IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JANCE HOY, On Behalf of Herself and All Others Similarly Situated, Plaintiff, v. UNITED HEALTHCARE SERVICES, INC., Defendant.	CASE NO. **CLASS ACTION COMPLAINT** **JURY TRIAL DEMANDED**

Plaintiff, Jance Hoy ("Plaintiff"), by and through her attorneys, brings this class action lawsuit, on behalf of herself and all others similarly situated, against Defendant, United Healthcare Services, Inc. ("UHC" or "Defendant"), and, except for information based on her own personal knowledge, alleges, upon information and belief based on the investigation conducted by her counsel, as follows:

I. NATURE OF ACTION

1. UHC is a health benefit programs provider. As part of its business, UHC provides benefits administration and third-party claims processing services to numerous employee benefit plans, including the health benefits plan sponsored and self-funded by Santander Holdings USA, Inc. -- the Santander Holdings USA, Inc. Flexible Benefits Plan (the "Plan").

2. Because UHC acts as a "fiduciary" of the employee benefit plans it administers, as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), UHC is obligated to administer plan benefits in accordance with the terms of the plan documents and applicable law. 29 U.S.C. § 1104(a)(1)(D). In administering plan benefits, UHC must adhere to ERISA's strict

duties of loyalty and care, including the obligation to act solely in the interests of the plan participants and the beneficiaries. 29 U.S.C. §§ 1104(a)(1)(A)(i) and 1104(a)(1)(B).

3. Notwithstanding these obligations and upon information and belief, at all relevant times, UHC has administered claims of the Plan and other ERISA plan participants and beneficiaries for lactation services in the Philadelphia, Pennsylvania metropolitan area, and in other geographic areas throughout the United States, in a manner contrary to the express terms and purpose of the Plan and the other ERISA plans it serves, as well as applicable law.

4. The Pregnancy Discrimination Act of 1978 ("PDA") and the 2010 Affordable Care Act ("ACA") require ERISA health plans to cover maternity-related expenses, and the ACA further requires breastfeeding support and supplies with no cost sharing on the part of the insured. Nevertheless, UHC has failed to provide in-Network (as defined below in paragraph 20) lactation consultants in the Philadelphia, Pennsylvania metropolitan area, and, upon information and belief, other geographic areas throughout the United States. Furthermore, UHC has refused and continues to refuse to reimburse participants in the Plan and other ERISA plans, such as Plaintiff, for their expenses incurred after being compelled to seek out-of-Network lactation services.

5. Contrary to the Plan's express claims procedures, UHC has failed to properly and timely process and/or respond to Plaintiff and other participants' benefit claims and appeals for denial of their benefit claims. In essence, UHC's claims administration is reminiscent of a Kafkaesque bureaucratic nightmare—written appeals do not qualify as appeals, disappear mysteriously into the "system," and are never substantively addressed or resolved, while claimants are repeatedly advised to make such written appeals when their previous written appeals are ignored and/or somehow have disappeared. UHC's claims "administration" process and violations of law detailed herein reflects a callous disregard for the rights and needs of insureds,

such as Plaintiff, and its behavior is particularly egregious when one considers the fact that these insured individuals are recent mothers confronting the challenges of caring for their newborn children, as well as themselves, during a period that can be emotionally and physically exhausting and in which Plaintiff and other similarly situated individuals should not be forced to endure the unwarranted denial of critical and needed health insurance coverage.

6. By administering benefits and processing claims in such a manner, UHC has denied participants and beneficiaries (collectively, "participants") in the Plan and other plan participants benefits to which those individuals are entitled under the terms of their respective ERISA plans. Moreover, by employing a benefit administration and claims processing system that furthers UHC's interests, rather than the interests of plan participants, UHC has breached its ERISA duties of loyalty and care.

7. As a result of UHC's unlawful healthcare benefit administration and claims processing practices, hundreds, if not thousands, of ERISA plan participants in the United States, including Plaintiff, have been: (a) improperly denied lactation and other medical service benefits; (b) forced to pay for lactation and other medical services which should have been approved and paid by the plans UHC administers; (c) forced to incur unnecessary time and expense in appealing UHC's improper denials of benefits; and/or (d) subjected to credit disparagement and the prospect of being denied future lactation or other medical services due to outstanding, unpaid medical bills.

8. Through this suit, Plaintiff seeks to recover, on her own behalf, her out-of-pocket expenses incurred for lactation services that should have been covered by the Plan, and, on behalf of herself and all others similarly situated, to enjoin UHC's improper and illegal practices, and recover other and additional relief as the Court deems appropriate and just.

II. JURISDICTION AND VENUE

9. This action is brought under ERISA. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e).

10. Venue is proper in this Court pursuant to 28 U.S.C. § 1391 and because a substantial part of the acts or omissions giving rise to the claims alleged herein occurred within this District, and the Defendant conducts significant business in this District.

11. This Court has personal jurisdiction over Defendant because it has purposefully availed itself of the privileges of conducting its business activities in the Commonwealth of Pennsylvania, Defendant has established minimum contacts sufficient to confer jurisdiction over them, and the assumption of jurisdiction over Defendant will not offend traditional notions of fair play and substantial justice. The exercise of jurisdiction over Defendant is, therefore, consistent with the constitutional requirements of due process.

III. PARTIES

12. Plaintiff is, and at all times relevant to this action has been, a resident of Montgomery County, Pennsylvania, and, thus, is a citizen of Pennsylvania. Plaintiff is, and was, at all relevant times, an employee of Santander Bank, N.A., a subsidiary of Santander Holdings USA, Inc,, and by virtue of that employment was a participant in the Plan.

13. Defendant is a corporation organized and existing under the laws of the State of Minnesota with its principal place of business located at 9700 Health Care Lane, Minnetonka, Minnesota 55343. As detailed above, UHC is in the business of providing health benefit plans and policies of health insurance, including individual health benefit plans, employer-sponsored group health plans, and government-sponsored health benefit plans. Defendant is the designated claims administrator for the Plan and other employer-sponsored group health plans.

14. As the claims administrator, Defendant has a business incentive to limit out-of-Network claims, whether to minimize its own expenses where it acts as a private insurance carrier or to minimize its clients' expenses, where the plan is self-funded.

IV. FACTUAL ALLEGATIONS

A. Federal Law On Maternity Care

15. Since 1978, the PDA has required employers of 15 or more employees that choose to provide their employees with health insurance to cover pregnancy-related expenses.

16. As explained by the United States Equal Employment Opportunity Commission:

> The Pregnancy Discrimination Act amended Title VII of the Civil Rights Act of 1964. Discrimination on the basis of pregnancy, childbirth, or related medical conditions constitutes unlawful sex discrimination under Title VII, which covers employers with 15 or more employees, including state and local governments. Title VII also applies to employment agencies and to labor organizations, as well as to the federal government. Women who are pregnant or affected by pregnancy-related conditions must be treated in the same manner as other applicants or employees with similar abilities or limitations.
>
> Title VII's pregnancy-related protections include:
>
> . . .
>
> • **Health Insurance**
> Any health insurance provided by an employer must cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions. An employer need not provide health insurance for expenses arising from abortion, except where the life of the mother is endangered.
>
> Pregnancy-related expenses should be reimbursed exactly as those incurred for other medical conditions, whether payment is on a fixed basis or a percentage of reasonable-and-customary-charge basis.
>
> The amounts payable by the insurance provider can be limited only to the same extent as amounts payable for other conditions. No additional, increased, or larger deductible can be imposed.
>
> Employers must provide the same level of health benefits for spouses of male employees as they do for spouses of female employees.

The U.S. Equal Employment Opportunity Commission, *Facts About Pregnancy Discrimination*, Sept. 8, 2008, *available at* https://www.eeoc.gov/facts/fs-preg.html (last visited Sept. 29, 2016).

17. In 2010, the ACA expanded the maternity-related coverage requirement to all new individual and small group policies. 42 U.S.C. § 18022((b)(1)(D). Thus, beginning August 1, 2012, unless grandfathered, all health insurance plans, including employer-sponsored health plans, must cover, with no charge to the patient for "a copayment, coinsurance or deductible for those services when they are delivered by a network provider," "[c]omprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment." U.S. Department of Health and Human Services, Health Resource and Services Administration, *Women's Preventive Services Guidelines*, *available at* http://www.hrsa.gov/womensguidelines/ (last visited Sept. 29, 2016); 29 C.F.R. 2590.715-2713. Section 715 of ERISA, 29 U.S.C. § 1185d, incorporates the pertinent requirements of the ACA into ERISA.

B. The Plan Terms And Appeals Process

18. In compliance with federal law, the Plan covers maternity services. Pursuant to the Summary Plan Description ("Plan Description"), attached hereto as Exhibit "A," the "Benefits for Pregnancy – Maternity Services will be the same as those stated under each Covered Health Service category." Ex. A, at 18.

19. The "List of Covered Preventative Care Services" includes "Breastfeeding education" or, in other words, lactation consulting services. *Id.*, at 18.

20. Preventative Care Services expenses are covered 100% if within the "Network," which is defined as "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." Ex.

A, at 18, 105. If the provider is out-of-Network, the Plan only covers 60% of the expense ***after*** meeting the "Annual Deductible," which is $1,000 for individuals and $2,000 for families. *Id.*, at 14, 18.

21. The Claims Administrator is defined as "UnitedHealthcare . . . and its affiliates, who provide certain claim administration services for the Plan." Ex. A, at 98. Its role "is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator," *i.e.*, Santander Holdings USA, Inc.

22. Pursuant to the Plan's claims procedures, a participant may make three types of claims for benefits for out-of-Network services: (1) Urgent Care request for benefits; (2) Pre-Service request for Benefits; and (3) Post-Service request for Benefits. Ex. A, at 63-64, 66-67.

23. An Urgent Care request for benefits is defined as "a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, Glossary," with "Urgent Care services" defined as "treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection." Ex. A, at 66, 109-110.

24. A Pre-Service request for benefits is defined as "a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UnitedHealthcare before non-Urgent Care is provided." Ex. A, at 67.

25. A Post-Service request for benefits is defined as "a claim for reimbursement of the cost of non-Urgent Care that has already been provided." Ex. A, at 67.

26. To submit a claim, the participant can either fill out a claim form or "attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below," or include the following information in the letter:

- [the participant or beneficiary's] name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on [the participant or beneficiary's] ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:

  - the Current Procedural Terminology (CPT) codes;

  - a description of, and the charge for, each service;

  - the date the Sickness or Injury began; and

  - a statement indicating either that [the participant or beneficiary is], or [is] not, enrolled for coverage under any other health insurance plan or program. If [the participant or beneficiary is] enrolled for other coverage [the participant or beneficiary] must include the name and address of the other carrier(s).

Ex. A, at 63-64. Failure to provide that information "may delay any reimbursement." *Id.*, at 64.

27. To appeal a denied pre-service or post-service claim for benefits, the participant or his/her representative must submit in writing the following:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;

- the reason [the participant or beneficiary] disagree[s] with the denial; and
- any documentation or other written information to support [the participant or beneficiary's] request.

Ex. A, at 65. Denials for Urgent Care request for benefits need not be in writing, and may be completed over the phone. *Id.* at 65-66.

28. The following tables provide for the required timing under which UHC must respond, based upon the type of request:

Urgent Care Request for Benefits

Type of Request for Benefits or Appeal	**Timing**
If your request for benefits is incomplete, UHC must notify the claimant within:	24 hours
The claimant must then provide completed request for benefits to UHC within:	48 hours after receiving notice of additional information required
UHC must notify the claimant of the benefit determination within:	72 hours
If UHC denies the claimant's request for benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UHC must notify the claimant of the appeal decision within:	72 hours after receiving the appeal

* Urgent Care appeals need not be in writing.

Pre-Service Request for Benefits

Type of Request for Benefits or Appeal	**Timing**
If the claimant's request for benefits is filed improperly, UHC must notify the claimant within:	5 days
If the claimant's request for benefits is incomplete, UHC must notify the claimant within:	15 days

The claimant must then provide completed request for benefits to UHC within:	45 days
UHC must notify the participant of the benefit determination:	
- if the initial request for benefits is complete, within:	15 days
- after receiving the completed request for benefits (if the initial request is incomplete), within:	15 days
The participant must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UHC must notify the participant of the first level appeal decision within:	15 days after receiving the first level appeal
The participant must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UHC must notify the participant of the second level appeal decision within:	15 days

Post-Service Request for Benefits

Type of Request for Benefits or Appeal	**Timing**
If the claimant's claim is incomplete, UHC must notify the claimant within:	30 days
The claimant must then provide completed request for benefits to UHC within:	45 days
UHC must notify the participant of the benefit determination:	
- if the initial claim is complete, within:	30 days
- after receiving the completed claim for benefits (if the initial request is incomplete), within:	30 days
The participant must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UHC must notify the participant of the first level appeal decision within:	30 days after receiving the first level appeal

The participant must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UHC must notify the participant of the second level appeal decision within:	30 days

Ex. A, at 67-68.

C. Plaintiff's Experience And UHC's Failure To Provide A Network Lactation Counseling Provider In The Philadelphia Metropolitan Area And Administer The Plan's Claims Process In A Timely Fashion

29. Despite federal law and the terms of the Plan, UHC failed and continues to fail to provide complete coverage of a lactation specialist in the Philadelphia metropolitan area, which has a population of approximately six million people according to U.S. Census estimates. United States Census Bureau, *Population Estimates-Metropolitan Statistical Area; and for Puerto Rico, April 1, 20120 to July 1, 2015*, *available at* http://www.census.gov/popest/data/metro/totals/2015/index.html (last visited September 29, 2016).

30. UHC does not identify or offer any in-Network lactation consultants or services in the Philadelphia metropolitan area and in many areas throughout the United States.

31. After having a baby on September 4, 2015, Plaintiff tried to access lactation counseling within the Plan Network, which would be completely covered under the terms of the Plan. Failing to find any Network lactation counseling providers, Plaintiff was forced make appointments with an out-of-Network provider for the services that she and her baby urgently needed.

32. Prior to receiving lactation counseling services from the out-of-Network provider, however, Plaintiff called UHC on September 9, 2015, to request complete coverage for those services on the basis that her inability to secure a Network lactation counseling provider was caused solely by UHC's failure to contract such providers in the Philadelphia area. But during

the call, reference no. C3207, the UHC representative, "Deanna," informed Plaintiff that UHC would not cover the out-of-Network services. That action was plainly taken in violation of the requirements of the ACA.

33. Plaintiff was advised that any lactation consultant services offered during Plaintiff's hospital stay were covered, but any outpatient lactation services were not necessarily required to be covered by the ACA. Deanna further advised Plaintiff that the Plan was silent as to whether outpatient lactation services were covered, so UHC would deny coverage. Finally, Deanna promised to speak with a "consumer advocate" and call back the next day. Plaintiff subsequently received a voicemail from Deana confirming that no coverage would be provided.

34. Due to the urgency of the medical needs of Plaintiff and her baby, Plaintiff went ahead with the appointment with the out-of-Network provider on September 10, 2015, with subsequent appointments on September 28, 2015 and October 5, 2015. Plaintiff was charged and paid $155 for the initial visit on September 10, 2015, $95 for the second visit on September 28, 2015, and $95 for the third visit on October 5, 2015, a total of $345.

35. On October 22, 2015, Plaintiff called UHC again. The UHC representative, "Brittany," again informed Plaintiff that UHC would deny full coverage, but for different reasons than those given by Deanna of UHC on September 9, 2015.

36. Specifically, Brittany advised that Network services were covered at 100%, while out-of-Network services were covered at 60%. Because the lactation counseling services Plaintiff received were out-of-Network, the claims would be covered at 60%. Brittany also confirmed that the lactation counseling services were considered "preventative care" under the ACA, and discussed the possibility of a "gap exception" due to the lack of any Network providers within

reasonable distance. Brittany advised Plaintiff to file a written appeal with supporting information to UHC, and that Plaintiff would receive a substantive response within 30 days.

37. Following Brittany's advice and in accordance with the Plan's claims procedures, on October 23, 2015, Plaintiff submitted a written appeal with the denied claims enclosed to UHC, explaining her claims denial and the issues described above. Plaintiff received a form letter from UHC dated October 28, 2015, acknowledging that the written appeal had been received and informing Plaintiff that a substantive response would be provided within 30 days.

38. On November 17, 2015, Plaintiff received another form letter from UHC, this time informing Plaintiff that her "questions and concerns . . . do not qualify as an appeal," and "[a]s a result, [her] letter and any attached documents have been forwarded to the appropriate [UHC] department for review." That letter further stated that Plaintiff would receive a response "shortly." Plaintiff received no such response.

39. On December 29, 2015, Plaintiff called UHC to follow up on her October 23, 2015 written appeal. The UHC representative, "Mona," again confirmed that preventative care, such as the lactation counseling Plaintiff had sought and received, would be completely covered if the provider was in Network. Mona also informed Plaintiff that UHC did not keep a record of what "department" Plaintiff's October 23, 2015 written appeal was forwarded to pursuant to UHC's November 17, 2015 letter, and advised Plaintiff to send another letter describing her appeal. When asked to review Plaintiff's claims information, Mona could not identify any missing information and concluded that everything appeared to be in order, but suggested that Plaintiff add the specific claim numbers to her written appeal and resubmit the written appeal via a fax number Mona provided. Indeed, Mona informed Plaintiff that her claims had been assigned the following numbers: 5712475617, 5750139510, and 5750139511.

40. Following Mona's instructions, Plaintiff faxed a letter to UHC on the same day, December 29, 2015, again describing her claims denial and the issues described above, as well as her appeals experience, and enclosing the October 23, 2015 written appeal and the denied claims.

41. At the same time, on December 29, 2015, Plaintiff filed a complaint with the Pennsylvania Insurance Department, describing her experience with the appeals process and UHC's failure to respond substantively.

42. On December 31, 2015, Plaintiff received another form letter from UHC -- which was identical to the form letter she received on October 28, 2015 – again acknowledging that the written appeal had been received and informing Plaintiff that a substantive response would be provided within 30 days.

43. On January 11, 2016, Plaintiff received another form letter from UHC – which was identical to the letter Plaintiff received on November 17, 2015. Like the November 17, 2015 letter, Plaintiff was advised that her "questions and concerns . . . do not qualify as an appeal," and "[a]s a result, [her] letter and any attached documents have been forwarded to the appropriate [UHC] department for review." That letter further stated that Plaintiff would receive a response "shortly." Again, Plaintiff received no such response.

44. On January 19, 2016, Plaintiff received a letter from the Pennsylvania Insurance Department regarding her December 29, 2015 complaint. In the letter, the Pennsylvania Insurance Department informed Plaintiff that it was unable to assist Plaintiff because, according to UHC, Plaintiff never appealed her claim denials internally and/or UHC never formally denied her appeal, notwithstanding Plaintiff's repeated contact with UHC as detailed above, and her two written appeals on October 23, 2015 and December 29, 2015.

45. In sum, more than 120 days had passed since Plaintiff first requested and was informed that she would be denied complete coverage for services on September 9, 2015 and more than 81 days had passed since Plaintiff filed her first appeal on October 23, 2015, until UHC informed Plaintiff on January 11, 2016, that, yet again, her written appeal did not qualify as an appeal—which was not a substantive response. Plaintiff has not received any updates regarding her claims from UHC subsequent to the January 11, 2016 letter and prior to the filing of this Complaint.

V. CLASS ALLEGATIONS

46. This action is brought by Plaintiff on her own behalf and as a class action pursuant to Fed. R. Civ. P. 23(a), (b)(1), (b)(2), and/or (b)(3) on behalf of the following proposed Class and Sub-Class:

> **Claims Review Class:** All participants and beneficiaries in one or more of the ERISA employee health benefit plans administered by United Healthcare Services, Inc. ("UHC") in the United States, which provide benefits for healthcare services and for which claims administration duties are delegated to UHC, including the ERISA plan sponsored by Santander Holdings USA, Inc.
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> **Lactation Services Class:** All participants and beneficiaries in one or more of the ERISA employee health benefit plans administered by United Healthcare Services, Inc. ("UHC") in the United States for which UHC fails and refuses to provide payment or reimbursement for lactation services without cost to such participants and beneficiaries.

47. Numerosity/Impracticability of Joinder: The members of the Claims Review Class and the Lactation Services Class (together, "Classes") are so numerous that joinder of all members is impracticable. The exact number of the members of the Classes is unknown to Plaintiff at this time, and can only be ascertained through appropriate discovery, but Plaintiff is informed and believes that there are at least thousands of members of the Classes throughout the United States.

48. Commonality and Predominance: This action is properly brought as a class action because of the existence of questions of law and fact common to the Classes. Common questions of law and fact include, but are not limited to, the following:

(a) For the Claims Review Class, whether UHC utilizes a system that administers claims from ERISA plan participants and beneficiaries in contravention of the express terms and conditions of the ERISA plans' documents by failing to provide timely and substantive responses to requests for out-of-Network benefits and/or appeals to denials of requests for out-of-Network benefits;

(b) For the Claims Review Class, whether UHC utilizes a system that administers claims from ERISA plan participants and beneficiaries that violates ERISA by failing to provide timely and substantive responses to requests for out-of-Network benefits and/or appeals to denials of requests for out-of-Network benefits;

(c) For the Lactation Services Class, whether UHC violated and violates the express terms and conditions of the ERISA plans' documents by failing to provide either in-Network lactation service providers within a reasonable distance of the plan participants and/or beneficiaries or full coverage of out-of-Network lactation service providers for plan participants and/or beneficiaries who do not have in-Network lactation service providers within a reasonable distance;

(d) For the Lactation Services Class, whether UHC breached its fiduciary duties under ERISA by failing to provide either in-Network lactation service providers within a reasonable distance of the plan participants and/or beneficiaries or full coverage of out-of-Network lactation service providers for plan participants and/or beneficiaries who do not have in-Network lactation service providers within a reasonable distance;

(e) Whether the ERISA plans and/or their beneficiaries and participants are entitled to declaratory and injunctive relief; and

(f) Whether the ERISA plans and/or their beneficiaries and participants are entitled to an accounting, disgorgement, restitution, and/or other appropriate equitable relief.

49. Typicality: Plaintiff's claims are typical of the claims of the members of the Classes because, *inter alia*, Plaintiff and all members of the Claims Review Class have been injured and damaged in the same way as a result of UHC's systematic process for handling claims and appeals for out-of-Network benefits, while Plaintiff and all members of the Lactation Services Class have been injured and damaged in the same way as a result of UHC's refusal to provide either in-Network lactation service providers within a reasonable distance of the plan participants and/or beneficiaries or full coverage of out-of-Network lactation service providers for plan participants and/or beneficiaries who do not have in-Network lactation service providers within a reasonable distance.

50. Adequacy of Representation: Plaintiff will fairly and adequately protect the interests of the members of the Classes because her interests are aligned and do not conflict with the interests of the members of the Classes she seeks to represent. Plaintiff has retained highly competent counsel who are experienced in ERISA class action litigation and possess the requisite resources and ability to vigorously prosecute this case as a class action. The interests of the Classes will be fairly and adequately protected by Plaintiff and her Counsel.

51. Superiority: A collective action is superior to other available means for the fair and efficient adjudication of this controversy. Most of the members of the Classes would not be likely to file individual lawsuits because they lack adequate financial resources, access to attorneys or knowledge of their claims, because the damages suffered by individual members of the Classes

may be relatively small, and because the expense and burden of individual litigation would make it impossible for such persons to individually to redress the wrongs done to them. Individualized litigation presents a potential for inconsistent or contradictory judgments, and increases the delay and expense to all parties and to the court system presented by the complex legal and factual issues raised by UHC's conduct. Moreover, Plaintiff's claims for equitable relief are based on actions, and refusals to act, by UHC that are generally applicable to Plaintiff and all other members of the Classes, making final injunctive relief or other relief appropriate with respect to the Classes as a whole.

52. Plaintiff knows of no difficulty which will be encountered in the management of this litigation that would preclude its maintenance as a class action.

VI. EXHAUSTION OF ADMINISTRATIVE REMEDIES

53. As detailed above, Plaintiff has spent a significant amount of time and resources attempting to resolve her benefit disputes with UHC, and complied with the appeals process set forth in the Plan. Notwithstanding her efforts, UHC has either ignored or "lost" Plaintiff's repeated written appeals, and has failed to respond substantively to Plaintiff's repeated written appeals. Accordingly, Plaintiff has exhausted the administrative remedies available to her and/or further pursuit of the administrative remedies would be futile.

54. Futility is also particularly clear since Plaintiff has sufficiently alleged breaches of fiduciary duty by UHC, and the existence of an inherent conflict of interest between UHC's obligation as a fiduciary for ERISA plan participants and its business incentives, as alleged above.

55. Moreover, Plaintiff alleges that, contrary to the plans' documents and ERISA, UHC: (1) uses an administrative system that fails to provide timely responses to requests for out-of-Network benefits and/or appeals to denials of requests for out-of-Network coverage; and (2)

fails to provide either in-Network lactation service providers within a reasonable distance of the plan participants and/or beneficiaries, or full coverage of out-of-Network lactation service providers for plan participants and/or beneficiaries who do not have in-Network lactation service providers within a reasonable distance. Since Plaintiff is challenging systematic processes, rather than an exercise of discretion with respect to an individual claim, any further effort to exhaust administrative remedies would be a futile act that is not required as a matter of law.

VI. EQUITABLE TOLLING

56. Plaintiff and other members of the Classes have been continuously and systematically denied benefits by UHC for lactation services and other health care services based on UHC's improper administration. Because UHC administered such claims based upon such improper methods created and known only to UHC, Plaintiff and other members of the Class and Sub-Class did not know, and could not have known, that UHC has been continuously breaching its fiduciary duties and administering benefits in a self-serving way that is inconsistent with the express terms of ERISA benefit plans and federal law. Accordingly, any statute of limitations which might otherwise bar any portion of the claims alleged herein, has been tolled under the doctrine of equitable tolling.

COUNT I

Declaratory and Injunctive Relief for UHC's Breaches of Fiduciary Duty in Violation of 29 U.S.C. §§ 1104(a)(1)(A)(I), 1104(a)(1)(B), and 1104(a)(1)(D), Violation of 29 U.S.C. § 1133, and For Other Appropriate Equitable Relief On Behalf of the Claims Review Class

57. Plaintiff re-alleges and incorporates the preceding paragraphs as if fully set forth herein.

58. Pursuant to 29 U.S.C. § 1132(a), Plaintiff brings this Count individually and on behalf of the Class under ERISA, 29 U.S.C. § 1101, *et seq.* By having been given and/or assumed

discretionary authority and responsibilities for administering healthcare benefits under employee benefit plans, UHC is a fiduciary as defined in 29 U.S.C. §§ 1002(21)(A), 1102(a)(2).

59. As the plans' fiduciary, UHC is obligated to discharge its duties "solely in the interest of the participants and beneficiaries" and exclusively for the purpose of providing and administering benefits to plan participants and beneficiaries. 29 U.S.C. §§ 1104(a)(1) and 1104(a)(1)(A)(I).

60. In carrying out these fiduciary duties, UHC is obligated to exercise ordinary care and must seek to administer plan benefits in strict accordance with the terms of the underlying plan documents. 29 U.S.C. §§ 1104(a)(1)(B) and 1104(a)(1)(D).

61. In addition, ERISA § 503, 29 U.S.C. 1133, requires every ERISA plan to provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

62. By utilizing a system when administering claims from ERISA plan participants and beneficiaries that fails to provide timely and substantive responses to requests for out-of-Network benefits and/or appeals to denials of requests for out-of-Network benefits, UHC has breached its fiduciary duties to: (1) discharge its duties "solely in the interest of the participants and beneficiaries" and exclusively for the purpose of providing and administering benefits to plan participants and beneficiaries; (2) exercise ordinary care; and/or (3) administer the plans' benefits in strict accordance with the terms of the underlying plan documents.

63. By utilizing a system when administering claims from ERISA plan participants and beneficiaries that fails to provide timely and substantive responses to requests for out-of-Network benefits and/or appeals to denials of requests for out-of-Network benefits, UHC has violated ERISA 503, 29 U.S.C. § 1133.

COUNT II

Declaratory and Injunctive Relief for UHC's Breaches of Fiduciary Duty in Violation of 29 U.S.C. §§ 1104(a)(1)(A)(I), 1104(a)(1)(B), and 1104(a)(1)(D) and for Other Appropriate Equitable Relief On Behalf of the Lactation Services Class

64. Plaintiff re-alleges and incorporates the preceding paragraphs as if fully set forth herein.

65. Pursuant to 29 U.S.C. 1132(a), Plaintiff bring this Count individually and on behalf of the Class under ERISA, 29 U.S.C. §1101, *et seq.* By having been given and/or assumed discretionary authority and responsibilities for administering healthcare benefits under employee benefit plans, UHC is a fiduciary as defined in 29 U.S.C. §1102(21)(A).

66. As the plans' fiduciary, UHC is obligated to discharge its duties "solely in the interest of the participants and beneficiaries" and exclusively for the purpose of providing and administering benefits to plan participants and beneficiaries. 29 U.S.C. §§ 1104(a)(1) and 1104(a)(1)(A)(I).

67. In carrying out these fiduciary duties, UHC is obligated to exercise ordinary care and must seek to administer plan benefits in strict accordance with the terms of the underlying plan documents. 29 U.S.C. §§ 1104(a)(1)(B) and 1104(a)(1)(D).

68. By failing to provide either in-Network lactation service providers within a reasonable distance of the plan participants and/or beneficiaries or full coverage of out-of-Network lactation service providers for plan participants and/or beneficiaries who do not have

in-Network lactation service providers within a reasonable distance, UHC has breached its fiduciary duty to discharge its duties "solely in the interest of the participants and beneficiaries," and exclusively for the purpose of providing and administering benefits to plan participants and beneficiaries, exercise ordinary care, and/or administer the plans' benefits in strict accordance with the terms of the underlying plan documents.

COUNT III

For Co-Fiduciary Breach and Liability for Knowing Breach of Trust On Behalf Of Both Classes

69. Plaintiff re-alleges and incorporates the preceding paragraphs as if fully set forth herein.

70. In the alternative, to the extent UHC is not deemed a fiduciary or co-fiduciary under ERISA, UHC is liable to Plaintiff and the Classes for all equitable relief as a non-fiduciary that knowingly participated in a breach of trust.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, on behalf of herself and all other persons similarly situated, requests this Court to award the following relief:

A. An Order declaring this action to be maintainable as a class action on behalf of the Claims Review Class and appointing Plaintiff as the representative, with her counsel as counsel for the Claims Review Class;

B. An Order declaring this action to be maintainable as a class action on behalf of the Lactation Services Class and appointing Plaintiff as the representative, with her counsel as counsel for the Lactation Services Class;

C. A declaratory judgment that UHC has breached its fiduciary duties to

Plaintiff and the Claims Review Class, in violation of 29 U.S.C. §§ 1104, and 1105;

D. A declaratory judgment that UHC has violated 29 U.S.C. § 1133;

E. A declaratory judgment that UHC has breached its fiduciary duties to Plaintiff and the Lactation Services Class, in violation of 29 U.S.C. §§ 1104, and1105;

F. An Order enjoining UHC from continuing to engage in the breaches of duty and violations of law described herein;

G. An accounting to the plans of the monies that UHC obtained by the breaches of duty and violations of law described herein;

H. Disgorgement, restitution, other monetary relief and restoration of benefits to participants and beneficiaries of claims that UHC wrongfully denied in connection with the breaches of duty and violations of law described herein;

I. Costs and disbursements of this action, including reasonable attorneys' and expert fees;

J. Pre-judgment and post-judgment interest; and

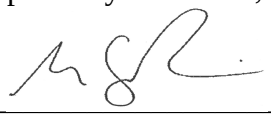
K. Such other, further, equitable, and different relief as may be just and proper.

NOTICE PURSUANT TO ERISA § 502(h)

To ensure compliance with the requirements of ERISA § 502(h), 29 U.S.C. § 1132(h), the undersigned hereby affirms that, on this date, a true and correct copy of this Complaint was served upon the Secretary of Labor and the Secretary of the Treasury by certified mail, return receipt requested.

DATED: October 25, 2016

Respectfully submitted,



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Attorneys for Plaintiff
And the Proposed Classes

EXHIBIT A

Summary Plan Description

Santander Holdings USA, Inc.
Medical Plan

Effective: January 1, 2013
Group Number: 752217

Passport Connect

Provider Network:
If you reside in New Hampshire, Massachusetts and Maine, the provider network is established by HPHC Insurance Company.
If you reside outside of New Hampshire, Massachusetts and Maine, the provider network is established by United HealthCare Services, Inc.

UnitedHealthcare®
A UnitedHealth Group Company

Harvard Pilgrim Health Care

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (888) 876-7830;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

Santander Holdings USA, Inc. 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 Santander Holdings USA, Inc. Flexible Benefits 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 this Plan.

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 14, *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 use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Santander Holdings USA, Inc. intends to continue this 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, your rights shall be determined under the Plan and not under this summary.

Employees who live in Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive Network Benefits through the Harvard Pilgrim Health Care Network when seeking Covered Health Services in

Massachusetts, Maine and New Hampshire or through the UnitedHealthcare Network when seeking covered health services outside Massachusetts, Maine and New Hampshire.

Employees who live outside Massachusetts, Maine and New Hampshire (and their covered dependents regardless of where those dependents live) will receive Network Benefits through the UnitedHealthcare Network.

Read this SPD thoroughly to learn how the Santander Holdings USA, Inc. Flexible Benefits Plan works. If you have questions contact the Santander Benefits Information Center at (800) 210-1426 Option 3 or call the number on the back of your ID card.

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. 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 **www.enrollone.com/shusa** or request printed copies by contacting the Santander Benefits Information Center at (800) 210-1426 Option 3.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Santander Holdings USA, Inc. 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 Plan;
- 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 Plan.

Eligibility

You are eligible to enroll in the Plan if you are a part-time or full-time Employee who is regularly scheduled to work 20 or more hours per week or a person under age 65 who retires while covered under the Plan.

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

- your same- or opposite-sex Domestic Partner, civil union partner or Spouse, as defined in Section 14, *Glossary*. (***Note:*** In all cases an ex-Spouse is not an eligible Dependent.);
- a child meeting each of the following criteria:
  - he or she must be your natural child, an adopted child, step child, child of your Domestic Partner, or a child for which you have documented legal guardianship from a court of law;
  - he or she may be covered up to the age of 26 (regardless of whether he or she is a student, is employed full-time, resides with you, or is your tax dependent); and
  - he or she is not otherwise eligible for Company benefits as an Employee; or
- a disabled dependent child of any age ((including a child of your Domestic Partner) who fully relies upon you for support.

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

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

How to Enroll and Cost of Coverage

Information on how to enroll for Plan Benefits and the cost of coverage is available in the Santander Flexible Benefits Plan Summary Plan Description or by calling the Santander Benefits Information Center at (800) 210-1426 Option 3.

Annual Open Enrollment

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

When Coverage Begins

Once you complete the enrollment process, coverage will begin on the first day of the month following 30 days of employment with Santander (or any of the employers in the Santander group of companies). Your time working for another Santander affiliate immediately prior to your transfer will count toward satisfying the 30-day waiting period.

Coverage for a Spouse or Dependent due to a qualified status change is effective the date of the event, provided you notify the Santander Benefits Information Center within 30 days from the date of the event.

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. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year if you experience a change in employment or family status. Refer to the Santander Flexible Benefits Plan Summary Plan Description for details on qualified status changes.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

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

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

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

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

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.

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

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

Employees who live in Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive Network Benefits through the Harvard Pilgrim Health Care Network when seeking Covered Health Services in Massachusetts, Maine and New Hampshire or through the UnitedHealthcare Network when seeking Covered Health Services outside Massachusetts, Maine and New Hampshire. For these Employees, references to the "Network" in this SPD refer to the Harvard Pilgrim Health Care Network when care is received Massachusetts, Maine and New Hampshire.

Employees who live outside Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive Network Benefits through the UnitedHealthcare Network.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services coordinated by a Network Physician in this manner, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

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

Network Providers

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 the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of Santander Holdings USA, Inc., UnitedHealthcare or Harvard Pilgrim Health Care.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to 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 Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 14, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. Santander Holdings USA, Inc. 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.

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 under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each Benefit Period for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the Benefit Period.

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

Copayment

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

Coinsurance

Coinsurance is the percentage of Eligible Expenses 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 Plan Benefits for outpatient surgery from a Network provider. Since the Plan 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 Benefit Period for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a Benefit Period exceed the annual

maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the Benefit Period.

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

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	No	No
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any penalties you incur by not obtaining prior authorization from Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No

How the Plan Works - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan and needs to see a Physician. He has met his Network Annual Deductible but not his non-Network Annual Deductible. The flow chart below shows what happens when he visits a Network Physician versus a non-Network Physician.

Network Benefits	Non-Network Benefits
1. Gary goes to see a Network Primary Physician, and presents his ID card.	1. Gary goes to see a non-Network Physician, and presents his ID card.
2. He receives treatment from the Physician. The Plan's Eligible Expense for the Network office visit equals $125.	2. He receives treatment from the Physician. The Eligible Expense for his visit is $175, however the Physician's fee is $225.
3. On his way out, Gary pays a $15 Copay. Since Network Primary Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.*	3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.**
4. The Plan pays $110 ($125 Eligible Expense minus $15 Copay).	4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.
5. Since Copays do not apply to the Out-of-Pocket Maximum, nothing is applied to Gary's Network Out-of-Pocket Maximum.	5. Gary receives a bill from the Physician, and pays the Physician directly.
	6. The Physician's office, at its discretion, might bill Gary for the remaining $50:

$225	-	$175	=	$50
(Physician's fee)		(Eligible Expense)		

Gary's $50 payment does not apply to his Annual Deductible.

7. UnitedHealthcare applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

*The $15 Copay is for the office visit only. If medical procedures such as endoscopic tests or X-rays are performed in addition to the office visit, the procedures are subject to the Plan Deductible and Coinsurance.

**Although non-Network providers have the right to request payment in full at the time of service, they bill UnitedHealthcare directly in most cases.

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support Nurse program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss

and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 6, *Additional Coverage Details* within each Covered Health Service category. A $250 penalty will apply if you do not obtain a required prior authorization.

It is recommended that you confirm with UnitedHealthcare 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 UnitedHealthcare 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 UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

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

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, 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 That Require Prior Authorization

Network providers are generally responsible for obtaining prior authorization from Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from Personal Health Support.

The Network services that require Personal Health Support authorization are:

- ambulance – non-emergent air and ground;
- dental services - accident-related;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- transplantation services.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from Personal Health Support before you receive these services. In many cases, a penalty will apply to your Non-Network Benefits if Personal Health Support has not provided prior authorization.

The non-Network services that require Personal Health Support authorization are:

- ambulance – non-emergent air and ground;
- dental services – accident-related;
- 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;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- manipulative treatment as described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;
- Mental Health 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; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;

- Substance Use Disorder 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; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- therapeutics - outpatient dialysis treatments as described under *Therapeutic Treatments - Outpatient* in Section 6, *Additional Coverage Details*; and
- transplantation services.

For prior authorization timeframes, and penalties that apply if you do not obtain prior authorization from Personal Health Support, see Section 6, *Additional Coverage Details*.

Note: If you are admitted to a Non-Network Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility as a result of an Emergency, you must notify UnitedHealthcare's Personal Health Support within two business days after the admission.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits on a secondary basis as described in Section 10, *Coordination of Benefits (COB)*. ***Note:*** An active Employee cannot have Medicare as primary coverage and this Plan as secondary. This Plan will remain the primary coverage as long as the Employee is actively working.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Copays[1,2]		
■ Hospital - Inpatient Stay (Copay is per admission)	Not Applicable	$500
■ Physician's Office Services - Primary Physician	$15	Not Applicable
■ Physician's Office Services - Specialist Physician	$25	Not Applicable
Annual Deductible[3,4]		
■ Individual	$350	$1,000
■ Family (not to exceed $350 per Covered Person for Network Benefits or $1,000 per Covered Person for Non-Network Benefits)	$700	$2,000
Annual Out-of-Pocket Maximum[5]		
■ Individual	$1,500	$3,000
■ Family (not to exceed $1,500 per Covered Person for Network Benefits or $3,000 per Covered Person for Non-Network Benefits)	$3,000	$6,000
Lifetime Maximum Benefit[6] There is no dollar limit to the amount the Plan will pay for Benefits that are essential health benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

[2]Copays do not apply toward the Annual Deductible or Out-of-Pocket Maximum.

[3]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. Network and non-Network Annual Deductibles do not cross-accumulate.

[4]When two or more covered family members are injured in the same accident, only one Deductible will be applied to the aggregate of Eligible Expenses related to the accident.

[5]Network and non-Network Out-of-Pocket Maximums do not cross-accumulate.

[6]Generally the following are considered to be essential health benefits under the Patient Protection and Affordable Care Act:
Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network**
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	60% after you meet the Annual Deductible
Dental Services - Accident Only (Copay is per visit)	100% after you pay a $25 Copay	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	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Durable Medical Equipment (DME)	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 Plan:	
	Network	Non-Network
Emergency Health Services - Outpatient	80% after you meet the Annual Deductible	
Hearing Aids Up to $1,000 per Benefit Period (combined Network and non-Network)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care Up to 100 visits per Benefit Period (combined Network and non-Network)	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 (Copay is per admission)	80% after you meet the Annual Deductible	60% after you pay a $500 Copay and after you meet the Annual Deductible
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 Services ■ Hospital - Inpatient Stay (Copay is per admission)	80% after you meet the Annual Deductible	60% after you pay a $500 Copay and after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit)	100% after you pay a $15 Copay	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders ■ Hospital - Inpatient Stay (Copay is per admission)	80% after you meet the Annual Deductible	60% after you pay a $500 Copay and after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit)	100% after you pay a $15 Copay	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	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury ■ Primary Physician (Copay is per visit)	100% after you pay a $15 Copay	60% after you meet the Annual Deductible
■ Specialist Physician (Copay is per visit)	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
In addition to the Office Visit Copay stated in this section, the Copay and/or Coinsurance and/or any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office: ■ lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics – Outpatient*; ■ diagnostic and therapeutic scopic		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*; ■ outpatient therapeutic procedures described under *Therapeutic Treatments – Outpatient*; and ■ rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.		
Pregnancy – Maternity Services A separate non-Network Hospital admission Copay will not apply for either a healthy or ill newborn child.	Benefits for Pregnancy – Maternity Services will be the same as those stated under each Covered Health Service category in this section	
Preventive Care Services See Section 6, *Additional Coverage Details* and *Addendum: List of Covered Preventive Care Services* for details on covered preventive care services.	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures ■ Physician's Office Services (Copay is per visit)	*Primary Physician* 100% after you pay a $15 Copay *Specialist Physician* 100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Hospital - Inpatient Stay (Copay is per admission)	80% after you meet the Annual Deductible	60% after you pay a $500 Copay and after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Prosthetic Devices	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
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
■ Physical Therapy and Occupational Therapy (Copay is per visit) Up to 30 visits per Benefit Period for physical and occupational therapy combined (combined Network and non-Network)	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Speech Therapy (Copay is per visit)	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Post-Cochlear Implant Aural Therapy (Copay is per visit)	*Primary Physician* 100% after you pay a $15 Copay *Specialist Physician* 100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Cognitive Rehabilitation Therapy (Copay is per visit)	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Pulmonary Rehabilitation	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 Plan:	
	Network	Non-Network
■ Cardiac Rehabilitation	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Manipulative (Chiropractic) Treatment (Copay is per visit) Up to 30 visits per Benefit Period for Manipulative Treatment (combined Network and non-Network)	100% after you pay a $25 Copay	60% after you meet the Annual Deductible, up to a maximum of $25 per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Copay is per admission) Up to 100 days per Benefit Period (combined Network and non-Network)	80% after you meet the Annual Deductible	60% after you pay a $500 Copay and after you meet the Annual Deductible
Substance Use Disorder Services		
■ Hospital - Inpatient Stay (Copay is per admission)	80% after you meet the Annual Deductible	60% after you pay a $500 Copay and after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit)	100% after you pay a $15 Copay	60% after you meet the Annual Deductible
Surgery - Outpatient	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	80% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Travel and Lodging (If services rendered by a Designated Facility) See Section 6, *Additional Coverage Details*, for limits	For patient and companion(s) of patient undergoing transplant procedures	
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Wigs	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]You must obtain prior authorization from Personal Health Support, as described in Section 4, *Personal Health Support* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from Personal Health Support before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

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

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

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. 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*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *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 Health Services.

The Plan 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.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, remember that you must obtain prior authorization from Personal Health Support as soon as possible prior to the transport. If authorization from Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

Dental Services - Accident Only

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

- treatment is necessary because of accidental damage to sound natural teeth;
- dental damage does not occur as a result of chewing, biting or other 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 Plan covers only dental services provided by a Physician or dentist immediately following an accidental injury. Follow-up services provided after the initial treatment are not Covered Health Services under the Plan.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic X-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings); and
- extractions.

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

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

Remember that you should obtain prior authorization from Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to obtain authorization before the initial Emergency treatment. When you obtain authorization, Personal Health Support can determine whether the service is a Covered Health Service.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including: ■ blood glucose monitors and related supplies; ■ insulin syringes with needles; ■ blood glucose and urine test strips; ■ ketone test strips and tablets; ■ lancets and lancet devices; ■ injection aids; and ■ infusion devices. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support 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. You must purchase or rent the DME from the vendor Personal Health Support identifies. If authorization from Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and

- appropriate for use in 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 Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- cranial orthotic devices;
- custom foot orthotics when prescribed by Physician; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

Benefits also include speech aid devices and tracheo-esophageal voice devices required to restore a method of speaking or for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

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

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.

Remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. To receive Network Benefits, you must purchase or rent the DME from the vendor Personal Health Support identifies or purchase it directly from the prescribing network physician. If authorization from Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

Emergency Health Services - Outpatient

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

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within two business days of the admission 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 not available for services to treat a condition that does not meet the definition of an Emergency.

Remember that you must notify Personal Health Support within two business days after you are admitted to a non-Network Hospital as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Hospital Stay will be subject to a $250 penalty.

Hearing Aids

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

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

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

Any combination of Network Benefits and Non-Network Benefits is limited to $1,000 per Benefit Period. This limit includes charges for hearing screenings and for the purchase, fitting, repair and replacement of the hearing aid device(s).

Home Health Care

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

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support 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 100 visits per Benefit Period. 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.

Remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving services or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

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.

Note: Any services provided by a Home Health Agency to a hospice patient do not count toward the visit limit for home health care services shown above under *Home Health Care*.

Remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving services. If authorization from Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

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 radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

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

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

For elective admissions, remember that you must obtain prior authorization from Personal Health Support five business days before admission to a Non-Network Hospital. If authorization from Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

For Emergency admissions (also termed non-elective admissions) remember that you must notify Personal Health Support within two business days after you are admitted to a Non-Network Hospital as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Hospital Stay will be subject to a $250 penalty.

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

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

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:

- 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 radiologists, anesthesiologists and pathologists.

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 under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

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

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

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

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

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted from the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Refer to Section 4, *Personal Health Support* for the specific services that require notification. Call the MH/SUD Administrator at the phone number that appears on your ID card. Without authorization, Benefits will be subject to a $250 penalty.

For Emergency admissions (also termed non-elective admissions) remember that you must notify Personal Health Support within two business days after you are admitted to a Non-Network facility as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Stay will be subject to a $250 penalty.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for

which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Refer to Section 4, *Personal Health Support* for the specific services that require notification. Call the MH/SUD Administrator at the phone number that appears on your ID card. Without authorization, Benefits will be subject to a $250 penalty.

For Emergency admissions (also termed non-elective admissions) remember that you must notify Personal Health Support within two business days after you are admitted to a Non-Network facility as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Stay will be subject to a $250 penalty.

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 Plan 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. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

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

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*.

> ***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 are typically 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.

Comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) require payment of certain routine services for prenatal care as preventive care services, with no member cost sharing. These services include, but are not limited to:

- routine prenatal obstetrical office visits;
- gestational diabetes screening;
- lab services for screenings such as anemia screening, bacteruria screening, Rh incompatibility screening and other tests specified under applicable guidelines;
- tobacco use cessation counseling specific to pregnant women; and
- immunizations recommended by the Advisory Committee on Immunization Practices.

Other maternity-related medical services not covered under the HRSA guidelines are Covered Health Services under the Plan, subject to any Copay, Coinsurance and/or Deductible. These services include, but are not limited to:

- radiology services such as obstetrical ultrasounds;
- delivery services; and
- prenatal services for a high-risk Pregnancy.

The Plan 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 this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

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

Remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support 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 authorization from Personal Health Support is not obtained, Benefits for the extended stay will be subject to a $250 penalty.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes 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 (HRSA), including:
  - well-woman visits;
  - domestic violence screening and counseling;
  - FDA-approved contraception methods, sterilization procedures and contraceptive counseling;
  - HIV counseling and screening for all sexually active women;
  - human papillomavirus DNA testing for all women 30 years and older; and
  - sexually transmitted infection counseling for all sexually active women annually.

In addition, preventive care Benefits defined under the HRSA requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are available only if breast pumps are obtained from a DME provider or Physician.

Note: For a listing of services currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) see *Addendum: List of Covered Preventive Care Services* in this SPD or visit the USPSTF A and B Recommendations web page at **http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm**.

When billed as preventive care, the following services are covered under this section:

- hearing screenings; and
- health counseling and referral to appropriate resources by your Physician about health issues, including:
  - healthy diet;
  - weight loss; and
  - smoking/tobacco use cessation.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests, including urinalysis;
- diagnostic consultations to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider as preventive care. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

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

Prosthetic Devices

Benefits are paid by the Plan 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.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.
Benefits are provided for the replacement of a type of prosthetic device once every three Benefit Periods.

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 Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. 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 Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *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.

> Remember that you must obtain prior authorization from Personal Health Support five business days before undergoing a Reconstructive Procedure. When you obtain prior authorization, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative (Chiropractic) Treatment

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

- physical therapy;
- occupational therapy;
- speech therapy;
- Manipulative Treatment;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, 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.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are limited to:

- 30 visits per Benefit Period for physical and occupational therapy combined; and
- 30 visits per Benefit Period for Manipulative Treatment.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

> Remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving Manipulative Treatment or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits for the extended stay will be subject to a $250 penalty.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan 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*.

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, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- 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 radiologists, anesthesiologists and pathologists.

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

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

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

Benefits are available only if:

- 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 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 Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 days per Benefit Period.

For elective admissions, remember that you must obtain prior authorization from Personal Health Support five business days before admission to a Non-Network facility. If authorization from Personal Health Support is not obtained, Benefits for the extended stay will be subject to a $250 penalty.

For Emergency admissions (also termed non-elective admissions) remember that you must notify Personal Health Support within two business days after you are admitted to a Non-Network facility as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Stay will be subject to a $250 penalty.

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted from the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Refer to Section 4, *Personal Health Support* for the specific services that require notification. Call the MH/SUD Administrator at the phone number that appears on your ID card.Without notification, Benefits will be subject to a $250 penalty.

For Emergency admissions (also termed non-elective admissions) remember that you must notify Personal Health Support within two business days after you are admitted to a Non-Network facility as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Stay will be subject to a $250 penalty.

Surgery - Outpatient

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

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 radiologists, anesthesiologists and pathologists.

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

Covered Health Services under this section include services and supplies for voluntary or therapeutic abortion.

Therapeutic Treatments - Outpatient

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

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

- education is required for a disease in which patient self-management is an important component of treatment; 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*.

Remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before scheduled dialysis services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

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 this Plan. 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;
- 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 United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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 Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Remember that you must obtain prior authorization from United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If authorization from United Resource Networks or Personal Health Support is not obtained, Benefits will be subject to a $250 penalty.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

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 transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $100 per day for the

patient or the patient plus one companion for up to 21 days per trip for one double-occupancy hotel room;

- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day;
- $250 per person per trip for round-trip coach airfare; up to six trips per transplant episode; and
- $25 per person per day for up to 21 days per trip for other expenses.

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

- Eligible Expenses for lodging for the donor (while not a Hospital inpatient). Benefits are paid at a per diem (per day) rate of up to $100 per day for up to seven days;
- $250 per trip for round-trip coach airfare for one trip per transplant episode; and
- $25 per day for up to seven days for other expenses.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

Support in the event of serious illness
If you or a covered family member 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 Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from chemotherapy.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

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

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Santander Holdings USA, Inc. believes in giving you the tools you need to be an educated health care consumer. To that end, Santander Holdings USA, Inc. 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 Santander Holdings USA, Inc. 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

Health Assessment

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

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

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Santander Holdings USA, Inc.'s way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Santander Holdings USA, Inc. has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

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 between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

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

Treatment Decision Support

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

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality 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; and

- coronary disease.

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, contact the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium℠ Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

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

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

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can 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 as a **www.myuhc.com** subscriber, 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 Copays 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 and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN 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 Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan 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, *Plan Highlights*. Review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. acupuncture;
3. aromatherapy;
4. hypnotism;
5. massage therapy;
6. Rolfing (holistic tissue massage); and
7. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment 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 - Accident Only* 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 accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* 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 – Accident Only* 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; and

   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 Plan, as identified in Section 6, *Additional Coverage Details*.

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 stabilize, straighten or re-shape a body part, except for cranial orthotic devices and custom foot orthotics as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*:

   Examples of excluded orthotic appliances and devices include, but are not limited to, braces that stabilize an injured body part, braces to treat curvature of the spine and any orthotic braces available over-the-counter.

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

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses;
   - 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 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.

Drugs

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

2. self-injectable 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);

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; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *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.

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;
   - 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; and

5. shoe inserts;

6. arch supports;

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

   This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease; and

8. shoe orthotics, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

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:

   - compression stockings and ace bandages; and
   - urinary catheters.

   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*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* 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/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

   - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
   - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
   - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
   - not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.

3. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;

5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;

8. learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

9. mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

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

11. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; and

12. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

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

2. non-preventive nutritional counseling for either individuals or groups;

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, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - 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;

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

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - 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 14, *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);
   - 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 to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

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

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

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

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

8. psychosurgery (lobotomy);

9. 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;

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

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. 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;

13. sex transformation operations and related services;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity even if there is a diagnosis of morbid obesity;

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

16. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered medical or dental in nature;

17. upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors or cancer or obstructive sleep apnea; and

18. breast reduction surgery except as coverage is 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*.

Providers

Services:

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

2. a provider may perform on himself or herself;

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

4. ordered or delivered by a Christian Science practitioner;

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

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

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

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

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

   This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including services required to treat or correct underlying causes of infertility and any assisted reproductive technology, regardless of the reason for the treatment;

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. in vitro fertilization regardless of the reason for treatment;

4. surrogate parenting, donor eggs, donor sperm and host uterus;

5. the reversal of voluntary sterilization;

6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

7. services provided by a doula (labor aide); and

8. parenting, pre-natal or birthing classes.

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. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

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

Transplants

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

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); 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. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. with respect to hospice care, dietitian services, homemaker services, maintenance therapy, dialysis treatment, custodial care, food or home-delivered meals are specifically excluded;.

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

5. Private Duty Nursing;

6. 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*;

7. rest cures;

8. services of personal care attendants;

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

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

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

3. purchase cost and associated fitting charges for eyeglasses or contact lenses. This exclusion does not apply to the first pair of eyeglasses or contact lenses required as a result of eye surgery;

4. bone anchored hearing aids except when either of the following applies:

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

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions;

5. eye exercise or vision therapy; and

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

All Other Exclusions

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

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; 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 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 are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
- for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
- that exceed Eligible Expenses or any specified limitation in this SPD;
- for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

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 and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:

   - Medically Necessary;
   - described as a Covered Health Service in this Summary Plan Description; and
   - not otherwise excluded in this Summary Plan Description under this Section 8, *Exclusions*.

9. 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.

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research.
    - related to judicial or administrative proceedings or orders; 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 Copay or Coinsurance, contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

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

Non-Network Benefits

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

How To File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting the Santander Benefits Information Center at (800) 210-1426 Option 3. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; 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 Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

You may not assign your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When an assignment is not obtained, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay a non-Network provider directly for services rendered to you. If Benefits are assigned or payment to a non-Network provider is made, Santander Holdings USA, Inc. reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Santander Holdings USA, Inc.

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

Coverage While Traveling Abroad

The Plan pays Benefits for Covered Persons while traveling outside the United States. Eligible Expenses for Emergency services are reimbursed at the Network benefit level, based on billed charges, and are subject to the Annual Deductible. Eligible Expenses for non-Emergency are reimbursed at the non-Network benefit level, based on billed charges, and are subject to the Annual Deductible. Any care received must be a Covered Health Service. If you receive treatment while traveling outside the United States, you must pay the provider at the time treatment is received and obtain appropriate documentation of services received including any bills, receipts and medical narrative. This information should be included when you submit your claim. If you have any questions about Benefits while traveling abroad, or before you travel, call UnitedHealthcare at the toll-free number on your ID card.

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 the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

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

Internal 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 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

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

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

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 Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine 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.

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 14, *Glossary*;

- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from 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**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

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

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided as soon as possible taking into account the medical exigencies but in any event 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.

Federal 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 the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; 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 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; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. 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 they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare'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 is that payment or referral will not be made, 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 the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against Santander Holdings USA, Inc. or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed.

You cannot bring any legal action against Santander Holdings USA, Inc. or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section, except for the external review process described above under *Federal External Review Program*. After completing the internal review process, if you want to bring a legal action against Santander Holdings USA, Inc. or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your internal appeal or you lose any rights to bring such an action against Santander Holdings USA, Inc. or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

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

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

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

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 the toll-free number on your ID card 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

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

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; 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 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 Plan 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, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan 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 this Plan, and as a Dependent under your Spouse's plan, this Plan 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. This Plan 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 This Plan is Secondary

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

- the Plan determines the amount it would have paid based on the allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

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

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary and the expense meets the definition of a Covered Health Service under this Plan, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

When a Covered Person Qualifies for Medicare

When the Plan is Primary to Medicare

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second are:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare (e.g., for COBRA participants or Employees on severance), the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

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

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If current information is not on file, a letter requesting other coverage information will automatically be generated by UnitedHealthcare. 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 UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

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

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If Santander Holdings USA, Inc. 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 Santander Holdings USA, Inc. if:

- 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 Santander Holdings USA, Inc. made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, Santander Holdings USA, Inc. may reduce the amount of any future

Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. Santander Holdings USA, Inc. may have other rights in addition to the right to reduce future Benefits.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

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 may, in its sole discretion:

- 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 meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced through any lawful means.

The Plan's Rights to Subrogation and Reimbursement

The right to subrogation means 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 a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g., an insurance carrier, if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

The right to reimbursement means that if a third party causes 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 received for that Sickness or Injury.

Some Additional Background on Subrogation and Reimbursement

Subrogation and reimbursement are legal terms that apply to certain claims when the Plan may have to recover payments made for medical expenses on behalf of an Employee and/or his or her Dependents where a third party is legally responsible for causing an injury or illness to the Covered Person, for which medical benefits are paid by the Plan.

Subrogation and reimbursement can arise in different situations but a common example is when a Covered Person is injured in an accident caused by a third party's negligence. If the Plan pays medical benefits to the Covered Person and the Covered Person recovers damages in a lawsuit against the third party who caused the accident, the Plan has a right to be reimbursed for the medical expenses it paid out of the Covered Person's financial recovery from the third party.

Here are some examples of how the Plan's subrogation and reimbursement rights might work:

- Rick is a participant in the Plan. Rick's car is rear-ended by David and Rick is injured and receives medical care. The Plan paid medical benefits of $25,000 for Rick's care. Rick then sues David and recovers $50,000 in the lawsuit. Rick is required to repay the Plan the $25,000 it paid in medical expenses from the $50,000 he recovered in the lawsuit.
- Rick is a participant in the Plan. Rick's car is rear-ended by David and Rick is injured and receives medical care. The Plan paid medical benefits of $25,000 for Rick's care. Rick then sues David but recovers only $20,000 in the lawsuit. Rick is required to pay the Plan the $20,000 he recovered in the lawsuit to reimburse the Plan. Rick would not be responsible for paying the Plan the additional $5,000 because he did not recover those funds in the lawsuit.

Note that the Plan' rights to subrogation and reimbursement apply regardless of whether a recovery in a lawsuit is designated by the parties as covering damages (such as property damage or pain and suffering) other than medical expenses. An example of how this works is as follows:

- Rick is a participant in the Plan. Rick's car is rear-ended by David and Rick is injured and receives medical care. The Plan paid medical benefits of $25,000 for Rick's care. Rick then sues David and recovers $50,000 in an out-of-court settlement of the lawsuit. In the settlement, the parties describe the settlement amount as covering only Rick's pain and suffering. Despite the parties' description of the payment in the settlement agreement, Rick is required to repay the Plan the $25,000 it paid in medical expenses from the $50,000 Rick recovered through the settlement.

In asserting subrogation and reimbursement rights, the Plan seeks to conserve its resources for the benefit of all Covered Persons, impose the expense for injuries or illness on those responsible for causing them, and avoid unjust enrichment.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan has rights of recovery, reimbursement and subrogation to the extent of any Benefits paid for an illness or injury that is caused or compensated by a third party.

Equitable Lien

By accepting Benefits under this Plan, Covered Persons agree to an equitable lien by agreement against any recovery they may receive in an action against a third party who caused an injury or illness which resulted in the Plan paying medical expenses for the Covered Persons. As a result, you or your eligible Dependent must repay to the Plan the Benefits paid on your behalf out of the amounts recovered from the other person or their insurance company, benefits plan or any other organization. The Plan's right of reimbursement applies even if your or your Dependent's claims are settled without an admission of fault and even if you or your eligible Dependent recover or have the right to recover no-fault insurance benefits. **The Plan has a lien on any amount recovered by you or your eligible Dependent, regardless of whether the amount is designated as payment for medical expenses. The Plan's lien arises through operation of the Plan. No additional reimbursement agreement is necessary. This lien will remain in effect until the Plan is reimbursed in full.**

Constructive Trust

If you (or your attorney or other representative) receive any payment through a judgment, settlement or otherwise, for an illness or injury that is caused by a third party for which the Plan has paid medical expenses, you agree to maintain the funds in a separate, identifiable account and that the Plan has an equitable lien on the funds. In addition, you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

Note: **The Plan may obtain reimbursement or satisfy its subrogation rights by reducing the covered expenses paid by the Plan to you or your eligible Dependent for covered expenses already incurred but not yet paid, and for covered expenses incurred in the future.**

The Plan is Not Subject to the "Make-Whole Doctrine"

Regardless of how the claims of recoveries are classified or characterized by the parties, the courts or any other entity, this shall not affect you or your eligible Dependent's responsibilities described above or the Plan's entitlement to first-dollar recovery, to the full extent of medical benefits paid by the Plan, regardless of whether you are made whole.

An example of this is as follows:

- Rick is a participant in the Plan. Rick's car is rear-ended by David and Rick is injured and receives medical care. The Plan paid medical benefits of $25,000 for Rick's care. Rick then sues David and recovers $50,000 through an out-of-court settlement of the lawsuit.

Rick, however, was not "made whole" by the settlement because his damages (including medical expenses, pain and suffering and property damage) exceeded the $50,000 he received in the settlement. Although Rick was not "made whole" by the settlement, he is required to repay the Plan the $25,000 it paid in medical expenses from the $50,000 he recovered in the lawsuit.

Attorney's Fees

The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing. This includes but is not limited to any reduction in the Plan's rights under common law doctrines such as the "common fund" or "make whole" doctrines.

An example of this is as follows:

- Rick is a participant in the Plan. Rick's car is rear-ended by David and Rick is injured and receives medical care. The Plan paid medical benefits of $100,000 for Rick's care. Rick then sues David and recovers $150,000. Although Rick was awarded $150,000, he incurred legal fees of $50,000 leaving him with a net recovery of $100,000. Although Rick incurred legal fees of $50,000, he is not allowed to reduce his repayment obligation to the Plan due to his having incurred legal fees and, therefore, must repay the Plan the full $100,000 the Plan paid in medical expenses.

Third Parties

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;
- Santander Holdings USA, Inc. in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a 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 you recover from a third party.

- 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, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. 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 shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - 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;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- 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 may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.

- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- 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 a 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.
- in case of your 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.
- your failure to cooperate with the Plan or its agents 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 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 a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

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.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; 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. Note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, Santander Holdings USA, Inc. 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. Note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you become ineligible; or
- the last day of the month UnitedHealthcare receives written notice from Santander Holdings USA, Inc. to end your coverage, or the date requested in the notice, if later

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 Santander Holdings USA, Inc. 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 this Plan.

Other Events Ending Your Coverage

The Plan will provide prior 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, false information relating to another person's eligibility or status as a Dependent. The date your coverage ends may be retroactive to the notice date, as permitted by applicable law.

In addition, the Plan has the right to terminate your coverage in its sole discretion if you commit an act of physical or verbal abuse that poses a threat to Santander Holdings USA, Inc.'s staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: Santander Holdings USA, Inc. has the right to demand that you pay back Benefits Santander Holdings USA, Inc. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, 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 Santander Holdings USA, Inc. proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Santander Holdings USA, Inc.'s request, that the child continues to meet these conditions.

The proof might include medical examinations at Santander Holdings USA, Inc.'s expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan 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 Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- three months from the date coverage would have ended.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *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 Santander Holdings USA, Inc. 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 Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

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:	May Elect COBRA:		
	Yourself	Your Spouse	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	36 months
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

If Coverage Ends Because of the Following Qualifying Events:	May Elect COBRA:		
	Yourself	Your Spouse	Your Child(ren)
Santander Holdings USA, Inc. files for bankruptcy under the United States Code.[2]	36 months	36 months[3]	36 months[3]

[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 Plan, 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:	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
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 Plan	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 Plan coverage ended.

During the 60-day election period, the Plan 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 the medical Plan under COBRA, you have the right to change your coverage election:

- during Annual Open 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 Plan; 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 Santander Benefits Information Center 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 15, *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 shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a pre-existing condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or

- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan 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 Plan 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 Plan 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 Plan 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 Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Santander Holdings USA, Inc.;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- 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 Santander Holdings USA, Inc.

In order to make choices about your health care coverage and treatment, Santander Holdings USA, Inc. 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 Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Santander Holdings USA, Inc. 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. Santander Holdings USA, Inc. and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Santander Holdings USA, Inc. and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Santander Holdings USA, Inc., UnitedHealthcare and Harvard Pilgrim Health Care and Network providers are solely contractual relationships between independent contractors. Network providers are not Santander Holdings USA, Inc.'s agents or employees, nor are they agents or employees of UnitedHealthcare and Harvard Pilgrim Health Care. Santander Holdings USA, Inc. and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and Harvard Pilgrim Health Care and any of its employees agents or employees of Network providers.

Santander Holdings USA, Inc. and UnitedHealthcare and Harvard Pilgrim Health Care do not provide health care services or supplies, nor do they practice medicine. Instead, Santander Holdings USA, Inc. and UnitedHealthcare and Harvard Pilgrim Health Care arrange 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 and Harvard Pilgrim Health Care'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 Santander Holdings USA, Inc.'s employees nor are they employees of UnitedHealthcare. Santander Holdings USA, Inc. and UnitedHealthcare and Harvard Pilgrim Health Care do not have any other relationship with Network providers such as principal-agent or joint venture. Santander Holdings USA, Inc. and UnitedHealthcare and Harvard Pilgrim Health Care are not liable for any act or omission of any provider.

UnitedHealthcare and Harvard Pilgrim Health Care are not considered to employers of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Santander Holdings USA, Inc. is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider (e.g., doctor or Hospital) 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 Copayments, 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

Santander Holdings USA, Inc. and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Santander Holdings USA, Inc. and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, Santander Holdings USA, Inc. may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Santander Holdings USA, Inc. does so in any particular case shall not in any way be deemed to require Santander Holdings USA, Inc. to do so in other similar cases.

Information and Records

Santander Holdings USA, Inc. and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Santander Holdings USA, Inc. and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Santander Holdings USA, Inc. and UnitedHealthcare will keep this information confidential. Santander Holdings USA, Inc. and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Santander Holdings USA, Inc. and UnitedHealthcare with all information or copies of records relating to the services provided to you. Santander Holdings USA, Inc. 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. Santander Holdings USA, Inc. and UnitedHealthcare agree that such information and records will be considered confidential.

Santander Holdings USA, Inc. 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 Plan, for appropriate medical review or quality assessment, or as Santander Holdings USA, Inc. is required or permitted to do by law or regulation. During and after the term of the Plan, Santander Holdings USA, Inc. and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Santander Holdings USA, Inc. 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, Santander Holdings USA, Inc. 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; or
- 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.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract,

including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Santander Holdings USA, Inc. recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Santander Holdings USA, Inc. 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. Santander Holdings USA, Inc. and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan 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 this Plan 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 Plan 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 Plan 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 form 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.

SECTION 14 - 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 Plan 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 Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. 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.

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder 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 Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a Benefit Period before the Plan will begin paying Benefits in that Benefit Period. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Annual Open Enrollment – the period of time, determined by Santander Holdings USA, Inc., during which eligible Employees may enroll themselves and their Dependents under the Plan. Santander Holdings USA, Inc. determines the period of time that is the Open Enrollment period.

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

Benefit Period – a calendar year beginning on January 1.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

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 Plan.

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 percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Santander Holdings USA, Inc.

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.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. 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 UnitedHealthcare determines to be:

- Medically Necessary;

- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

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.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership. Please refer to the Santander Flexible Benefits Plan Summary Plan Description for the Plan's requirements for a domestic partnership.

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 – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For Services Provided by a:	Eligible Expenses are Based On:
Network Provider	Contracted rates with the provider
Non-Network Provider	■ negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator. ■ If rates have not been negotiated, then one of the following amounts: - for Covered Health Services other than those services further specified below, Eligible Expenses are determined based on competitive fees in that geographic area. If no fee information is available for a Covered Health Service, the Eligible Expense is based on 50% of billed charges, except that certain Eligible Expenses for Mental Health Services and Substance Use Disorder Services are based on 80% of the billed charge.; - for Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor; - for Covered Health Services that are Pharmaceutical Products, Eligible Expenses are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market. When a rate

For Services Provided by a:	Eligible Expenses are Based On:
	is not published by *CMS* for the service, the Claims Administrator will use the gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomas Reuters* (published in its Red Book) or *UnitedHealthcare* based on internally developed pharmaceutical pricing resource. These provisions do not apply if you receive Covered Health Services from a non-Network provider in an Emergency or as otherwise arranged by the Claims Administrator. In that case, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, 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 – Santander Holdings USA, Inc.

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 use disorders 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 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- 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 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 Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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 use disorders, 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.

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 Outpatient Treatment – a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

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 – 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 – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) 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. UnitedHealthcare 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 UnitedHealthcare's sole discretion.

UnitedHealthcare 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 UnitedHealthcare 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 UnitedHealthcareOnline.

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 – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by Santander Holdings USA, Inc. who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

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 by way of their participation in the Shared Savings Program. 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.

Note: Employees who live in Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive Network Benefits through the Harvard Pilgrim Health Care Network when seeking Covered Health Services in Massachusetts, Maine and New Hampshire or through the UnitedHealthcare Network when seeking Covered Health Services outside Massachusetts, Maine and New Hampshire. For these Employees, references to the Network in this SPD refer to the Harvard Pilgrim Health Care Network when care is received Massachusetts, Maine and New Hampshire.

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 providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every Benefit Period. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan 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 Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Santander Holdings USA, Inc. Flexible Benefits Plan.

Plan Administrator – Santander Holdings USA, Inc. or its designee.

Plan Sponsor – Santander Holdings USA, Inc.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- no skilled services are identified;
- 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; or
- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.

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 Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder 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.

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.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance use disorder, regardless of the cause or origin of the Mental Illness or substance use 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 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 Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – an individual to whom you are legally married. For purposes of the Plan, a Spouse includes your same-sex spouse or your civil union partner, as defined by state law, or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

Total Disability – an Employee's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be 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 arrangement which are residences such as transitional living 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.

UnitedHealth Premium Program℠ – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

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**.

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.

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 – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires

prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, *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

Santander Holdings USA, Inc. is the Plan Sponsor and Plan Administrator of the Santander Holdings USA, Inc. Flexible Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
Santander Holdings USA, Inc.
1130 Berkshire Blvd.
Wyomissing, PA 19610
(800) 210-1426, Option 3

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan'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 St.
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 is:

Agent for Legal Process – Medical Plan
Santander Holdings USA, Inc.
1130 Berkshire Blvd.
Wyomissing, PA 19610
(800) 210-1426, Option 3

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

The Plan Sponsor also has selected a Provider Network established by United HealthCare Services, Inc and, within the Harvard Pilgrim Health Care service area, a Provider Network established by Harvard Pilgrim Health Care.

Plan Name:	Santander Holdings USA, Inc. Flexible Benefits Plan
Plan Number:	501
Employer ID:	23-2453088
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan 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; 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 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.

You will be provided a certificate of creditable coverage in writing, free of charge, from UnitedHealthcare:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a certificate of creditable coverage before losing coverage; or
- if you request a certificate of creditable coverage up to 24 months after losing coverage.

You may request a certificate of creditable coverage by calling the toll-free number on your ID card.

If you have creditable coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, Plan Benefits for the treatment of a preexisting condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage. 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, who are called "fiduciaries" of the Plan, 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 (866) 444-3272.

The Plan's Benefits are administered by Santander Holdings USA, Inc., the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Santander Holdings USA, Inc. 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 Santander Holdings USA, Inc. 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 the number on the back of your ID card.

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 the number on the back of your ID card.

ADDENDUM - LIST OF COVERED PREVENTIVE CARE SERVICES

Preventive services that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) are listed below. This list is subject to change according to the guidelines and recommendation provided by USPSTF. Coverage is subject to guidelines based on age, dosage, and frequency.

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

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~ Listing follows on next page ~

<table>
<tr><th colspan="3">List of Covered Preventive Care Services</th></tr>
<tr><th>Children</th><th colspan="2">Adults</th></tr>
<tr>
<td>Newborns
■ Screening for hearing loss, hypothyroidism, sickle cell disease, and phenylketonuria (PKU)
■ Gonorrhea preventive medication for eyes</td>
<td>General Health Screenings
■ Blood pressure screening
■ Cholesterol screening
■ Type 2 diabetes screening
■ HIV and STI screenings</td>
<td>Men
■ Abdominal aortic aneurysm one-time screening</td>
</tr>
<tr>
<td>Immunizations
■ Diphtheria, Tetanus, Pertussis
■ Haemophilus influenzae type B
■ Hepatitis A and B
■ Human Papillomavirus (HPV)
■ Influenza (Flu)
■ Measles, Mumps, Rubella
■ Meningococcal
■ Pneumococcal (pneumonia)
■ Inactivated Poliovirus
■ Rotavirus
■ Varicella (chicken pox)</td>
<td>Cancer Screenings
■ Breast cancer mammography
■ Breast cancer chemoprevention counseling
■ Cervical cancer pap test for women
■ Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy, or colonoscopy
■ Prostate cancer (PSA) screening for men</td>
<td>Women
■ Osteoporosis screening
■ Chlamydia infection screening
■ Gonorrhea and syphilis screening
■ BRCA counseling about Genetic Testing</td>
</tr>
<tr>
<td>General Health Screenings
■ Medical history for all children throughout development
■ Height, weight, and Body Mass Index (BMI) measurements
■ Developmental screening
■ Autism screening
■ Behavioral assessment
■ Visual acuity screening
■ Oral health risk assessment
■ Hematocrit or hemoglobin screening
■ Obesity screening and weight management counseling
■ Lead screening
■ Dyslipidemia screening
■ Tuberculin testing
■ Depression screening
■ Alcohol and drug use assessment
■ Counseling to prevent sexually transmitted infections (STIs)
■ Cervical dysplasia screening
■ HIV screening
■ Blood Pressure screening</td>
<td>Health Counseling
Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed:
■ Healthy diet
■ Weight loss
■ Tobacco use
■ Alcohol misuse
■ Depression
■ Prevention of STIs
■ Use of aspirin to prevent cardiovascular disease
■ Immunizations
■ Hepatitis A and B
■ Herpes Zoster
■ Human Papillomavirus (HPV)
■ Influenza (Flu)
■ Measles, Mumps, Rubella
■ Meningococcal
■ Pneumococcal (pneumonia)
■ Tetanus, Diphtheria, Pertussis
■ Varicella (chicken pox)</td>
<td>Pregnant Women
■ Anemia screening for iron deficiency
■ Tobacco cessation counseling
■ Syphilis screening
■ Hepatitis B screening
■ Rh incompatibility blood type testing
■ Bacteriuria urinary tract infection screening
■ Breastfeeding education</td>
</tr>
</table>

JS 44 (Rev. 07/16)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

JANCE HOY, On Behalf of Herself and All Others Similarly Situated,

(b) County of Residence of First Listed Plaintiff Montgomery County, PA
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Marc A. Goldich and Noah Axler, Axler Goldich LLC
1650 Market St., Suite 3600, Philadelphia, PA 19103 (267) 207-2920

DEFENDANTS

UNITED HEALTHCARE SERVICES, INC.,

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff (For Diversity Cases Only) and One Box for Defendant)*

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☒ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
ERISA, 29 U.S.C. § 1101, et seq.

Brief description of cause:
Failure to provide in-network lactation consultants or to reimburse for out-of-network lactation services.

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $ 5,000,000.00+

CHECK YES only if demanded in complaint
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions) JUDGE DOCKET NUMBER

DATE
10/25/2016

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CASE MANAGEMENT TRACK DESIGNATION FORM

JANCE HOY, On Behalf of Herself and All Others Similarly Situated,	:	CIVIL ACTION
v.	:	
UNITED HEALTHCARE SERVICES, INC	:	NO.

In accordance with the Civil Justice Expense and Delay Reduction Plan of this court, counsel for plaintiff shall complete a Case Management Track Designation Form in all civil cases at the time of filing the complaint and serve a copy on all defendants. (See § 1:03 of the plan set forth on the reverse side of this form.) In the event that a defendant does not agree with the plaintiff regarding said designation, that defendant shall, with its first appearance, submit to the clerk of court and serve on the plaintiff and all other parties, a Case Management Track Designation Form specifying the track to which that defendant believes the case should be assigned.

SELECT ONE OF THE FOLLOWING CASE MANAGEMENT TRACKS:

(a) Habeas Corpus – Cases brought under 28 U.S.C. § 2241 through § 2255. ( )

(b) Social Security – Cases requesting review of a decision of the Secretary of Health and Human Services denying plaintiff Social Security Benefits. ( )

(c) Arbitration – Cases required to be designated for arbitration under Local Civil Rule 53.2. ( )

(d) Asbestos – Cases involving claims for personal injury or property damage from exposure to asbestos. ( )

(e) Special Management – Cases that do not fall into tracks (a) through (d) that are commonly referred to as complex and that need special or intense management by the court. (See reverse side of this form for a detailed explanation of special management cases.) (x)

(f) Standard Management – Cases that do not fall into any one of the other tracks. ( )

10/25/16		Plaintiff Jance Hoy
Date	**Attorney-at-law**	**Attorney for**
(267) 207-2920	267-319-7901	mgoldich@axgolaw.com
Telephone	**FAX Number**	**E-Mail Address**

(Civ. 660) 10/02

FOR THE EASTERN DISTRICT OF PENNSYLVANIA — DESIGNATION FORM to be used by counsel to indicate the category of the case for the purpose of assignment to appropriate calendar.

Address of Plaintiff: 8004 Ardmore Ave. Wyndmoor, PA 19038

Address of Defendant: 9700 Health Care Lane, Minnetonka, Minnesota 55343

Place of Accident, Incident or Transaction: Wyndmoor, PA

(Use Reverse Side For Additional Space)

Does this civil action involve a nongovernmental corporate party with any parent corporation and any publicly held corporation owning 10% or more of its stock?

(Attach two copies of the Disclosure Statement Form in accordance with Fed.R.Civ.P. 7.1(a)) Yes☒ No☐

Defendant is a subsidiary of UnitedHealth Group Incorporated.

Does this case involve multidistrict litigation possibilities? Yes☐ No☒

RELATED CASE, IF ANY:

Case Number: N/A Judge N/A Date Terminated: N/A

Civil cases are deemed related when yes is answered to any of the following questions:

1. Is this case related to property included in an earlier numbered suit pending or within one year previously terminated action in this court? Yes☐ No☒
2. Does this case involve the same issue of fact or grow out of the same transaction as a prior suit pending or within one year previously terminated action in this court? Yes☐ No☒
3. Does this case involve the validity or infringement of a patent already in suit or any earlier numbered case pending or within one year previously terminated action in this court? Yes☐ No☒
4. Is this case a second or successive habeas corpus, social security appeal, or pro se civil rights case filed by the same individual? Yes☐ No☒

CIVIL: (Place ✔ in ONE CATEGORY ONLY)

A. *Federal Question Cases*:

1. ☐ Indemnity Contract, Marine Contract, and All Other Contracts
2. ☐ FELA
3. ☐ Jones Act-Personal Injury
4. ☐ Antitrust
5. ☐ Patent
6. ☐ Labor-Management Relations
7. ☐ Civil Rights
8. ☐ Habeas Corpus
9. ☐ Securities Act(s) Cases
10. ☐ Social Security Review Cases
11. ☒ All other Federal Question Cases
    (Please specify) ERISA

B. *Diversity Jurisdiction Cases*:

1. ☐ Insurance Contract and Other Contracts
2. ☐ Airplane Personal Injury
3. ☐ Assault, Defamation
4. ☐ Marine Personal Injury
5. ☐ Motor Vehicle Personal Injury
6. ☐ Other Personal Injury (Please specify)
7. ☐ Products Liability
8. ☐ Products Liability — Asbestos
9. ☐ All other Diversity Cases
   (Please specify) _____

ARBITRATION CERTIFICATION

(Check Appropriate Category)

I, Marc A. Goldich, counsel of record do hereby certify:

☒ Pursuant to Local Civil Rule 53.2, Section 3(c)(2), that to the best of my knowledge and belief, the damages recoverable in this civil action case exceed the sum of $150,000.00 exclusive of interest and costs;

☒ Relief other than monetary damages is sought.

DATE: 10/25/16 _____ 93055

Attorney-at-Law Attorney I.D.#

NOTE: A trial de novo will be a trial by jury only if there has been compliance with F.R.C.P. 38.

I certify that, to my knowledge, the within case is not related to any case now pending or within one year previously terminated action in this court except as noted above.

DATE: 10/25/16 _____ 93055

Attorney-at-Law Attorney I.D.#

CIV. 609 (5/2012)

ClassAction.org

This complaint is part of ClassAction.org's searchable class action lawsuit database and can be found in this post: United Healthcare Services Up Against ERISA Class Action