Determination was based;

- a statement that the participant is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim for benefits;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination; and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon written request; and
- if the Adverse Benefit Determination is based on a Medical Necessity, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Pre-Service Claim Appeal

The Claims Administrator will make a decision on an appeal of an Adverse Benefit Determination that was rendered on a Pre-Service Claim within 30 days after receipt of the appeal

Post-Service Claim Appeal

The Claims Administrator will make a decision on an appeal of an Adverse Benefit Determination that was rendered on a Post-Service Claim within 60 days after the receipt of the appeal.

Urgent Care Claim Appeal

The Claims Administrator will make a decision on an appeal of an Adverse Benefit Determination that was rendered on an Urgent Care Claim within 72 hours after the receipt of the appeal.

Scope of Review

During its review of an appeal of an Adverse Benefit Determination on a Claim, the Claims Administrator shall:

- take into account all comments, documents, records and other information submitted by the participant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents; and
- follow reasonable procedures to ensure that the applicable Plan provisions are applied to the participant in a manner consistent with how such provisions have been applied to other similarly-situated participants

The Claims Administrator shall serve as the final review under the prescription benefit and shall have sole and complete discretionary authority to determine conclusively for all parties,

and in accordance with the terms of the documents or instruments governing the prescription benefit, any and all questions arising from:

- administration of the prescription benefit and interpretation of all prescription benefit provisions;
- determination of all questions relating to participant or eligible individuals and eligibility for benefits;
- determination of all relevant facts;
- determination of the amount and type of medical benefits to be provided to any eligible individual or covered Eligible Dependent; and
- construction of all terms of the Plan.

Definitions

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a prescription benefit, including any such denial, reduction, termination of, or a failure to provide or make a payment that is based on a determination of a participant's eligibility to participate in the Plan.

Claim – A request for a prescription benefit that is made by the participant in accordance with the Plan's established procedures for filing benefit claims under the Plan.

Claims Administrator – The health care company authorized by the prescription benefit to administer prescription benefits under the prescription benefit.

Medically Necessary (Medical Necessity) – The determination of Medical Necessity is made by the Claims Administrator and is for pre-service claim denials that were upheld in the first appeal. Care is considered Medically Necessary if:

- it is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- it is based on recognized standards of the health care specialty involved; and
- it represents the most appropriate level of care depending on the seriousness of the condition being treated, with respect to the frequency and duration of services and the place where services are performed.

Post-Service Claim – A Claim for a benefit that is not a Pre-Service Claim.

Precertification – The process by which the Claims Administrator reviews the Medical Necessity of a particular medication and makes a determination for coverage based on a pre-defined set of criteria.

Pre-Service Claim – A Claim for a benefit that is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care, such as a request for pre-certification of a medication.

Urgent Care Claim – A Claim for care or treatment where a delay could seriously jeopardize the life or health of the patient or the ability to regain maximum function. Such a Claim is also one involving a condition that would, in the opinion of a Physician with knowledge of the condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment that is related to the Claim.

ATTACHMENT III - HEALTH SAVINGS ACCOUNT

What this attachment includes:

- About Health Savings Accounts;
- Who is eligible and how to enroll;
- Contributions;
- Additional medical expense coverage available with your Health Savings Account;
- Using the HSA for Non-Qualified Expenses; and
- Rolling over funds in your HSA.

Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the Lubrizol CDHP which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the Lubrizol CDHP that is associated with the HSA.

The Lubrizol Corporation has entered into an agreement with United HealthCare Services, Inc., Hartford, CT ("UnitedHealthcare"), under which UnitedHealthcare will provide certain administrative services to the Lubrizol CDHP and HSA.

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

The HSA described in this section is not an arrangement that is established and maintained by The Lubrizol Corporation. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the Lubrizol CDHP described in the SPD.

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

You have three tools you can use to meet your health care needs:

- The Lubrizol CDHP, a high deductible medical plan which is discussed in your Summary Plan Description;
- an HSA you establish; and
- health information, tools and support.

Benefits available under the Lubrizol CDHP are described in your medical plan Summary Plan Description (SPD).

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

- accumulate over time with interest or investment earnings;
- are portable after employment; and
- can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible And How To Enroll

Eligibility to participate in the Health Savings Account is described in the SPD for the Lubrizol CDHP. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS).
- must not participate in a full health care Flexible Spending Account (FSA);
- must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare);
- must not be claimed as a Dependent on another person's tax return;
- must not be enrolled in TRICARE or TRICARE for life;
- must not receive care from the Indian Health Service (exclusion doesn't apply if you are eligible for IHS services but have not received care in past three months); and
- must not receive benefits (other than preventive care) from the US Department of Veterans Affairs (exclusion doesn't apply if you have a disability rating or have not received benefits in past three months).

Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible Dependents' out-of-pocket costs under the medical plan, including Annual Deductibles and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the Lubrizol CDHP design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible Dependents, meaning your spouse and any other family members whom you are allowed to claim as Dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

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

Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the Lubrizol CDHP and COBRA premiums while COBRA coverage is in effect.

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

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

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

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

ATTACHMENT IV – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

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

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

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

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

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

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

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

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

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

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

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

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

ATTACHMENT V – GETTING HELP IN OTHER LANGUAGES OR FORMATS

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

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

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဝန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏇ ᏴᎵ ᏁᏟᏃᎮᏁ ᏁᏎᏍᏗᏁ ᏥᎪᏜᏔ ᎥᏏ ᏣᏤᎵ ᏙᏋ ᏴᎡ ᏁᎫᎪᏙᏁ ᎪᏟᏍᏙᏁ ᏆᎾᏲᏍᏗᏁᎢ, ᏧᏐᏬᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana.

Language	Translated Taglines
	E kama‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n’efu n’akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါခွဲးတါယာ်လၢနကဒီးန့ါဘဉ်တါမၤစၢးဒီးတါဂ့ါတါကျိုၤလၢနကျိုဉ်ဒဉ်နဝဲလၢတလိဉ်ဟ့ဉ်အ ပူၤဘဉ်နှဉ်လီၤ.လၢတါကယ့နှါပှၤကတိၤကျိုးထံတါတကၤအဂီၤကီးဘဉ်လီတဲစိအကျိုၤလၢကစၢဖိအတလိဉ်ဟ့ဉ်အပူၤလၢအအိဉ်လၢနတါအိဉ်ဆူဉ်အိဉ်ချအတါခဲဉ်တါကဲ့ အကၢးအလိၤဒီးဆိဉ်လီၤနီါဂၤ် 0 တကှ့်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711

Language	Translated Taglines
30. Kru-Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bąąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit ‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.

Language	Translated Taglines
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croatian	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito

Language	Translated Taglines
	para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܚܣܘܟܘܢ ܐܝܬܠܘܟܘܢ ܢܝܫܘܬܐ ܕܩܒܠܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܚܬܢܐܝܬ ܠܡܫܐܠܬܐ ܡܢ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܠܡ ܡܢܝܢܐ ܕܠܐ ܐܓܪܐ ܕܐܝܠܗ ܒܓܒܐ ܕܐܝܕܝ ܬܠܦܘܢ ܕܣܘܠܚܢܐ ܘܚܕ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг

Language	Translated Taglines
	перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM – REAL APPEAL

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

Real Appeal

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

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

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

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

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