LEGACY RAYTHEON
TOTAL REWARDS
career work/life pay benefits
INVESTING IN YOU & YOUR FUTURE.

Issued March 2021

YOUR 2021
LEGACY RAYTHEON
Benefits Handbook

For Eligible Re-Employed Recipients of Pension Payments

Medical

Health Savings Account (HSA)

CVS Caremark Prescription Drug Program

Vision

Dental

Business Travel Accident Insurance

RAYSIP

Administrative

The specific plan sections included in this handbook constitute the summary plan descriptions for the legacy Raytheon benefit plans. If there is any difference between the information contained in this handbook and the actual plan documents, the plan documents will always govern.

The company reserves the right to amend or terminate any of the plans at any time. Such amendments or modifications may be retroactive, if necessary, to meet statutory requirements or for any other appropriate reason.

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

Raytheon Technologies

Eligibility

Regardless of hours worked, re-employed recipients of pension payments are eligible only for medical (including prescription drug), health savings account (HSA), vision and dental coverage as well as BTA insurance. In addition, they are eligible to make contributions to the Raytheon Savings and Investment Plan (RAYSIP).

You are a re-employed recipient of a pension payment if you:

- Are receiving or have received payment of benefits from a company-sponsored defined benefit pension plan, regardless of your age and service and regardless of the form of payment of your benefit; and
- Previously incurred a separation from service with the company; and
- Are employed by the company again on or after March 1, 2007.

Note that you are *not* a re-employed recipient of a pension payment if:

- Your only payment from a legacy Raytheon pension plan was a mandatory cashout of a small benefit, as defined in the applicable plan, or a return of your pension plan contributions and interest, or
- You have received (or are eligible to receive) only Retirement Income Savings Program (RISP) benefits. In this case, you are considered a RISP-only retiree.

In both cases, if you are re-employed, you are eligible for the benefits that any rehired employee in the union code that covers your position receives. For more information, see *Your Benefits Handbook, For Eligible Employees*.

If you are eligible for company-sponsored retiree medical coverage because you met the eligibility requirements for RISP retiree medical coverage at the time you terminated your employment (as defined in the applicable *Eligibility Summary*, available on *Desktop Benefits*), your retiree medical coverage is suspended during your employment and can be resumed when you subsequently terminate your employment.

Note: As described later in this section, you and the company share the cost of your medical, vision and dental coverage. If the hours you work in a given pay period do not produce sufficient pay to cover the amount you contribute toward the cost of your benefits, any shortfall will be made up in subsequent pay periods where there is sufficient pay. Only one pay period's shortfall will be made up in each subsequent pay period. If 90 or more days of shortfall remain unpaid, the RBC will issue you a bill. If you do not settle this bill, your coverage will be terminated retroactively.

ABOUT *YOUR BENEFITS HANDBOOK*

This document provides summary information about the benefits plans available to you. As you review this document, please ignore any references to the following plans that do not apply to you:

- *Wellness Reward program;*
- *Flexible spending accounts (FSAs);*
- *Short-term, long-term and occupational disability plans;*
- *Life insurance plans;*
- *Accidental death & dismemberment insurance (AD&D) plan;*
- *LifeResources employee assistance program (EAP); and*
- *Severance plan.*

If you have questions about your eligibility for a particular benefit plan, call the Raytheon Benefit Center (RBC) at 800-358-1231.

SICK LEAVE

You earn sick leave as required by law if you work in a state or municipality that mandates paid sick leave. Accrual rates, usage, carryover limits and allowable reasons vary by statute.

When using sick leave, note the following:

- *You may use your accrued sick leave as soon as it is earned—there is no waiting period.*
- *Generally, you may use accrued sick leave to care for your own or a covered family member's medical needs, purposes related to domestic violence and public health emergencies.*
- *While you must coordinate all requests to use accrued sick leave with your supervisor, you are not required to provide medical documentation.*
- *Unused sick leave hours are not paid out at termination. Under certain circumstances that vary by statute, hours may be reinstated upon rehire.*

If you have questions about sick leave, call Payroll at 877-291-9990.

Employee Discount Program

The Employee Discount Program is administered by Benefithub. The program provides you with access to exclusive employee offers and discounts from hundreds of merchants and services nationwide.

Offers include:

- Discounts on movie tickets at Landmark and AMC theatres;
- Company-exclusive offers on wireless phones, mortgage services, as well as Ford, GM and Mitsubishi vehicles; and at Royal Jewelers;
- Discounts on tickets to Disneyland and Universal Studios;
- Accidental death & dismemberment insurance plan;
- Up to 25% off of apparel from Timberland and Lane Bryant;
- 25% off purchases at Eastern Mountain Sports; and
- 15% off any flower arrangement from FTD.com.

These offers and more are available at no charge to you and your family members. To see the complete list of merchants and offers now available, go to https://raytheon.benefithub.com and create an account using your email address and the referral code FFRD5N. You'll then create a password to be used with your email address whenever you visit the site.

Can't locate one or more of the documents that are required to add a dependent to some of your benefit plans? For a fee, Vitalchek can provide official government certificates (e.g., birth, marriage, divorce). For more information, go to www.vitalchek.com.

Questions about Your Benefits?

- Go to *Desktop Benefits* at https://raytheon.benefitcenter.com—the only address you need to access all your benefits online, with personalized and general benefits information, as well as transactional capabilities.
  With *Desktop Benefits*, you can:
  - Connect with benefit plan carriers and resources using the *Benefit Provider Contacts* list under *My Resources*;
  - View your benefit elections, costs and medical plan summary charts;
  - Use tools available on the *My Resources* listing, such as *DecisionAssist* to choose an HSA Advantage plan, as well as links to find participating doctors, dentists and hospitals;
  - Change the amount of your health savings account (HSA) contribution (up to the annual limit). From the *My Life Changes* tab, select *Change Your HSA Contribution Amount;*
  - Update your address or marital status;
  - Change your benefit elections if you have a qualified change in status or other qualifying event. Note that if you are eligible to add a dependent to your medical, vision and/or dental plans (as outlined in the *Medical*, *Vision and Dental* sections), you will need to provide dependent eligibility verification (such as a marriage certificate, birth certificate or joint tax return). Your dependent's coverage will not be effective until the verification documents are received.
- Contact the Raytheon Benefit Center (RBC). Simply:
  - Call 800-358-1231 (TDD# 800-877-8339); from outside the United States, call collect 412-505-6905. Representatives are available Monday through Friday from 8 a.m. to 8 p.m. Eastern Time (ET) to answer specific benefit questions and help you with any necessary changes.
  - Email questions to rbcmail@conduent.com.
  - Send correspondence to:

    Raytheon Benefit Center
    P.O. Box 5243
    Cherry Hill, NJ 08034-5243

    For overnight delivery, the street address is 101 Woodcrest Road, Cherry Hill, NJ 08003.
  - Fax questions to 855-291-5941.

  Note: Whenever you contact the RBC, be sure to include your employee ID number, your full name and your email address.

Wellness Programs

Investing in Your Health

From health and wellness benefits to work/life and financial programs, the company provides easy access to a variety of wellness services and programs that you and, in many cases, your family can use to get started or stay on the path to improving your health.

For example, because preventive care plays an important role in identifying disease and maintaining proper health, ***company-sponsored medical plans cover eligible, in-network preventive-care services (as identified by the* Affordable Care Act *(ACA) under the Preventive Care Services benefit) at 100% with no out-of-pocket expense.****

Beyond these benefits, you have access to:

- Nurse lines, disease management programs, maternity care programs and online services through your medical plan (see the chapter about your medical plan for details);
- At many locations, free, on-site biometric screenings for employees that conclude with a brief health coaching session;
- Flu shots; and
- In some locations, presentations and seminars from on-site nurses and fitness center staff members.

For information about the wellness programs currently available, see the *live*well homepage on oneRTN at http://home.ray.com.

*For a description of preventive-care services available through Global Choice or the Kaiser Permanente plan available in Hawaii, see the appropriate *Evidence of Coverage*.

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

Health Advocate℠

Help Navigating the Complexities of Health Care Is Just a Phone Call Away

When it comes to cutting through the red tape that is so often associated with health care, everyone can use a helping hand.

That's why the company offers Health Advocate. Available to you at no cost, Health Advocate can help you make smart decisions regarding your family's medical care.

Personal Health Advocates are typically registered nurses who are supported by medical directors and medical claims specialists. A Personal Health Advocate can help you:

- Manage claims and billing issues;
- Manage prenotifications and make payment arrangements with in- and out-of-network providers;
- Find payment solutions for prescription drug costs, including manufacturer coupons;
- Find doctors and schedule appointments, especially with hard-to-reach specialists;
- Secure second opinions (although not those related to workers' compensation or disability claims); and
- Understand medical test reports.

To contact a Personal Health Advocate, call 866-695-8622. While Personal Health Advocates can be reached 24 hours a day, seven days a week, normal business hours are Monday through Friday from 8 a.m. to 10 p.m. Eastern Time (ET).

To visit the Health Advocate website, go to www.healthadvocate.com/members and enter "Raytheon" as the company name. Here you'll find health and finance tips as well as the many ways the service can provide assistance. (Note: The first time you visit the website from your work computer, begin typing "Raytheon" to access the dropdown menu where you can select "Raytheon Employees and Retirees.")

Note that this benefit is available to you and your spouse, as well as your dependent children, parents and parents-in-law.

It's important to stress that all Personal Health Advocates follow careful protocol and comply with all government privacy standards. Your medical and personal information is strictly confidential and, with your consent, will only be shared as needed to help resolve your question.

Health Advocate, a subsidiary of West Corporation, is not a direct healthcare provider, is not affiliated with any insurance company or third-party provider and does not apply to workers' compensation or disability programs.

HealthAdvocate Solutions℠

866.695.8622

Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

AT A GLANCE

YOUR 2021
LEGACY RAYTHEON
Benefits

This chart provides a brief overview of the benefits described in this handbook. Please be sure to read each section for more details about each plan, including specific plan provisions.

Benefit Plan	Highlights
Medical	With an HSA Advantage plan, you take an active role in managing the cost of your care, often with considerable savings. The company offers two HSA Advantage plans administered by UnitedHealthcare (UHC): UHC HSA Advantage 1 and UHC HSA Advantage 2. An HSA Advantage plan administered by Kaiser Permanente is also available in California, Colorado and the mid-Atlantic states. Note that with the exception of emergency care, the Kaiser plans do not offer coverage if you seek care outside the Kaiser network. If you live in an area where a fully developed UHC provider network is not available, you have access to the UHC Out-of-Area plan. If you are on an international assignment, the company offers eligible expatriates Global Choice (which provides medical and dental coverage). Note that coverage options vary in Hawaii. For more information, see *Important Information for Employees in Hawaii* later in this section.
Health Savings Account (HSA)	With the HSA Advantage plans, the company makes a lump-sum contribution to a health savings account (HSA) in your name in January. The amount of the company's contribution varies by plan and coverage level. (For new employees: The company's contribution to your HSA is prorated for that year. For more information, see *For New Hires* in the *Health Savings Account* section.) You also can choose to make tax-free contributions to your HSA, lowering your taxable income. Note that state income tax laws in Alabama, California, New Hampshire, New Jersey and Tennessee differ from the federal income tax treatment of HSA contributions and earnings. The maximum amount you and the company combined can contribute is subject to an annual federal limit, which varies by coverage level. Note that if you are age 55 or older, you may make an additional $1,000 catch-up contribution to your HSA each year (including the year you turn 55). You always own the money in your HSA. Any unused money carries over to the next year and may earn interest—there are no "use-it-or-lose-it" rules. And if you leave the company or retire, the money in your HSA belongs to you. Note that you are not eligible to make or receive contributions to an HSA if you are enrolled in other medical coverage that is not an HSA-qualified plan, including Medicare, TRICARE or a non-high-deductible plan or health care flexible spending account (FSA), such as may be available through your spouse's employer.
Prescription Drugs	Prescription drug coverage for the UHC plans is administered as a separate program by CVS Caremark. Kaiser Permanente provides prescription drug coverage for the plans it administers. For Global Choice participants, your coverage depends on where you fill a prescription: Outside the United States, coverage is administered by the plan; inside the United States, coverage is administered by CVS Caremark.
Vision	The company provides vision coverage through VSP® Vision Care, the nation's largest vision benefits provider. You may choose from two vision plan options—the Basic Vision Plan or, if you need expanded benefits, the Vision Plus Plan.
Dental	Regular dental care is essential to your overall health. The company's dental program offers up to three dental options. You may choose the one that best suits your needs and the needs of your family.
Business Travel Accident (BTA) Insurance	The company provides company-paid business travel accident (BTA) insurance, which provides accidental death and dismemberment coverage if you are injured or die as a result of a covered accident while traveling on company business, including travel between company facilities.
Raytheon Savings and Investment Plan (RAYSIP)	No matter what your savings goals, the Raytheon Savings and Investment Plan (RAYSIP) can help you achieve them.

Medical
at a glance

in this section

- The company offers two HSA Advantage plans administered by UnitedHealthcare (UHC). The UHC HSA Advantage plans are available in most parts of the country.

  If you live in California, Colorado or the mid-Atlantic states, you also have access to an HSA Advantage plan administered by Kaiser Permanente. If you live in an area where a network-based plan is not available, you have access to the UHC Out-of-Area plan. If you are on an international assignment, the company offers eligible expatriates Global Choice (which provides medical and dental coverage).

  Note that coverage options vary in Hawaii. For more information, see *Important Information for Employees in Hawaii* later in this section.

- You may choose from four coverage levels: employee only; employee and spouse; employee and child(ren); or employee and family.

- New employee? You must enroll within 31 days of the date shown on your *Personalized Enrollment Worksheet* or your date of hire, whichever is later. Your coverage becomes effective on your first day of work.

- You can make changes to your medical coverage (i.e., add or remove dependents, add or drop coverage, or change plans) each year during the benefits open enrollment period.

- Outside of the annual benefits open enrollment period, you may make changes only under certain circumstances as outlined in *Changing Your Coverage, At Other Times of the Year* later in this section.

continued on next page

- You and the company share the cost of your coverage. You pay your share of premiums with pre-tax dollars through payroll deduction.

- The plans cover a wide range of services and supplies; including inpatient and outpatient hospital services; physician services; emergency, urgent and convenient care as well as mental health and substance use disorder treatment. The plans also provide 100% coverage for preventive care with no out-of-pocket expense when your network primary care physician or network OB/GYN provides eligible services.

- The UHC HSA Advantage plans differ in:
  - The amount of the company's lump-sum contribution to your health savings account (HSA);
  - How much you pay out-of-pocket for deductibles and coinsurance; and
  - The amount you pay in premium contributions.

- The claims administrator makes the final decision as to whether a particular service is covered, based on the benefits available under your plan. For information about how to appeal a denied claim, see the *Administrative* section.

Medical
at a glance

Important Information for Employees in Hawaii

Registered Civil Union Partners

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

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

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

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

Note that references throughout this handbook to the following do not apply to employees who live in Hawaii: HSA Advantage plan, *DecisionAssist,* health savings accounts (HSAs) and Global Choice.

Medical Coverage Options

The medical coverage options available in Hawaii vary from options available elsewhere in the U.S. Specifically, employees in Hawaii may choose from two medical plans—the UnitedHealthcare (UHC) Hawaii plan or the Kaiser Permanente health maintenance organization (HMO).

UnitedHealthcare (UHC) Hawaii Plan

The UnitedHealthcare (UHC) Hawaii plan provides the flexibility of both in-network and out-of-network coverage. While not required, it is recommended that a primary care physician (PCP) coordinate your care.

With the UHC Hawaii plan, you are eligible for all of the benefits described under *Wellness and Preventive-Care Benefits* later in this section, including those listed under *Additional Preventive Care Services.*

For non-preventive care, after you meet the annual in-network deductible of $300 per person ($900 per family), most in-network care is covered at 90%. Preventive well-child visits are covered at 100% with no deductible (up to age 18), as are preventive screenings such as colonoscopy, mammogram, pap smear, prostate specific antigen test screening, sigmoidoscopy and standard immunizations.

Prescription drug coverage, provided by CVS Caremark, offers you the flexibility of retail coverage, and significant savings when you use Maintenance Choice. For more information, see the *CVS Caremark Prescription Drug Program* section.

For more information about the UHC Hawaii plan—including how the plan covers preventive care—refer to the plan's separate summary plan description (SPD). Details are also available on *Desktop Benefits* by choosing *Compare My Medical Plan Choices* and then choosing the medical comparison chart for the UHC Hawaii plan.

The UHC Hawaii plan uses the MDX network, which provides broad comprehensive coverage throughout Hawaii. To check if your provider is in the MDX network, go to www.myuhc.com.

Kaiser Permanente Health Maintenance Organization (HMO)

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

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

With the Kaiser Permanente HMO, your eligibility for the benefits described under *Wellness and Preventive-Care Benefits* later in this section may vary. Refer to the plan's *Evidence of Coverage* for more information.

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

UHC Hawaii Plan
www.myuhc.com; 800-638-8884

Kaiser Permanente HMO
www.kp.org; 800-966-5955

Important Information for Employees in Hawaii (continued)

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

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

For more information on the Kaiser Permanente HMO, refer to the plan's *Evidence of Coverage.* Details are also available on *Desktop Benefits* by choosing *Compare my medical plan choices* and then choosing the medical comparison chart for the Kaiser Permanente Hawaii HMO.

Note for New Hires

As is the case elsewhere in the U.S., you must enroll in medical coverage within 31 days of the date shown on your *Personalized Enrollment Worksheet,* or your date of hire, whichever is later. Your coverage becomes effective on your first day of work.

If you live in Hawaii and do not enroll within this 31-day period, you will automatically be enrolled in the UHC Hawaii plan at the employee-only coverage level. This coverage remains in effect for the remainder of the calendar year. You may change your plan and/or coverage level during the next benefits open enrollment period, held each fall. You are permitted to make certain changes sooner if you meet the guidelines outlined in *Changing Your Coverage* later in this section.

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

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

UHC Hawaii Plan
www.myuhc.com; 800-638-8884

Kaiser Permanente HMO
www.kp.org; 800-966-5955

Enrolling in a Medical Plan

Coverage Levels

When you enroll in a company-sponsored medical plan, you may choose from four coverage levels:

- Employee only;
- Employee and spouse;
- Employee and child(ren); or
- Employee and family (spouse and children).

This allows you to choose the coverage level that best meets your specific family situation while ensuring that you pay for only the coverage you actually need.

You may select different coverage levels for medical, dental and vision coverage. For example, you may choose medical coverage for your entire family and vision coverage for just yourself. Note: If you participate in Global Choice (which includes medical and dental coverage), you may select one coverage level for Global Choice and the same or a different coverage level for vision coverage.

Eligible Dependents

You may enroll your eligible dependents for medical coverage. Eligible dependents include your:

- *Spouse.* A spouse includes a *common-law spouse* if your common-law marriage was established in a state that legally recognizes common-law marriage; all requirements of that state have been met; and the common-law marriage has not ended.

  Note that a spouse from whom you are divorced or legally separated is *not* eligible for coverage. Note also that with the exception of the Kaiser Permanente plans in Colorado, a party to a civil union is not a spouse. In addition, the Kaiser Permanente plans available in California, Colorado and the mid-Atlantic states provide coverage for registered same-sex domestic partners;
- *Children before their 26th birthday,* including natural children, legally adopted children (including children lawfully placed for adoption), stepchildren and foster children, regardless of residency, financial dependence, student status, employment status or marital status;
- *Children and other dependents up to their age of majority (usually 18) for whom you are a legal guardian.* If you or your spouse is not the child's parent (or step-parent) and the child is not a foster or adopted child, you must have a court order designating you or your spouse as the child's legal guardian or as the person who has legal responsibility for the care, control and custody of the child that is equivalent to the responsibility of a legal guardian. (Please note that if the court order extends the guardianship beyond the age of majority, the child's coverage will still end no later than the child's 26th birthday.) In all cases, the child must also meet the IRS definition of a dependent of you or your spouse; and
- *Unmarried children age 26 and older who are disabled as well as other dependents age 26 and older for whom you have legal guardianship who are disabled,* if approved by a company-sponsored health plan to be disabled. In general, to qualify, the disabled child must have become disabled before age 26 and be incapable of self-sustaining employment because of intellectual disability, serious mental illness, physical sickness or injury. Coverage may continue for as long as your coverage continues and as long as your child remains incapacitated and is otherwise eligible for coverage.

Note that if you are eligible to add a dependent to your company-sponsored medical plan, you will need to provide dependent eligibility verification (such as a marriage certificate, birth certificate or joint tax return). Your dependent's coverage will not be effective until the verification documents are received. Complete details are on *Desktop Benefits.*

If your covered dependent becomes ineligible for coverage during the year (for example, due to divorce or legal separation), you must remove your dependent from your coverage as of the date that person is no longer eligible for coverage. Coverage for your dependent child who reaches age 26 automatically ends at 11:59:59 p.m. local time on the day before his/her 26th birthday. For more information, see *Changing Your Coverage* later in this section.

Can't locate one or more of the documents that are required to add a dependent to your company-sponsored medical plan? For a fee, Vitalchek can provide official government certificates (e.g., birth, marriage, divorce). For more information, go to www.vitalchek.com.

Qualified Medical Child Support Order

All company-sponsored medical plans honor qualified medical child support orders (QMCSOs) issued under state domestic relations laws that require health benefits be provided to a child. For more information about QMCSOs, refer to the *Administrative* section.

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

Cost of Coverage

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

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

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

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

In all cases, the amount of your premium contribution depends on the level of coverage you choose (employee only, employee and spouse, employee and child(ren) or employee and family). The amount of your premium contribution is provided in your new hire materials as well as during the annual benefits open enrollment period.

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

For current contribution amounts and additional information, go to *Desktop Benefits* or call the RBC.

If You and Your Spouse Are Both Employees of Raytheon Technologies and Eligible for Legacy Raytheon Benefits

If you and your spouse both work for Raytheon Technologies and are both eligible for legacy Raytheon benefits, you have three options when electing medical coverage:

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

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

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

Before deciding which option is best for you and your spouse, be sure to consider the premiums, out-of-pocket costs and the company's HSA contribution associated with each option and coverage level. For assistance, use *DecisionAssist* (described later in this section).

Initial Enrollment for New Employees

You may enroll in a company-sponsored medical plan within the 31-day period following the date listed on your *Personalized Enrollment Worksheet* or your date of hire, whichever is later. Since Kaiser Permanente plans require referrals for some services, if you enroll in a Kaiser Permanente HSA Advantage plan, you are advised to choose a primary care physician (PCP) for yourself and each family member that you cover when you first enroll. You can elect your PCP online or by calling Kaiser Permanente.

If you do not enroll within this 31-day period, you will automatically be enrolled at the employee-only coverage level in the HSA Advantage 2 plan, without an HSA. Please note: If your ZIP code indicates you are not eligible for a network plan, you are automatically enrolled in the UHC Out-of-Area plan, again, with employee-only coverage.

This medical coverage option remains in effect for the remainder of the calendar year. (If you enroll in an HSA Advantage plan and do not open your HSA when you are first eligible,

Note that there are no pre-existing condition limitations under any company-sponsored medical plan.

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

you may open your account at any time. See the *Health Savings Account* section for details.) You may change your plan and/or coverage level during the next benefits open enrollment period, held each fall. You are permitted to make certain changes sooner if you meet the guidelines outlined in *Changing Your Coverage* later in this section.

Your medical coverage is effective on your first day of employment. Coverage for your dependents generally begins at the same time as your coverage, or as soon as the dependent becomes eligible and his/her verification documents are confirmed (see *Eligible Dependents* earlier in this section for more information).

Changing Your Coverage

After you make your initial enrollment elections as a new employee, you are permitted to make changes to your medical coverage as outlined here. In all cases, if you are adding eligible dependents, all necessary verification documents must be confirmed before a dependent's coverage becomes effective. See *Eligible Dependents* earlier in this section for more information.

Annual Benefits Open Enrollment

Each year, the company conducts a benefits open enrollment during which you may make changes to your medical coverage (i.e., add eligible dependents, remove dependents, add or drop coverage, or change plans , if applicable). Any changes you make become effective the following January 1.

In addition, each year during the benefits open enrollment period, *you must actively elect how much you want to contribute to your HSA during the following calendar year—your current contribution election does not carry forward.*

At Other Times of the Year

Outside of the annual benefits open enrollment period, you are permitted to make changes to your medical coverage (add or remove a dependent, or add or drop coverage) only in the event of the following:

- If you have a qualified change in status, as follows:
  - Marriage.
  - Divorce or legal separation.
  - Gain or loss of an eligible dependent, such as a child reaching age 26.
  - Change in your, your spouse's or your dependent's employment status, for example:
    - Gain or involuntary loss of medical coverage,
    - Change from full time to part time or vice versa,
    - Transfer between different contracts or positions, providing there is a change in the plans that are available to you or a significant change in the cost of coverage (for example, to or from a Service Contract Act or RayTech position), or
    - Begin or end an unpaid leave of absence.
- If your home address changes to outside your current medical plan's service area.

  ***Note that in the situations above, the change(s) you make must be due to and consistent with your change in status. For details, see the following inset* Making Changes to Your Coverage Outside the Annual Open Enrollment Period.**
- If your spouse's employer holds open enrollment at a time other than the company's and, as a result of its benefit offerings, you would like to make a change.
- If you, your spouse or your dependent becomes enrolled in Medicare or Medicaid, or if you, your spouse or your dependent becomes ineligible for Medicare or Medicaid.
- If you, your spouse or your dependent becomes eligible for a special enrollment opportunity under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA); for a description of your HIPAA rights, see the inset box later in this section.

If any of these situations apply to you, you can make your change on *Desktop Benefits* or by calling the RBC.

Be sure you understand the enrollment procedures and enroll for the coverage you want when you're first eligible. Once your coverage begins, it will be in effect for the remainder of the calendar year. You are not permitted to change your elected coverage during the year unless you meet certain criteria described under *Changing Your Coverage.*

In general, you are not permitted to change your medical plan until the next annual benefits open enrollment period, unless you move out of the service area covered by your plan. If you move out of the service area for your plan, you are permitted to elect coverage with another company-sponsored medical plan. To enroll in a new plan, you must call the RBC.

In the event of the birth or adoption of a child, you must enroll your child within 31 days of the birth date or, for adoptions, the custody date. You can enroll your child either online through *Desktop Benefits* or by calling the RBC. ***Note that if you do not add your newborn or newly adopted child, he/she will not be covered—even if you currently have family coverage.***

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

MAKING CHANGES TO YOUR COVERAGE OUTSIDE THE ANNUAL OPEN ENROLLMENT PERIOD

Remember: If you are eligible to make a change to your medical coverage due to a qualified change in status (as listed earlier in this section) or because your home address changes to outside your current medical plan's service area, the change(s) you make must be due to and consistent with your change in status. ***This means you cannot add or remove other still-eligible dependents from your coverage or, with the exception of a change in your home address that is outside your medical plan's service area, choose a different plan.***

Event	What Happens/Action Required
You gain an eligible dependent by marriage	• You have six months from the date of your marriage to add your spouse to your coverage. • You must provide dependent eligibility verification (such as a marriage certificate or joint tax return). Your dependent's coverage will not be effective until the verification documents are received and confirmed.
You divorce, legally separate or your common law marriage to your spouse terminates	• You must remove your dependent from your coverage on or before the date that person is no longer eligible for coverage. Coverage for that dependent ends as of 11:59:59 p.m. local time on the day before the event that makes him/her ineligible for coverage. • ***If you don't remove your previously eligible dependent from your coverage as of the date of the event, you must reimburse the company for any claims incurred after that date.***
You gain an eligible dependent by birth or adoption	• You must enroll your child within 31 days of his/her birth/adoption, even if you already have family coverage. • You will need to provide dependent eligibility verification (birth certificate or proof of custody). Your dependent's coverage will not be effective until the verification documents are received and confirmed. • Once the verification documents are confirmed, coverage is effective as of the birth or custody date. If you make your change before the date of the qualified change, coverage becomes effective as of the date of the qualified change.
Your child ages out of the plan	• If your child reaches age 26, his/her coverage automatically ends at 11:59:59 p.m. local time on the day before his/her 26th birthday.
You take or return from a personal leave	• Your active coverage ends and you will be offered COBRA continuation coverage. • If you elect COBRA coverage, any amounts you have accrued toward the current calendar-year's deductible(s) and out-of-pocket maximum(s) while you were an active employee will transfer and be applied to your COBRA coverage. If you return to work within the same calendar year, the cumulative totals will then transfer back to your active plan. To ensure an accurate accounting, contact your plan carrier. • When you return to work, you will have two options: Enroll in the same coverage you had before going out on leave (both the same plan and covering the same dependent(s)) or drop coverage completely. If you did *not* elect COBRA coverage while on leave and you enroll in the same coverage you had before going out on leave, your plan's deductible(s) and out-of-pocket maximum(s) start over when you return to work. • For more information, see *Continued Coverage under COBRA* in the *Administrative* section.
Your home address changes and is outside your plan's service area	• You can change to a plan that is available in your new zip code.

COVID-19 Update

During the national emergency related to COVID-19, the *Coronavirus Aid, Relief and Economic Security (CARES) Act* passed by Congress in 2020 allows for the extension of certain deadlines.

If you need to enroll yourself or an eligible dependent in your benefits because you or he/she has lost other coverage or he/she is newly eligible to be added to your coverage, you now have until 90 days after the national emergency (or "outbreak period") ends to enroll in coverage, retroactive to the event effective date. You will still be required to pay your contributions, retroactively, for the entire time you and any family members are covered.

This section provides an overview of events that are considered qualified changes in status. For questions related to your specific situation, call the RBC.

Raytheon Benefit Center
800-358-1231

Desktop Benefits
https://raytheon.benefitcenter.com

HIPAA PRIVACY AND SPECIAL ENROLLMENT OPPORTUNITIES

The Health Insurance Portability and Accountability Act of 1996 *(HIPAA) is designed to help keep personal health information private as well as to make it easier for you and your family members to have continued group health plan coverage when you or a family member loses coverage through an employer. Here is a summary of the act's provisions.*

Protected Health Information. *The health benefit plans'* HIPAA Notice of Privacy Practices for Protected Health Information *explains what "protected health information" is; how the plans may use and disclose this information; and how you can exercise your rights concerning this information. HIPAA requires that the plans remind you that this notice is available on* Desktop Benefits *(click on the link to* Notice of Privacy Practices *under* My Resources *in the* Other Benefits *section) or by calling the RBC.*

Special Enrollment Opportunities. *If you decline coverage for yourself or your eligible family members because of other health insurance coverage, you may be able to enroll yourself or your dependents in a company-sponsored health plan or change your health plan election in the future, provided that you request enrollment within 31 days of when your other coverage ends.*

This special enrollment right is available only if one of the following conditions is met:

- *You or a family member becomes ineligible for coverage under another employer's health plan or other health insurance;*
- *An employer's contributions for the other coverage stop; or*
- *In the case of COBRA coverage, because the maximum COBRA period has expired.*

In addition, if you or a dependent gains or loses eligibility for Medicaid, Medicare or a state children's health plan, or if you or a dependent becomes eligible or ineligible for state assistance for coverage under the plan, you may be able to enroll or end coverage for yourself or your dependents, provided you request enrollment within 31 days of the date eligibility was gained or lost or within 60 days in the case of a Medicaid or state assistance event.

You also have a special enrollment opportunity if:

- *You marry; or*
- *You or your spouse acquires a dependent through your marriage or the birth, adoption or placement for adoption of the dependent.*

In all cases, if you are adding eligible dependents, all necessary verification documents must be confirmed before a dependent's coverage becomes effective. See Eligible Dependents *earlier in this section for more information.*

If Your Coverage Ends. *If your coverage under a company-sponsored health plan ends, you may request a written certificate of coverage from the RBC.*

About the Medical Plans

The two primary medical plans the company offers are administered by UnitedHealthcare (UHC): UHC HSA Advantage 1 and UHC HSA Advantage 2. The UHC HSA Advantage plans are available in most parts of the country.

If you live in California, Colorado or the mid-Atlantic states, you also have access to an HSA Advantage plan administered by Kaiser Permanente. If you live in an area where a fully developed provider network is not available, you have access to the UHC Out-of-Area plan. If you are on an international assignment, the company offers Global Choice (which provides medical and dental coverage).

A brief description of the UHC HSA Advantage plans follows. For a detailed description of your medical plan, see the appropriate section. If you participate in an HSA Advantage plan, see also the *Health Savings Account* section.

UHC HSA Advantage Plans

With the UHC HSA Advantage plans, you take an active role in managing the cost of your care, with tax advantages and often considerable savings.

About Health Savings Accounts (HSAs)

With a UHC HSA Advantage plan, you are eligible to elect an HSA. Here is a brief summary of how HSAs work:

- The company makes a lump-sum contribution to your HSA in January. The amount of the company's contribution varies by plan and coverage level. (For new employees: the company's contribution to your HSA is prorated for that year. For more information, see *For New Hires* in the *Health Savings Account* section.)
- You also can choose to make tax-free contributions to your HSA, lowering your taxable income. Note that state income tax laws in Alabama, California, New Hampshire, New Jersey and Tennessee differ from the federal income tax treatment of HSA contributions and earnings.
- The maximum amount you and the company combined can contribute is subject to an annual federal limit, which varies by coverage level. Note that if you are age 55 or older, you may make an additional $1,000 catch-up contribution to your HSA each year (including the year you turn 55).
- You always own the money in your HSA. Any unused money carries over to the next year and may earn interest—there are no "use-it-or-lose-it" rules. And if you leave the company or retire, the money in your HSA belongs to you.
- Depending on your circumstances, you can use your HSA to pay for a variety of eligible health care expenses—including those that help you meet the medical plan's deductible (meaning you have "first-dollar coverage")—or save it for the future.
- Your HSA debit card makes it easy to access the funds in your HSA. Use this card to pay for eligible expenses wherever the provider accepts Visa®.
- Fidelity Investments® administers the HSAs. Any questions regarding your HSA should be directed to Fidelity at www.netbenefits.com/raytheon or by calling 800-544-3716.
- Note that you are not eligible to make or receive contributions to an HSA if you are enrolled in other medical coverage that is not an HSA-qualified plan, including Medicare, TRICARE or a non-high-deductible plan or health care flexible spending account (FSA), such as may be available through your spouse's employer.

For more information about HSAs, including a description of situations where you may not be eligible to fund an HSA, see the *Health Savings Account* section.

Each medical plan (except those available in Hawaii) is described in a separate section of this handbook. Refer to each section and its associated chart of benefits for detailed information about the costs (including deductibles, coinsurance and out-of-pocket maximums) associated with common services. The *UnitedHealthcare Plans* section also includes a list of limitations and exclusions. For details about your HSA, see the *Health Savings Account* section. A brief description of the plans available in Hawaii can be found earlier in this section.

To help you and other eligible family members manage your health care benefits, the company offers Health Advocate.SM Available to you at no cost, Health Advocate can help you manage any claims and billing issues, help resolve medical- and/or prescription drug-related issues and schedule hard-to-get appointments with specialists.

For more information about Health Advocate, see the description earlier in this section, or call 866-695-8622.

UHC: www.myuhc.com; 800-638-8884

Kaiser Permanente California
https://my.kp.org/raytheon; 800-464-4000

Kaiser Permanente Colorado
https://my.kp.org/raytheon; 303-338-3800

Kaiser Permanente Mid-Atlantic States
https://my.kp.org/raytheon; 800-777-7902

Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

About Medical Coverage

Here is a summary of how medical coverage with a UHC HSA Advantage plan works.

- The federal government regulates the design of health plans that are HSA-eligible.
- Covered expenses are subject to a deductible, with the following exceptions:
  - Routine in-network preventive care, which is covered at 100% in-network with no deductible. In compliance with the *Affordable Care Act* (ACA), this coverage extends to include Women's Health Services, certain preventive supplements and smoking-/tobacco-cessation prescriptions (for a description, see *Common Medical Plan Features* later in this section);
  - Drugs on the federal Treasury Guidance list, specifically:
    - *Generic* preventive prescription drugs to treat chronic conditions, including high cholesterol, high blood pressure and asthma, which are covered at 100%, no out-of-pocket cost;
    - Oral and insulin *diabetic medications* (and supplies, if purchased at the same time), which are covered at 100%, no out-of-pocket cost. **Note: To avoid extra steps, your pharmacist must submit the charges for the insulin/medication *first* (before the supplies).** If the supplies are submitted first, you will be charged for them. Should this happen, you'll need to ask your pharmacist to reprocess the charges in the appropriate order *before* you pick up your medications/supplies or call Customer Care to request that the charges be reprocessed; and
    - *Brand-name* preventive prescription drugs—including those used to treat high blood pressure, cardiovascular diseases, osteoporosis and mental health disorders, which are subject to coinsurance.

    To review the Treasury Guidance list, go to www.caremark.com or call CVS Caremark at 866-329-4023.
- Electing a PCP is recommended, but not required.
- The plans are network-based, meaning you choose whether to visit a network provider and receive the highest level of benefits, or visit an out-of-network provider and pay more out-of-pocket.
- The deductible can be satisfied by one family member or a combination of family members. **If you have family coverage, you must satisfy the family deductible before the deductible is considered satisfied. In other words, benefits are payable only after you satisfy the family deductible.**
- After you meet the applicable deductible, the plans pay a percentage of eligible expenses (in-network services are covered at a higher percentage than services you may receive out-of-network). You pay the remainder of charges until you reach the calendar-year in-network or out-of-network out-of-pocket maximum (both of which include the applicable deductible and coinsurance for all eligible services and supplies).
- If you reach the out-of-pocket maximum, the plan covers eligible expenses at 100% in-network (up to negotiated amounts out-of-network; see *How Eligible Expenses Are Paid Out-of-Network* in the *UnitedHealthcare Plans* section for more information) for the remainder of the calendar year. Note that while the family in-network calendar-year out-of-pocket maximum for UHC HSA Advantage 1 is $8,200, the most any one individual family member needs to spend to satisfy his/her share of this plan's out-of-pocket maximum is $7,150.
- Contact information: www.myuhc.com, 800-638-8884.

Have Health-Related Questions? Ask a Nurse!

All company-sponsored medical plans offer a "nurseline" service where you can speak directly with a nurse 24 hours a day, seven days a week. You can call your plan's nurseline to:

- Find in-network doctors, specialists or hospitals;
- Understand treatment options;
- Ask medication questions;
- Help choose appropriate medical care; and
- Locate available resources.

For more information about your plan's nurseline, call the Customer Service number listed on your medical ID card.

UHC: www.myuhc.com; 800-638-8884

Kaiser Permanente California
https://my.kp.org/raytheon; 800-464-4000

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Kaiser Permanente Mid-Atlantic States
https://my.kp.org/raytheon; 800-777-7902

Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

NOTE FOR EMPLOYEES WHO ARE ENROLLED IN MEDICARE

Federal regulations prohibit any one who is making or receiving contributions to an HSA from having "other health care coverage," including Medicare Part A, Part B and/or Part D. That means if you are enrolled in Medicare, you are not eligible to make or receive contributions to an HSA.

Because the HSA Advantage plans are not linked to an HSA, if you are enrolled in Medicare, you can elect an HSA Advantage plan without funding an HSA.

Note that if you are enrolled in Medicare, you can use an existing HSA to pay for eligible expenses incurred by you and your tax dependents; in this case your HSA is not considered other health care coverage.

Other Company-Sponsored Medical Plans

In addition to the UHC HSA Advantage plans, the company offers:

- An HSA Advantage plan administered by Kaiser Permanente in California, Colorado and the mid-Atlantic states. While these plans work similarly to the UHC HSA Advantage 1 plan, with the exception of emergency care, they do not provide coverage if you seek care outside the Kaiser Permanente network. They do, however, cover preventive prescription drugs at 100% (no deductible, no coinsurance). In addition, since the Kaiser Permanente plans require a referral for certain services, you are advised to elect a PCP for yourself and each family member you cover when you first enroll. You can elect your PCP online or by calling Kaiser Permanente;
- The UHC Out-of-Area Plan, if you live in an area where a fully developed UHC provider network is not available; as well as
- Global Choice (which includes medical and dental coverage), for eligible employees on international assignments.

Again, the plan(s) available to you are shown on *Desktop Benefits.*

TRICARE SUPPLEMENT PLAN*

The TRICARE Supplement Plan is available as a voluntary benefit to eligible employees and their spouses who have retired from any of the U.S. armed forces with at least 20 years of service. The company does not sponsor this plan but provides access to it through pre-tax deductions. For more information about the TRICARE Supplement Plan, contact Selman & Company ASI, the plan's administrator, at 800-638-2610 or go to www.asicorporation.com/raytheon. To enroll in the TRICARE Supplement Plan, call the RBC.

**Beginning January 1, 2021, the TRICARE Supplement Plan will not be available in Colorado, Maine, New Hampshire, Utah or Washington.*

MEDICAL COVERAGE FOR INTERNATIONAL BUSINESS TRAVELERS

Offered by Cigna, Medical Benefits Abroad® (MBA) provides medical coverage for U.S.-based employees who travel outside the United States on business for up to six months.

To review a description of how coverage works and print out an ID card, go to www.cignaenvoy.com (see your travel itinerary for login information). If you need assistance while traveling, dial the International Access Code (IAC), available at www.att.com/traveler, and then 800-243-1348 or call 302-797-3535 collect.

UHC: www.myuhc.com; 800-638-8884

Kaiser Permanente California
https://my.kp.org/raytheon; 800-464-4000

Kaiser Permanente Colorado
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Kaiser Permanente Mid-Atlantic States
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Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

Choosing a Medical Plan

DecisionAssist

Choosing a medical plan is one of the most important financial decisions you make each year. That's why the company offers *DecisionAssist,* an easy-to-use online tool that can help you choose which HSA Advantage plan will best match your needs.

DecisionAssist can provide you with a side-by-side comparison of the plans available to you, showing a comprehensive view of your health care costs. All you have to do is:

1. Answer a few questions about yourself, such as what type of coverage you're researching (employee only, family, etc.); and
2. Choose the health care scenario you anticipate for the next year or enter your own cost estimates. Note that if you're currently enrolled in a UHC medical plan, you can choose to have 12 months of your common medical and prescription drug expenses automatically imported into the tool.

DecisionAssist takes into consideration the design of the HSA Advantage plans, including deductibles, coinsurance and out-of-pocket maximums. The tool also has up-to-date service costs, and takes into account the company's HSA contribution, if applicable, your premium contributions and even your anticipated tax rate. You can easily change your expected health expenses or add family members, and quickly see how these factors affect your results. Plus, you can model as many scenarios as you want.

DecisionAssist takes only a few minutes to use. Model a few scenarios today. Doing so could save you a significant amount of money next year!

Other Tools

To help learn about your medical plan, you also have access to:

- *Links to lists of participating doctors and hospitals.* Get help finding participating providers in the health care plans you're eligible for; and
- *Online medical plan summary charts* that compare how benefits are paid and out-of-pocket costs.

To access these tools, see the *My Resources* listing available on *Desktop Benefits*.

If you have questions about the HSA Advantage plans, call the RBC. When you call, you can speak with an HSA Service Team representative who can help you assess your options as well as answer any questions you may have. Representatives are available Monday through Friday from 8 a.m. to 8 p.m. ET. If you have questions about HSAs, call Fidelity at 800-544-3716.

If you participate in a UHC plan, you can elect to have 12 months of common prescription drug costs automatically imported into *DecisionAssist.* To estimate future expenses, go to www.caremark.com and click on *Check Drug Costs.* Note that you will need to register with www.caremark.com in order to access this link.

Summary of Benefits and Coverage (SBC)

Group health plans are required to provide consumers with a *Summary of Benefits and Coverage* (SBC), a document that describes health plan benefits and coverage using simple and consistent language. To view the SBC for your company-sponsored medical plan, go to *Desktop Benefits.*

UHC: www.myuhc.com; 800-638-8884

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Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

APPROACHING AGE 65?
BE SURE TO UNDERSTAND YOUR MEDICAL COVERAGE OPTIONS

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

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

If You Choose to Enroll in Medicare Part A and/or Part B as an Active Employee

If, in consultation with your tax advisor, you intend to enroll in Medicare Part A and/or Part B when you first become eligible, you can elect an HSA Advantage plan for the year you will become eligible and elect an HSA. In this case, you are eligible to receive the company's lump-sum contribution to your HSA in January (as long as the company contribution is made before you enroll in Medicare) and make your own contributions (not to exceed the annual federal limit listed in the Health Savings Account *section) until you enroll for Medicare. Note that before you enroll in Medicare, your tax advisor may suggest that you maximize your contributions to your HSA, subject to IRS proration rules (including by making a direct contribution to your HSA).*

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

While all contributions to your HSA must stop once you enroll in Medicare, your participation in an HSA Advantage plan will continue automatically. Note that if your spouse or dependents enroll in Medicare but you (as the employee) do not, you can continue making contributions and receiving company contributions to your HSA. You may also continue to use any funds in your HSA to pay for eligible expenses incurred by your tax dependents.

No matter which company-sponsored medical plan you participate in, as long as you're an active employee, your company-sponsored plan remains the primary payor and Medicare is the secondary payor on any claims incurred.

For more information about making your decisions, refer to the letter the RBC will send you approximately five months before you turn 65. In addition, this document provides detailed information on rules and guidelines. Questions? Call the RBC at 800-358-1231.

In the event the RBC is notified that you have enrolled in Medicare, the RBC will send you a letter asking you to confirm or deny your enrollment. If you:

- Confirm your Medicare enrollment, *your HSA contributions will end and Payroll will withdraw any company contributions you were not eligible to receive. To withdraw any ineligible contributions you may have made to your HSA, contact Fidelity.*
- Deny that you enrolled in Medicare, or if you do not respond to the RBC inquiry, *no changes will be made to your HSA or to your HSA contributions.*

Note that in all cases, the tax implications of your Medicare enrollment on your eligibility to receive or make HSA contributions are your responsibility. For more information, see Taxes and Penalties Associated with HSA Contributions Made in Error *in the* Health Savings Account *section.*

If you participate in Medicare Part A, B and/or D, you can elect an HSA Advantage plan *without funding an HSA.* If you currently participate in Medicare, you should not elect an HSA during open enrollment or at any other time during the year if you become eligible to make a medical plan election.

If you will enroll in Medicare during the calendar year following open enrollment, while you may elect an HSA during open enrollment, all contributions to your HSA must stop when your participation in Medicare begins.

If contributions are made to your HSA while you are enrolled in Medicare (either by the company or you), you will be subject to taxes and penalties. For more information, see *Taxes and Penalties Associated with HSA Contributions Made in Error* in the *Health Savings Account* section.

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

UHC: www.myuhc.com; 800-638-8884

Kaiser Permanente California
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Kaiser Permanente Mid-Atlantic States
https://my.kp.org/raytheon; 800-777-7902

Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

Highlights of the Medical Plans

The company's medical plans provide comprehensive benefits for you and your covered family members. Each option covers a range of services and supplies, including:

- ***Comprehensive wellness and preventive-care coverage*** (see the *Wellness and Preventive-Care Benefits* inset box for a description);
- ***Inpatient care;***
- ***Outpatient care;***
- ***Physician services;***
- ***Emergency and urgent care;*** and
- ***Mental health and substance use disorder treatment.***

When you enroll in a company-sponsored medical plan, you and your eligible dependents also receive coverage for prescription drugs. CVS Caremark administers prescription drug coverage for the UHC plans and for Global Choice when you fill a prescription in the United States (see the *CVS Caremark Prescription Drug Program* section for details).

Note that prescription drug coverage is provided by the individual medical plan for Kaiser Permanente and for eligible expatriate employees and their Global Choice-enrolled dependents who fill a prescription outside the United States. For more information about prescription drug benefits for these plans, refer to the applicable medical plan section.

Medical ID Card

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

If You Participate in a UHC Plan. Your UHC ID cards list the name of your plan's network (Choice Plus for the UHC HSA Advantage plans or the Options PPO for the Out-of-Area plan).

For employees in Massachusetts, Maine, New Hampshire and Rhode Island who participate in a UHC HSA Advantage plan, the Harvard Pilgrim Passport Connect Program® logo also appears on your ID card. Note that in New England, the network you use depends on where you live and where you seek care. For details, see the first page of the *UnitedHealthcare Plans* section. When you go to www.myuhc.com, be sure to search for providers using the name of your network, not the name of your plan.

ONLINE SERVICES

The company's medical plans offer a variety of services and resources you can access online, such as locating network providers, printing ID cards, getting health information, using a cost-estimator and checking the status of a claim. While services and resources vary by plan carrier, your medical plan's website is a great place to start if you have questions about your plan or about your health in general.

To take advantage of the online information available from your medical plan, go to Desktop Benefits *and link to the website for your plan from the* Benefit Provider Contacts *list under* My Resources.

UHC: www.myuhc.com; 800-638-8884

Kaiser Permanente California
https://my.kp.org/raytheon; 800-464-4000

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Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

Common Medical Plan Features

While benefits coverage varies among medical plan options, the following features are common to all company-sponsored plans. Note that preventive-care services may vary for Global Choice and the Kaiser Permanente plan available in Hawaii; see the appropriate *Evidence of Coverage* for details.

WELLNESS AND PREVENTIVE-CARE BENEFITS

All company-sponsored medical plans provide coverage for eligible, in-network preventive-care services (as identified by the ACA under the Preventive Care Services benefit) at 100% with no out-of-pocket expense. Examples of covered preventive-care services include:

- *An annual routine physical exam for adults;**
- *Routine preventive lab tests;*
- *Well-woman exam;*
- *Routine mammogram, beginning at age 40 or as recommended by your physician. Note that UHC and Global Choice cover 3D mammograms for routine exams; contact your plan carrier for details;*
- *Well-baby and well-child care, from birth through age 18;**
- *Immunizations for adults and children;*** and*
- *Preventive nutritional counseling.****

Each preventive-care benefit is generally limited to one per calendar year, with the exception of well-baby and well-child care, which is available according to a schedule, and preventive nutritional counseling, for which two visits per year are covered. Lab tests and screenings are covered according to age and gender recommendations of the U.S. Preventive Services Task Force (USPSTF) and/or the guidelines supported by the Health Resources and Services Administration.

For the UHC HSA Advantage plans, note that wellness and preventive care received from an out-of-network provider is subject to a deductible and coinsurance.

Additional Preventive Care Services

In addition to the preventive care services outlined above, all company-sponsored medical plans provide 100% coverage without any deductible for the following preventive care services, as required by the ACA:

- *Women's Health Services, including:*
  - *Breast-feeding equipment;*
  - *Contraceptives for women, including FDA-approved oral, injectable and emergency contraceptives;*
  - *Domestic violence screenings;*
  - *Folic acid supplements for women (patients must meet age guidelines);*
  - *Gestational diabetes screenings; and*
  - *Voluntary sterilization;*
- *Iron supplements for infants;*
- *Oral fluoride supplements for preschool children; and*
- *Smoking-/tobacco-cessation counseling and prescriptions, such as bupropion; nicotine-replacement patches, gum and lozenges; and Chantix®*

In order to receive 100% coverage for any prescription that qualifies as preventive care, you must use a generic.

For more information about how your plan covers specific services, call the plan's Customer Service number on your medical ID card. For more information about prescriptions that qualify as preventive medications for the UHC plans and Global Choice, go to www.caremark.com or call CVS Caremark at 866-329-4023. For information related to plans administered by Kaiser Permanente, contact Kaiser.

*Physical exams required by a third party, such as a school or camp, are not covered. An exam is considered routine if you are presenting no unusual complaints to your physician.

**Travel-related immunizations are not covered.

***Preventive nutritional counseling for the Kaiser Permanente plans works differently. For a description, refer to the *Evidence of Coverage* booklet for your plan.

For specific information about how your plan covers preventive care, refer to the summary of benefits chart for your plan or call the toll-free Customer Service number listed on your medical ID card.

To be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. If you have any questions, call the toll-free Customer Service number listed on your medical ID card.

UHC: www.myuhc.com; 800-638-8884

Kaiser Permanente California
https://my.kp.org/raytheon; 800-464-4000

Kaiser Permanente Colorado
https://my.kp.org/raytheon; 303-338-3800

Kaiser Permanente Mid-Atlantic States
https://my.kp.org/raytheon; 800-777-7902

Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

Primary Care

Your PCP is generally the first person you'll call when you have a health care need. Although the UHC plans do not require you to choose a PCP or obtain a PCP referral to see a specialist, it's always recommended. (Note that since the Kaiser Permanente plans require a referral for certain services, it is recommended that you elect a PCP when you first enroll.)

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

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

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

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

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

IMPORTANT INFORMATION ABOUT RECEIVING CARE

While choosing a PCP to coordinate your care is always recommended, the UHC plans do not require that you make a PCP election.

Since the Kaiser Permanente plans require a referral for certain services, you are advised to elect a PCP for yourself and each family member that you cover when you first enroll. You can elect your PCP online or by calling Kaiser Permanente.

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

A Note for Participants in the UHC Out-of-Area Plan. *Because the Out-of-Area Plan is not network-based, coverage is provided at the same benefit level regardless of your choice of provider or location within the United States. However, you can save money when you use a provider in UHC's Options PPO, which is available nationwide. For more information about the Options PPO, see the description of the Out-of-Area plan in the* UnitedHealthcare Plans *section.*

Specialty Care

All medical plans offer access to specialists, including:

- Cardiologists;
- Chiropractors;*
- Dermatologists;
- Ear/nose/throat doctors;
- OB/GYNs (note that routine annual exams, pap smears and mammograms with a network OB/GYN specialist are covered as preventive care, as described earlier);
- Physical, speech, occupational, cardiac rehabilitation and pulmonary therapists; and
- Podiatrists.

*Note that chiropractic care may require you to use a specific network. Before receiving care, refer to the summary of benefits chart for your plan or call the toll-free Customer Service number listed on your medical ID card.

Outpatient Diagnostic Services

Outpatient diagnostic services (such as simple lab tests and x-rays as well as complex services, such as MRIs, CT scans and PET scans) are covered separately from physician or specialist office visits—***even if you receive these services in a physician's office.*** For information about coverage for outpatient diagnostic services, refer to the summary of benefits chart for your plan.

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Kaiser Permanente Mid-Atlantic States
https://my.kp.org/raytheon; 800-777-7902

Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

Note that the Kaiser Permanente plans require a referral for certain services. That's why you are advised to elect a PCP for yourself and each family member that you cover when you first enroll. In addition, for network-based plans that do not require a referral, you must receive care from a network specialist to receive the highest level of benefits.

For information about how your plan covers specialty care, refer to the summary of benefits chart for your plan or call the toll-free Customer Service number listed on your medical ID card.

Pregnancy and Maternity Care

With the ACA, certain services and supplies related to pregnancy and maternity care are covered at 100%. Other services are subject to deductible and coinsurance amounts.

The following provides a general description of how services related to pregnancy and maternity care are covered. In all cases, the amount you pay for a particular service varies by the specific medical plan (for a description of benefits for your plan, see the appropriate section).

Medical Services Generally Covered at 100%

In addition to an annual well-woman exam (which includes a breast exam and pap smear), some services related to pregnancy and maternity care are covered at 100% with no deductible or coinsurance when you visit a network provider. Examples include:

- A preconception counseling visit;
- Routine prenatal care visits (not including the initial consultation visit). Note that in cases of high-risk pregnancies, prenatal care visits are subject to deductible and/or coinsurance;
- Certain screenings, such as for anemia and Rh incompatibility (eligible screenings must be billed using the appropriate diagnosis code);
- Breast pumps (note that eligible breast pumps must generally be purchased from a network supplier and can be ordered within 30 days of the baby's estimated delivery date); and
- Lactation support and counseling provided through a network physician or health care professional.

Services Subject to Deductible and Coinsurance

All other pregnancy- and maternity-related services are subject to the deductible and coinsurance amounts (as outlined by each plan). Examples include:

- Initial pregnancy-related consultation visit;
- Delivery (including midwife and birthing center services);
- Prenatal services that are not considered well-woman care, such as lab tests and radiology services (including obstetrical ultrasounds and sonograms); and
- Postnatal care.

If you have any questions regarding how pregnancy- and maternity-related care is covered, call the toll-free Customer Service number listed on your medical ID card.

Emergency and Urgent Care

All company-sponsored medical plans pay in-network benefits for initial emergency and urgent care even if you use out-of-network providers—as long as you follow plan rules. Once the initial care has been provided, you must follow plan procedures; otherwise, future services provided in relation to the emergency or urgent care either will not be covered or be paid at the out-of-network benefit level, if available.

For more information about how your plan covers emergency and urgent care, refer to the summary of benefits chart for your plan or call the toll-free Customer Service number listed on your medical ID card.

Reminder for Participants in a Kaiser Permanente HSA Advantage Plan

For detailed information about the Kaiser Permanente HSA Advantage plans, you should always refer to the *Evidence of Coverage* booklet—which describes covered services, any limitations and special programs that may be offered—or call the Member Services number on your medical ID card. To view the *Evidence of Coverage* booklet, go to http://my.kp.org/raytheon (for a hard copy, call the toll-free Member Services number on your medical ID card). Note that in the case of any discrepancy between this description and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

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Kaiser Permanente Mid-Atlantic States
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Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

Emergency care is usually needed because of an accidental injury or the sudden onset of a medical condition that cannot be safely postponed for the time it takes to contact your doctor; for example, a heart attack or a stroke.

To be covered as an emergency, your condition must be considered an emergency. This means care and treatment provided after a serious medical condition or symptom that resulted from an injury, a sickness, a mental illness or substance use disorders, and that:

- 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.

You are covered for emergency care no matter where you are. If you need emergency care, go to the nearest emergency room. In order to receive the highest level of benefits, you must contact your plan or PCP within 48 hours of receiving emergency care or on the next business day (whichever comes first). If follow-up care is not provided by your PCP or a network physician, or authorized by your plan, those services will either not be covered or paid at the lower out-of-network benefit level, if available.

Urgent care is health care that prevents serious deterioration of your health but that can be safely postponed for the time it takes to contact your PCP or a network physician for advice. Examples include a sprained ankle, an earache or a cut requiring stitches.

If you need urgent care and participate in:

- A UHC plan, you may proceed directly to an urgent care facility. Benefits are paid according to how your plan covers eligible services.
- A plan other than a UHC plan, in most cases, you must contact your PCP or a network physician, or call the toll-free Customer Service number listed on your medical ID card ***before*** receiving care. Your PCP, the network physician or your plan, as applicable, will determine where you can most effectively receive treatment. If this procedure is not followed, services will either not be covered or paid at the lower out-of-network benefit level, if available.

For more information about how your plan covers urgent care, see the appropriate medical plan section.

CVS MINUTECLINIC®

If you have a minor health issue when your regular provider isn't available—including if you're away from home, CVS MinuteClinic® walk-in medical clinics are a cost-effective way to get the care you need. Note: If you participate in a Kaiser Permanente HSA Advantage plan, your visit to a MinuteClinic is covered only *if you are traveling outside a state where Kaiser Permanente operates.*

Staffed by nurse practitioners and physician assistants (in select states) who specialize in family health care, MinuteClinics care for children and adults, every day with no appointment needed.

Practitioners:

- *Diagnose, treat and write prescriptions for common family illnesses such as strep throat, bladder infections, pink eye and infections of the ears, nose and throat;*
- *Provide common vaccinations for flu, pneumonia, pertussis and hepatitis, among others;*
- *Treat minor wounds, abrasions, joint sprains, and skin conditions such as poison ivy, ringworm, lice and acne; and*
- *Offer routine lab tests, instant results and education for those with diabetes, high cholesterol or high blood pressure.*

With your permission, MinuteClinic will share records with your primary care provider.

Note that you should not seek care at MinuteClinic if you are experiencing severe chest pain, severe shortness of breath or difficulty breathing, suspected poisoning or a high fever. Patients with conditions or health needs outside of the clinical scope available will be directed to other health care providers within the community.

To find a MinuteClinic near you, go to https://www.cvs.com/minuteclinic.

If you need emergency care, go to the nearest hospital.

If you need urgent care whether at home or away and you participate in a UHC plan, be sure to visit a UHC network urgent care facility and not a hospital's free-standing emergency room (or "urgency" center). That's because the cost of care at a hospital-owned facility can be up to 20 times more than the cost of care at a network urgent care facility!

To compare quality and cost before you seek care, go to www.myuhc.com and link to the *myHealthcare Cost Estimator.* This tool makes searching for health care options as easy as any online shopping experience, with local cost information about procedures, treatments, providers and facilities.

If you need urgent care and do *not* participate in a UHC plan, call the toll-free Customer Service number listed on your medical ID card for assistance in how to receive maximum benefits from your plan.

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Ambulance Services

The medical plans cover emergency ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be performed.

For more information about how your plan covers ambulance services, refer to the summary of benefits chart for your plan or call the toll-free Customer Service number listed on your medical ID card.

Mental Health and Substance Use Disorder Care

All company-sponsored medical plans provide benefits for medically necessary, confidential counseling and referral services for mental and nervous disorders as well as for substance use disorders. For a description of benefits, see the summary of benefits chart for your plan or call the toll-free Customer Service number listed on your medical ID card. To ensure you receive the highest level of benefits, be sure to contact your medical plan *before* seeking care.

TREATMENT FOR AUTISM SPECTRUM DISORDER (ASD)

Autism Spectrum Disorder (ASD) is a mental health disorder that spans a wide range of symptoms and levels of impairment, from mild to severe. According to recent data from the Centers for Disease Control, the incidence of ASD is growing—with one in 68 children now being diagnosed with ASD.

All company-sponsored medical plans provide coverage for a range of services related to treating ASD, including Applied Behavior Analysis (ABA) therapy. Covered services and any limitations vary by medical plan. For a description of how your plan covers these services, see the appropriate section of this handbook or contact your provider.

UHC SUBSTANCE USE TREATMENT PROGRAM

To help those with a substance use disorder, UHC offers the Substance Use Treatment Program, which includes a helpline. This service is part of your health benefit and is provided at no additional cost to you.

When you call 855-780-5955 (available 24/7), a licensed clinician can answer your questions and help you determine next steps.

To learn more about the warning signs of alcohol and drug use, including ideas about how to support an adult child and descriptions of different treatment methods, call the helpline at 855-780-5955 or go to liveandworkwell.com/recovery.

When You Are Away from Home

The company's medical plans provide coverage at the in-network level for certain care, such as emergency care received while you or a covered family member is traveling, including children who attend school away from home. You must contact your PCP or your plan within 48 hours or the next business day (whichever comes first) of receiving emergency care.

In some cases, a network doctor or facility may be available in the area in which you are traveling or where your child attends school. In this case, you may choose a network provider in that area and receive care at the in-network level. To find network providers or urgent care centers outside of your home area, go to your plan's website or call the toll-free Customer Service number listed on your medical ID card. Note that in some cases, you may want to seek care at a CVS MinuteClinic; see the inset box earlier in this section for more information. Note: If you participate in a Kaiser Permanente HSA Advantage plan, your visit to a MinuteClinic is covered *only* if you are traveling outside a state where Kaiser Permanente operates.

If there are no network providers in the area, all other non-emergency services (for example, physical therapy) will not be covered or will be paid at the out-of-network benefit level, if available. If you or a covered family member needs routine preventive care, such as physicals or well-child visits, you must schedule these with your PCP or a network physician. If you do not, eligible services will not be covered or paid at the out-of-network benefit level, if available.

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Global Choice: www.cignaenvoy.com; 800-441-2668 or 302-797-3100 (24/7, collect calls accepted from outside the U.S.)

Coverage for Eligible Dependents Who Live Away from Home

If your covered child or spouse permanently resides outside your plan's service area or is temporarily living away from home, he or she is still covered by your medical plan.

Your covered dependents are always covered for care received in an emergency. (See *Emergency and Urgent Care* earlier in this section for a definition.)

In the case of non-emergency care, your covered dependent may choose a network provider in his or her area and receive care at the in-network level. To find network providers or urgent care centers outside of your home area, go to your plan's website or call the toll-free Customer Service number listed on your medical ID card. Note that in some cases, your covered dependent may want to seek care at a CVS MinuteClinic; see the inset box earlier in this section for more information. Note: If you participate in a Kaiser Permanente HSA Advantage plan, your visit to a MinuteClinic is covered *only* if you are traveling outside a state where Kaiser Permanente operates.

Non-emergency care (including preventive care) received from an out-of-network provider is covered at the out-of-network benefit level, if available. If your plan does not offer out-of-network coverage, non-emergency care is not covered. Note that since the UHC Out-of-Area plan is not network-based, eligible non-emergency care is covered regardless of where your dependent lives.

FINAL COVERAGE DETERMINED BY MEDICAL PLAN CARRIER

The medical plan carrier makes the final decision as to whether or not a particular service is covered. In order to determine what is and is not covered under your plan, see your plan's summary of benefits chart as well as the list of limitations and exclusions, or contact your medical carrier at the toll-free Customer Service number listed on your medical ID card.

For information about how to appeal a denied claim, see Applying for Benefits *in the* Administrative *section.*

COORDINATION OF BENEFITS AND SUBROGATION PROVISIONS

All company-sponsored medical plans include coordination of benefits (COB) and subrogation provisions.

COB means that payments from a company-sponsored plan are coordinated with those you may be entitled to receive from other plans. This prevents duplication of payment if you or your dependents are covered by another group insurance plan.

Subrogation applies if you receive payment from a third party that is held liable for any injury that required medical care. In this case, you may be required to reimburse your plan for claim payments.

See the Administrative *section for more information about COB and subrogation.*

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UnitedHealthcare Plans

With an extensive nationwide network, a commitment to wellness and 'round-the-clock access to nurses, UnitedHealthcare (UHC) plans are available to the majority of employees and their family members.

As an eligible employee, you can choose from two UHC medical plan options: UHC HSA Advantage 1 and UHC HSA Advantage 2. If you live outside the network area for these plans, you have access to the UHC Out-of-Area plan.

This section provides a description of features that are common to the UHC plans, information about each plan, including a summary of benefits chart, and a list of limitations and exclusions for all three plans, with slight differences noted.

If you have questions about specific benefits, call UHC at 800-638-8884. (TDD number available by appointment.)

While UHC does not require you to choose a primary care physician (PCP) or obtain a PCP referral to see a specialist, it is always recommended that you choose a PCP to coordinate all your care, including routine physical exams and related preventive-care services.

If you are a new employee and want to learn more about the UHC plans available to you, go to UHC's pre-enrollment website at http://welcometouhc.com/raytheon.

UHC offers an extensive national network of doctors, specialists, hospitals and other health care providers/facilities. While the name of the network generally varies depending on where you live (see the chart to the left), for purposes of simplicity, this section references the Choice Plus network.

ABOUT THE UHC NETWORK

UHC offers an extensive national network of doctors, specialists, hospitals and other health care providers/facilities, including more than 895,000 physicians and health care professionals, and more than 5,600 hospitals. These providers /facilities contract with UHC to provide quality medical services at predetermined rates.

For UHC HSA Advantage Plan Participants in New England:
Access to the Passport Connect Program®

For UHC HSA Advantage plan participants in New England, UHC partners with Harvard Pilgrim Health Care (HPHC) to offer the Passport Connect Program.® This program combines Harvard Pilgrim's doctor and hospital network in Massachusetts, Maine and New Hampshire with UHC's extensive coast-to-coast network, giving you access to many of the best providers/facilities in the country.

In New England, the network you use depends on where you live and where you access care, as shown in the following chart. ***Note that in all cases, chiropractors and behavioral health providers can be found in the UnitedHealthcare Choice Plus network, not the Passport Connect Program.***

If You Live In …	… And You Access Care In …	… Use This Network To Receive In-Network Benefits
Massachusetts, Maine or New Hampshire	Massachusetts, Maine or New Hampshire	Passport Connect Program
Rhode Island	Rhode Island	UnitedHealthcare Choice Plus
	Massachusetts, Maine or New Hampshire	Passport Connect Program

New employee? To check if a doctor participates in the Choice Plus network or the Passport Connect Program, go to UHC's pre-enrollment website at http://welcometouhc.com/raytheon, or call UHC at 800-638-8884.

For Participants in the Out-of-Area Plan

If you participate in the Out-of-Area plan, you have access to the UHC Options Preferred Provider Organization (PPO)—a network of physicians, specialists and health care providers/facilities that has negotiated discounted rates for covered health services. For more information, see the Out-of-Area Plan *section.*

A Word about ID Cards

Note that your UHC ID card lists the name of the network *your plan utilizes (Choice Plus or, for the Out-of-Area plan, the Options PPO). If you live in New England, the Passport Connect Program logo also appears on your ID card. If you have any questions, call UHC.*

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

TAKE ADVANTAGE OF THE UHC MEMBER WEBSITE

The UHC website provides a personalized digital experience, with information and recommendations designed just for you!

Accessible from any Internet-connected computer or mobile device, the site is easy to navigate, making it simple to find the health information you're looking for and manage your health care online.

To get started, simply go to www.myuhc.com, select Register Now *and provide the requested information. You will then have 24/7 access to the site where you can:*

- *Identify, choose and locate UHC providers/facilities;*
- *Check the status of any claims, including the amount charged, amount paid and your required contribution;*
- *Request, view and print ID cards;*
- *Review your benefits and verify eligible enrolled dependents;*
- *Link to UnitedHealthcare's Health Forums for more personalized health information, e-mail newsletters, online events, as well as wellness tips and topics;*
- *View, print and download an* Explanation of Benefits;
- *Access a wide range of health care information; and*
- *Update coordination of benefits information for your dependents.*

Questions? Call 800-638-8884. If you are hearing impaired, the TDD number is available by appointment. All numbers are available Monday through Friday, 8 a.m. to 8 p.m. Eastern Time (ET).

MANAGING YOUR HEALTH CARE COSTS

The HSA Advantage plans work best when you do a little research before choosing your service. When you go to www.myuhc.com, you can compare quality and cost before seeking care. For example, you can:

- *Link to* myHealthcare Cost Estimator, *which makes searching for health care options as easy as any online shopping experience, with local cost information about procedures, treatments, providers and facilities,*
- *Get a picture of your spending,*
- *Track and see the status of your claims, including the amount charged, the amount paid and your required contribution,*
- *View a personalized claims video, which breaks down charges and helps you understand the amount you owe,*
- *View a snapshot of your activity, benefits paid and outstanding balances,*
- *Learn about available discounts on health and wellness products and services.*

And, if you need to pay your health care provider/facility, you may be able to send a payment through InstaMed.® Note that some providers/facilities are not able to accept payments via InstaMed.

To access these features and for details about covered services and supplies, go to www.myuhc.com or call UHC.

UHC makes it easy to manage your health plan and make informed decisions about your care. Just go to www.myuhc.com and you'll have access to everything you need, including your own personalized plan information, choices for where to go for care, budgeting tools and helpful wellness tips.

For easy access to your UHC plan while you're on the go, download the Health4Me® app. Here you can view plan details, contact a registered nurse 24/7, use the *Talk to Me* tool to request a call from a service representative, check claims or find a doctor. Available for both Apple and Android devices; be sure to download the app today!

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

Telehealth and Virtual Visits

Want to schedule a remote appointment with your regular provider? Need to speak with a doctor when your regular provider isn't available? UHC has a program for you.

Telehealth

Whether over the phone or via video, for 2021, the UHC plans provide coverage for scheduled telehealth consultations with medical/mental health providers with whom covered members have an established relationship or for an initial consultation with a new provider.

Retroactively to January 1, 2021, and available through December 31, 2021,* telehealth services are covered as follows:

Reason for Telehealth Appointment	Coverage
COVID-related	100% with no out-of-pocket cost
All other	Same as in-person services (subject to your plan's deductible, coinsurance and out-of-pocket maximum)

*The UHC plans covered telehealth visits in 2020 as part of the *CARES Act,* which mandated coverage for COVID-related telehealth visits during the national emergency period. With the national emergency period being extended through April, 2021 (subject to further extensions by the federal government), the company will provide coverage for COVID and non-COVID telehealth visits for 2021. If your claim for a telehealth visit early in 2021 was denied, note that UHC will automatically reprocess your claim(s). Questions? Call UHC.

Note that for purposes of this benefit, telehealth means the use of telecommunications, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication and secure asynchronous information exchange, in order to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purposes of delivering enhanced health care services and information to parties separated by distance, establishing a physician-patient relationship, evaluating a patient or treating a patient.

Virtual Visit with a Doctor 24/7 from Anywhere

With UHC's new Virtual Visit program (also referred to as Virtual Care), you have access to urgent on-demand health care delivered through video-conferencing or over the phone for treatment of acute but non-emergency medical needs. Doctors, available 24/7 without a scheduled appointment, can diagnose a variety of common medical conditions, and in some cases, prescribe medications.

Available through myuhc.com or via the UHC app, a Virtual Visits appointment costs $49, which is subject to your plan's deductible, coinsurance and out-of-pocket maximum. In other words, once you meet your deductible, you will pay coinsurance on the $49. If you reach your plan's calendar-year out-of-pocket maximum, the fee is covered in full.

Note that eligibility and benefit confirmation is real time, so if you have met your deductible and out-of-pocket maximum, you will not be required to pay upfront.

Network benefits are available only when services are delivered through Designated Virtual Network Providers, which includes doctors affiliated with Doctors on Demand, Amwell and Teladoc. To access a Designated Virtual Network Provider, go to myuhc.com or use the UHC app.

To learn more, visit myuhc.com or call UHC. Note that not all medical conditions canbe treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is needed. In addition, note that plan limitations and exclusions apply to virtual care services.

With UHC's Virtual Visits (also referred to as Virtual Care), you can video or phone chat with a doctor any time regarding non-emergency conditions, including allergies, bronchitis, an eye infection, the flu, a headache/migraine, a rash, sore throat or a stomachache.

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NURSELINE℠

UHC's NurseLine provides immediate access to registered nurses who have an average of 15 years of clinical nursing experience. To reach the NurseLine, call UHC at 800-638-8884 and follow the prompts. From here, you can:

- *Access more than 1,100 health and well-being topics. Need help in a language other than English? Many messages are available in Spanish, and all can be translated into 140 languages.*
- *Speak with a nurse to get help choosing care, managing a chronic condition or understanding treatment options.*
- *Get professional advice as to whether you should seek treatment and professional answers to medical questions.*
- *Find a doctor, specialist or hospital. UHC nurses may even be able to make an appointment for you.*

The NurseLine is available 24 hours a day, seven days a week.

HOW ELIGIBLE EXPENSES ARE PAID OUT-OF-NETWORK

Network providers/facilities contract with UHC to provide quality medical services at predetermined rates. If you choose to visit an out-of-network provider/facility for a non-emergency service, remember that these providers/facilities are not credentialed by UHC. In addition, the cost of services may vary widely and your out-of-pocket costs will be higher. Before seeking non-emergency care with an out-of-network provider/facility, it is recommended that you call UHC.

Shared Savings Program

Depending on your geographic area and the service(s) you receive from an out-network provider/facility, you may have access to Shared Savings, a program where UHC has negotiated discounts with certain out-of-network providers/facilities for certain covered services (e.g., emergency care). The plan's out-of-network deductible and coinsurance apply to any reduced charges.

When you seek out-of-network care with a Shared Savings provider/facility, eligible services are covered up to the rate UHC has negotiated with that provider/facility. In this case, your out-of-pocket costs may be lower than they would be with out-of-network providers/facilities that are not part of the Shared Savings program.

It's important to note that out-of-network providers/facilities may bill you for the difference between the negotiated rate or percentage of eligible expense that UHC pays and the provider's/facility's actual charge. If your provider/facility charges more than the negotiated charge, you may be required to pay the difference (called "balance billing"). For more information, call UHC.

In addition, if you are billed for amounts in excess of your applicable deductible or coinsurance, contact UHC. UHC will not pay excessive charges or amounts that you are not legally obligated to pay.

If rates haven't been negotiated with the provider/facility, UHC pays covered expenses based on the competitive fees in that provider's/facility's geographic area or an amount permitted by law.

When contractually permitted, the plan may pay the lesser of the Shared Savings program discount or an amount determined by the claims administrator, such as:

- *A percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market;*
- *An amount determined based on available data resources of competitive fees in that geographic area;*
- *A fee schedule established by a third-party vendor, such as FairHealth or Viant; or*
- *A negotiated rate with the out-of-network provider/facility.*

In cases where plan provisions or administrative practices conflict with the scheduled rate, UHC may determine a different rate. In these cases, the out-of-network provider/facility may bill you for the difference between the billed amount and the rate determined by UHC (see description of balance billing above). If this happens, contact UHC.

In all cases, note that Shared Savings providers/facilities are not network providers/facilities and are <u>not</u> credentialed by UHC.

WHEN SERVICES RECEIVED FROM AN OUT-OF-NETWORK PROVIDER MAY BE COVERED AT THE IN-NETWORK LEVEL

If a covered health service is not available from an in-network provider, you may be eligible to receive in-network benefits from an out-of-network provider. To be eligible, your in-network physician must notify UHC and UHC must confirm that the covered health service is not available from an in-network provider. If confirmed, UHC will work with you and your in-network physician to coordinate care through the out-of-network provider.

Personal Health Support

The UHC Personal Health Support program is designed to encourage personalized, efficient care for you and your covered dependents. By providing authorization for coverage for certain care and determining if an expense is a covered health service, Personal Health Support helps you get the right care, while making the most of your coverage.

UHC requires prenotification for any of the following:

- ***All inpatient admissions,*** including out-of-network hospitalizations; admissions to rehabilitation facilities, mental health (including Applied Behavior Analysis (ABA) therapy)/substance-related and addictive disorders facilities; skilled nursing facilities; and elective admissions to out-of-network facilities (five-day notification is required);
- ***Ambulance transportation that is not an emergency;***
- ***Bariatric surgery*** (UHC requirements outlined in the inset at the end of this list);
- ***Breast reduction and reconstruction,*** except after surgery related to cancer;
- ***Cellular therapy and gene therapy;***
- ***Congenital heart disease services;***
- ***Durable medical equipment (DME)*** that exceeds $1,000 in cost (includes oxygen and items related to the management and treatment of diabetes);
- ***Emergency health services*** that result in an inpatient stay in an out-of-network hospital (within 48 hours of admission);
- ***Gender dysphoria*** as it relates to surgery;
- ***Home health care;***
- ***Hospice care*** received from a licensed out-of-network facility;
- ***Infertility services*** (UHC requirements outlined in the inset at the end of this list);
- ***Lab, x-ray and diagnostic services*** (including major diagnostic services and genetic testing);
- ***Maternity inpatient stays*** exceeding 48 hours for a vaginal delivery or 96 hours for a Caesarean section in an out-of-network facility;
- Select ***mental health (including ABA therapy)/substance-related and addictive disorders treatment*** services, as outlined in *Mental Health and Substance-Related and Addictive Disorders Coverage* and *Treating Autism Spectrum Disorders (ASD)* later in this section;
- ***Neurobiological disorders;***
- ***Obesity surgery;***
- ***Prosthetic services;***
- ***Reconstructive procedures;***
- ***Surgery (outpatient);***
- ***Therapeutic treatments (outpatient);*** or

Personal Health Support is designed to help you and your doctor coordinate your care, to make sure your needs are met and to minimize any gaps in your coverage. The program is not designed to be a substitute for your provider's medical judgment or otherwise interfere with your care. Only you and your health care provider can make final decisions about the care you or your family member receives. However, Personal Health Support does determine if a service or supply is a covered health service under your plan.

Be sure to contact Personal Health Support in advance of any of the services listed here **(with the exception of emergency health services, as noted). If you do not, *benefits will be reduced to 50% of eligible expenses.***

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800-638-8884

- ***Transplantation services*** (notification must be provided as soon as the possibility of a transplant arises and before the time a pre-transplantation evaluation is performed at a transplant center).

ABOUT INFERTILITY-RELATED SERVICES AND BARIATRIC SURGERY

Before seeking infertility-related services or bariatric surgery, UHC requires that you complete one phone call with a Fertility Solutions or Bariatric Resources Services (BRS) nurse. Since both Fertility Solutions and BRS fall under Personal Health Support, a direct call to either is considered a call to Personal Health Support.

If you do call Personal Health Support before seeking treatment for infertility-related services or bariatric surgery, in order to be eligible for benefits, UHC requires that you also complete one call with a nurse from the respective program. To reach Fertility Solutions directly, call 866-774-4626. To reach BRS directly, call 888-936-7246.

For more information, see Fertility Solutions or UHC Bariatric Surgery Centers of Excellence later in this section.

In general, if you seek care with a network provider/facility, your provider/facility will provide the necessary prenotification. ***However, it is your responsibility to ensure that your provider/facility has notified UHC of your care.***

If you seek care outside the network or if you participate in the Out-of-Area plan, you are responsible for providing prenotification. ***It's important to note that a referral does not qualify as prenotification.***

To provide prenotification, call UHC and follow the prompts for Personal Health Support. In most cases, you must call no later than five days in advance of your scheduled service or, in the case of emergency care, within 48 hours of receiving care.

If you or your provider/facility, as applicable, does not notify Personal Health Support, your benefits will be reduced to 50% of eligible expenses. Note that any penalties you pay do not apply to your plan's calendar-year out-of-pocket maximum.

Once a Personal Health Support Nurse receives notification, he or she will decide if your care is a covered health service with your plan. You or your provider will receive a telephone response either at the time you call or shortly thereafter, with written notification to follow. Once you receive authorization, review it carefully to understand what services have been approved and what providers/facilities are authorized to provide those services.

Planning for and Recovering from a Hospital Stay

Once your inpatient stay is authorized, UHC connects you with a Personal Health Support Nurse who works to help ensure you receive the most appropriate and cost-effective care possible through prevention, education and closing any gaps in your care. For example, UHC can offer:

- ***Admission counseling.*** Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- ***Inpatient care management.*** Personal Health Support Nurses work with your physician during your hospitalization to ensure you're getting the care you need and your physician's treatment plan is being carried out effectively.
- ***Readmission management.*** If you are at a high risk of being readmitted, Personal Health Support Nurses serve as a bridge between the hospital and your caregivers at home. You may receive a phone call from UHC to confirm that your medications, any needed equipment or follow-up services are in place. The Personal Health Support Nurses can also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- ***Risk management.*** If you have a certain chronic or complex condition, a Personal Health Support Nurse may assist you with accessing medical specialists, understanding medication information, and coordinating any needed equipment or supplies.

While UHC strives to ensure a Personal Health Support Nurse connects with any patient who may benefit, you can initiate the relationship by calling UHC.

Infertility Services

Infertility is a condition of the reproductive tract that prevents the conception of a child or the ability to carry a pregnancy to delivery.

Infertility is defined as the failure to achieve a successful pregnancy after 12 months of therapeutic donor insemination (TDI) if you are a female under age 35; after six months if you are a female age 35 or older. TDI is insemination with a donor sperm sample for the purpose of conceiving a child. The donor can be an anonymous or directed donor.

To be eligible for the infertility services benefit, you must have a diagnosis of infertility and meet one of the following criteria:

- You are a female under age 44 and using own oocytes (eggs) or you are a female under age 55 and using donor oocytes. *Note:* As long as treatment is initiated prior to the pertinent birthday (44 or 55), services are covered to completion of the initiated cycle;
- You are not able to achieve pregnancy due to impotence/sexual dysfunction;
- You have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization;
- There is a diagnosis of a male factor causing infertility (e.g., treatment of sperm abnormalities, including the surgical recovery of sperm).

The waiting period may be waived when you have a known infertility factor, including but not limited to: congenital malformations, known male factor, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes. Note that for treatment initiated prior to the pertinent birthday, services will be covered to completion of the initiated cycle.

Coverage is provided to the following individuals as long as they meet the requirements stated above:

- Female member without a male partner;
- Male member without a female partner;
- Child dependents.

Therapeutic services for the treatment of infertility are covered when provided by or under the direction of a physician. Benefits are limited to the following procedures:

- Assisted Reproductive Technologies (ART), the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve pregnancy. Examples of such procedures include:
  - In vitro fertilization (IVF),
  - Gamete Intrafallopian Transfer (GIFT),
  - Pronuclear stage tubal transfer (PROST),
  - Tubal embryo transfer (TET),
  - Zygote intrafallopian transfer (ZIFT);
- Frozen Embryo Transfer cycle (including thawing);
- ICSI (intracytoplasmic sperm injection);
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI));
- Embryo transportation related network disruption;
- Ovulation induction (or controlled ovarian stimulation);
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA)—male factor associated surgical procedures for retrieval of sperm;
- The following surgical procedures: Laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, ovarian cystectomy;
- Electroejaculation;

Before seeking infertility-related services, UHC requires that you complete one phone call with a Fertility Solutions nurse at 866-774-4626. For more information, see *Fertility Solutions* later in this section.

- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR). When the genetic parents carry a gene mutation, PGT-M or PGT-SR is used to determine whether that mutation has been transmitted to the embryo.

For benefits coverage information related to diagnostic tests and certain pharmaceutical products—including specialty pharmaceutical products—to treat infertility that are administered on an outpatient basis in a hospital, alternate facility, physician's office or in your home, call Fertility Solutions at 866-774-4626.

For coverage information related to pharmaceutical products that are filled by a prescription order or refill as described under the CVS Caremark prescription drug program, call CVS Caremark Customer Care toll-free at 866-329-4023.

MATERNITY SUPPORT PROGRAM

UHC offers a special maternity care program that provides benefits to encourage early determination of whether a member is at risk for premature delivery; education, including healthy newborn care once the mother and baby return home; and outpatient post-partum care, depending on the mother's length of stay in the hospital following delivery.

To maximize the benefits available from this program, be sure to contact UHC early in your pregnancy (although you may call at any time during your pregnancy if you want to participate). For information about your eligibility for benefits, call UHC.

Mental Health and Substance-Related and Addictive Disorders Treatment Coverage

UHC covers mental health and substance-related and addictive disorders treatment 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. As outlined below, all care is subject to the prenotification requirements described in *Personal Health Support* earlier in this section.

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

- Crisis intervention;
- As applicable, detoxification (sub-acute/non-medical);
- Diagnostic evaluations and assessment;
- Individual, family, therapeutic group and provider-based case management services;
- Medication management;
- Referral services; and
- Treatment planning.

Benefits include partial hospitalization/day treatment and services at a residential treatment facility. UHC determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis (a room with two or more beds).

For specific information about how your plan covers mental health and substance-related and addictive disorders care, refer to the summary of benefits chart for your plan.

While UHC provides extensive coverage for mental health and substance-related and addictive disorders treatment, there are some services that are not covered. For more information, refer to *Limitations and Exclusions* later in this section.

Prenotification

You must notify UHC in advance of receiving mental health and substance-related and addictive disorders services. This includes:

- Partial hospitalization/day treatment and services at a residential treatment facility;
- Intensive outpatient program treatment (a structured outpatient mental health or substance-related and addictive disorders 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);

For a description of covered services to treat Autism Spectrum Disorders (ASD), including Applied Behavior Analysis (ABA) therapy, see *Treating Autism Spectrum Disorders (ASD)* later in this section.

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

- Outpatient electro-convulsive treatment;
- Psychological testing; and
- Extended outpatient treatment visits with or without medication management.

For information about how to provide prenotification, see *Personal Health Support* earlier in this section.

SUBSTANCE USE TREATMENT PROGRAM

Studies show nearly two-thirds of Americans report some level of drinking[1], and 10 percent are using an illegal substance[2]. While some people can moderate the use of alcohol and illicit drugs, others are not as fortunate. When alcohol or drug use moves from casual use to abuse and finally, addiction, it becomes a medical condition known as substance use disorder.

How do you know when to seek care for yourself or a loved one? There are many signs indicating it's time to seek help, including:

- *Mood swings or mysterious changes in personality,*
- *Neglecting responsibilities or abruptly changing friends, and*
- *Weight loss or decline of appearance.*

To help those with a substance use disorder, UHC offers the Substance Use Treatment Program, which includes a helpline. This service is part of your health benefit and is provided at no additional cost to you.

When you call 855-780-5955, a licensed clinician can answer your questions and help you determine next steps. Available 24/7, substance use treatment advocates will:

- *Take the time to fully understand your personal situation and guide you on the next steps most helpful to you,*
- *Explain appropriate treatment options and types of providers/facilities, and*
- *Arrange a face-to-face clinical evaluation for you by a trusted licensed substance use treatment provider—usually within 24 hours.*

To learn more about the warning signs of alcohol and drug use, including ideas about how to support an adult child and descriptions of different treatment methods, call the helpline at 855-780-5955 or go to liveandworkwell.com/recovery.

1 Gallup poll. Alcohol and Drinking, July 27, 2015. Available at www.gallup.com/poll/1582/Alcohol-Drinking.aspx.

2 Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, September 2015, HHS Publication No. SMA15-4927, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health.

TREATING AUTISM SPECTRUM DISORDERS (ASD)

Autism Spectrum Disorder (ASD) is a neurobiological disorder that spans a wide range of symptoms and levels of impairment, from mild to severe. According to recent data from the Centers for Disease Control, the incidence of ASD is growing—with one in 68 children now being diagnosed with ASD.

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

- *Focus on the treatment of core deficits of ASD;*
- *Be provided by a board-certified behavior analyst (BCBA) or other qualified provider under appropriate supervision;*
- *Focus on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.*

Benefits are available for the following levels of care:

- *Inpatient treatment,*
- *Residential treatment,*
- *Partial hospitalization/day treatment,*
- *Outpatient treatment (including intensive outpatient treatment).*

Services include the following:

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

To receive these benefits, you must notify the mental health/substance-related and addictive disorders administrator (via Personal Health Support). See below for details.

Note that habilitative services (defined in Exclusions *later in this section) are not covered.*

For a description of limitations and exclusions related to the treatment of ASD, including a definition of habilitative services, see later in this section. For more information, or if you have any questions, contact UHC.

Remember:

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

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

Note: If you do not follow these prenotification procedures, benefits will be reduced to 50% of eligible expenses.

Autism Spectrum Disorder (ASD) refers to a range of conditions characterized by challenges with social skills, repetitive behaviors, speech and nonverbal communication, as well as by unique strengths and differences. The term "spectrum" reflects the wide variation in challenges and strengths possessed by each person with autism.

Note: To be considered covered services, speech and nonverbal communication services must comply with *restorative-only* requirements. To be considered restorative, the speech or nonverbal communication function must have been previously intact.

Alternative Care Settings

UHC provides coverage for times when care can be delivered more comfortably and cost-effectively in an alternative setting, such as a skilled nursing facility, your home or a hospice facility.

For specific information about how your plan covers care in alternative settings, refer to the summary of benefits chart for your plan. If you have questions about covered services, call UHC. Note that all care is subject to the prenotification requirements described in *Personal Health Support* earlier in this section.

Skilled Nursing Facility

UHC covers services and supplies while the patient is confined as a bed patient in a skilled nursing facility as long as:

- 24-hour-a-day nursing care is necessary for recuperation from the injury or illness;
- The care is ordered and approved by a physician and is not custodial care (as defined in this section); and
- Such confinement takes the place of a hospital confinement or immediately follows a hospital confinement for the same illness.

Eligible expenses include the facility's charge for a semi-private room as well as all other eligible services and supplies provided by the facility when the patient is entitled to room and board allowance. All care is subject to the prenotification requirements described in *Personal Health Support* earlier in this section.

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

CUSTODIAL CARE

*Benefits are **not** provided for custodial care, domiciliary care, respite care or rest cures, which is defined as 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);*
- *Do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or*
- *Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.*

Home Health Care

UHC covers eligible expenses for treatment of a disease or injury in the patient's home instead of a hospital or skilled nursing facility when such treatment is:

- Received from a home health agency;
- Ordered by a physician;
- Provided by or supervised by a registered nurse in the covered person's home;
- Not considered custodial care; and
- Provided on a part-time, intermittent schedule when skilled home health care is required.

UHC covers the following home health care expenses:

- Part-time or occasional care by a licensed nurse;
- Intermittent home health aide services;
- Services of a medical social worker;
- Physical, occupational, speech and inhalation therapy;
- Medical supplies and medicines prescribed by a physician; and
- Services of a nutritionist.

Skilled home health care is skilled nursing, teaching and rehabilitation services. These services are covered when:

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

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

UHC ***does not cover:***

- Services provided by a person who usually lives with you or is a member of your or your spouse's family;
- Transportation costs; or
- Custodial care (as described earlier in this section).

All care is subject to the prenotification requirements described in *Personal Health Support* earlier in this section.

Hospice Care

Hospice care provides supportive care to terminally ill individuals and their families. This care may be provided instead of a hospital confinement when a covered individual is terminally ill.

Hospice care can be provided on an inpatient or outpatient basis, and includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Covered services include:

- Confinement in a licensed hospice facility or skilled nursing facility;
- Home hospice care provided by an approved hospice team;
- Nursing care by or under the supervision of a registered nurse (R.N.);
- Physical and/or occupational therapy;
- Medical social services;
- Home health aide services;
- Counseling; and
- Drugs or medical supplies.

Benefits are only available when hospice care is received from a licensed hospice agency. Hospice care received from an out-of-network licensed facility is subject to prenotification. All care is subject to the prenotification requirements described in *Personal Health Support* earlier in this section.

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

Disease Management Programs

UHC aims to help patients with chronic diseases understand the risks of their disease and what they can do to minimize these risks by focusing on long-term education and self-care. Disease Management Program registered nurses can help guide you through treatment by providing education, consulting with specialists, answering questions and helping to identify lifestyle changes that could help reduce the risk. Nurses can help patients with a chronic illness or complex condition manage self-care, as well as obtain the care, medications and equipment they need.

Disease management programs are available for UHC members and their covered dependents living with:

- Heart failure;
- Chronic obstructive pulmonary disease (COPD);
- Asthma;
- Coronary artery disease; and
- Diabetes.

While UHC strives to ensure a Disease Management Program registered nurse connects with any patient who may benefit, you can initiate the relationship by calling UHC.

In addition, UHC offers several extensive programs for covered members with cancer, congenital heart disease (CHD), or who are in need of bariatric surgery or an organ transplant, as described on the following pages.

Remember: You must notify Personal Health Support as soon as one of these conditions is suspected or diagnosed, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

DECISION SUPPORT

In addition to the support offered by the programs listed in this section, UHC offers Decision Support. This program offers:

- *Access to accurate, objective and relevant health care information;*
- *Help making decisions about your treatment and care with coaching from a nurse;*
- *Insight into what to expect with treatment; and*
- *Information about high-quality providers and programs.*

Decision Support focuses on:

- *Back pain;*
- *Knee and hip replacement;*
- *Prostate disease;*
- *Prostate cancer;*
- *Benign uterine conditions;*
- *Breast cancer;*
- *Coronary disease; and*
- *Bariatric surgery.*

Participation in Decision Support is voluntary and offered without extra charge. If you think you may be eligible to participate or would like additional information, call UHC and ask to be connected with Decision Support.

Centers of Excellence

For certain complex medical conditions, UHC offers access to Centers of Excellence—top-performing providers/facilities that UHC contracts with for their quality metrics. When you seek treatment at a Center of Excellence, your treatment is based on a "best practices" approach from health care professionals with demonstrated expertise.

Note that if you need infertility-related services or bariatric surgery, UHC requires you to contact a specific program that is designed to make sure you get the highest level of care. For specifics, see the descriptions of *Fertility Solutions* and *UHC Bariatric Surgery Centers of Excellence* later in this section.

Cancer Resource Services (CRS)

The Cancer Resource Services (CRS) program offers access to CRS Centers of Excellence—leading cancer centers nationwide—even if they are not in the UHC network.

If you or a covered dependent needs treatment for a condition that has a primary or suspected diagnosis related to cancer, you may:

- Be referred to CRS by a UHC registered nurse;
- Call CRS at 866-936-6002; or
- Go to www.myoptumhealthcomplexmedical.com for more information.

To ensure network benefits are received under this program, you or someone on your behalf should contact CRS at 866-936-6002 before receiving care. UHC plans will only pay benefits under the CRS program if CRS provides the proper authorization to the designated provider/facility (even if you self-refer to a provider or facility in that network).

If you choose *not* to receive benefits for cancer-related treatment with/in a designated provider/facility, your UHC plan will cover eligible services with other providers or at other facilities (in- or out-of-network, if applicable) the same as any other eligible service.

Note that the services described under *Transportation and Lodging* later in this section are covered only in connection with cancer-related services received from/at a designated provider/facility.

Cancer Support Program

Whether or not you seek care through the CRS program, the UHC Cancer Support Program connects cancer patients with registered nurses who act as patient advocates. This means you may call or be called by a registered nurse who is a specialist in cancer.

To ensure network benefits are received under this program, you or someone on your behalf should contact Cancer Resource Services at 866-936-6002 before receiving care.

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

Advocates are available to help you:

- Prevent and manage symptoms and side effects of cancer treatments;
- Ensure that your treatment plan, which was developed in consultation with your physicians, is followed;
- Make informed decisions about your care;
- Offer support as you live with cancer, including providing referrals to behavioral health and other specialists as needed;
- Navigate the health care system; and
- If necessary, provide information about hospice services or palliative care.

Advocates work with physicians and other health professionals to coordinate care, including hospital admissions, emergency room visits and prescription management.

Note that this program is not designed to be a substitute for your provider's medical judgment or otherwise interfere with your care. The Cancer Support Program only assists you and your doctor in coordinating your care—to make sure your needs are met and to minimize any gaps in your coverage. Only you and your health care provider can make the final decision about the medical care you or your family member receives.

If you or a family member is diagnosed with cancer, you will receive information directly from the Cancer Support Program. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information, call 866-936-6002.

Congenital Heart Disease (CHD) Resources Services Program

UHC plans cover congenital heart disease (CHD) services when ordered by a physician and received at a CHD Resource Services program, including Centers of Excellence. Benefits include the facility charge and the charge for supplies and equipment, including:

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

CHD services other than those listed above are excluded from coverage, unless determined by Personal Health Support to be proven procedures for the involved diagnoses. For more information, call UHC and follow the prompts for Personal Health Support.

If you choose *not* to receive benefits for CHD-related treatment with/in a designated provider/facility, your UHC plan will cover eligible services with other providers or at other facilities (in- or out-of-network, if applicable) the same as any other eligible service.

Note that the services described under *Transportation and Lodging* later in this section are covered only in connection with CHD-related services received at a designated facility.

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

Comprehensive Kidney Solution (CKS) Program

Comprehensive Kidney Solution (CKS) is a voluntary program that provides support to members who are diagnosed with chronic kidney disease (CKD) or end-stage renal disease (ESRD).

For those needing dialysis, CKS provides access to hundreds of top-performing dialysis centers across the country that are considered Centers of Excellence. In situations where a member cannot conveniently access a contracted dialysis enter, CKS will negotiate a patient-specific agreement with another center on your behalf. Note that dialysis is covered only at in-network facilities (dialysis received at out-of-network facilities is not covered). To find an in-network facility, go to www.myuhc.com and use the *Find a Doctor* tool. Questions? Call UHC.

Remember: You must notify Personal Health Support if you seek the services described here. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

To learn more about CKS, go to www.myoptumhealthcomplexmedical.com or call the number on the back of your ID card.

Note that coverage for dialysis and kidney-related services is based on the terms of your plan, including exclusions, limitations, conditions, eligibility requirements and coverage guidelines. If you decide to no longer participate in the program, please inform CKS of your decision.

Transplantation Services

Organ and tissue transplants are covered when ordered by a physician. Benefits are available for transplants when the transplant meets the definition of a covered health service, and is not an experimental, investigational or unproven service.

Transplants eligible for benefits include the following: Bone marrow, CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this plan. Donor costs that are directly related to organ removal or procurement are covered health services for which benefits are payable through the organ recipient's coverage under the plan.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Center of Excellence or with/at the provider/facility of your choice.

UHC has specific guidelines regarding benefits for transplant services. Contact UHC at the number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* later in this section are covered health services only in connection with transplant services received from/at a designated provider/facility.

You must notify 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 Personal Health Support is not notified and services are performed at a facility that is not a designated facility, benefits will be reduced to 50% of eligible expenses.

Note that you are not required to notify Personal Health Support of a cornea transplant. In addition, it is not required that cornea transplants be performed at a designated facility.

Fertility Solutions

Fertility Solutions provides support to members who are beginning infertility services. The program includes education, counseling, infertility treatment management and access to a national network of premier infertility treatment clinics, some of which are considered Centers of Excellence.

To participate in the Fertility Solutions program, call a nurse at 866-774-4626. Note that while you are encouraged to take full advantage of this program, at a minimum, ***you must complete one initial call with a Fertility Solutions nurse in order for UHC and CVS Caremark to cover eligible infertility-related medical services and prescription drugs.***

Note that if you or a covered dependent does not live within a 60-mile radius of a Fertility Solutions designated provider, you are encouraged to contact a Fertility Solutions case manager to determine a network provider/facility prior to starting treatment. Again, for infertility-related services and prescription drugs to be considered covered health care services through this program, you must contact Fertility Solutions and speak with a nurse consultant prior to receiving services.

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

UHC Bariatric Surgery Centers of Excellence

To be eligible for coverage for bariatric surgery, you must meet the requirements of UHC's clinical policy. If you qualify for coverage, all authorization information and enrollment for bariatric surgery should be initiated through Bariatric Resources Services (BRS). ***As part of the qualification process for bariatric surgery benefits, UHC requires that you complete one initial call with a BRS nurse by calling at 888-936-7246***.

As a UHC member, you have the option of having your bariatric surgery performed at one of the UHC Bariatric Surgery Centers of Excellence—leading treatment centers available nationwide. Note that excision or elimination of hanging skin on any body part is covered after bariatric surgery as long as these services meet UHC's clinical guidelines. For information regarding UHC's clinical policy, and to find Centers of Excellence facilities near you, call 888-936-7246.

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

When you call, BRS can connect you with specialized bariatric surgery nurses who act as patient advocates. Advocates are available to help with:

- Preventing and managing symptoms and side effects of treatments;
- Ensuring that your treatment plan, which was developed in consultation with your physician, is followed;
- Making informed decisions about your care;
- Offering support, including providing referrals to behavioral health and other specialists as needed;
- Navigating the health care system; and
- If necessary, providing information about palliative care.

Advocates work with physicians and other health professionals to coordinate care, including hospital admissions and prescription management.

Note that if you choose not to receive services in a designated provider/facility, your UHC plan will cover eligible services with other providers or at other facilities (in- or out-of-network, if applicable) the same as any other eligible service.

Note also that the services described under *Transportation and Lodging* later in this section are covered only in connection with bariatric surgery services received from/at a designated provider/facility.

TRAVEL AND LODGING ASSISTANCE PROGRAM

If you are eligible for the Cancer Support Program, the Congenital Heart Disease (CHD) Resource Services Program, transplantation services or Bariatric Resource Services (BRS), UHC provides travel and lodging assistance if you meet certain qualifications, as outlined below. Eligible expenses are reimbursed after the required expense forms have been completed and submitted with the appropriate receipts.

Provided the patient resides more than 50 miles from the designated provider/facility and is not covered by Medicare, *the UHC plans cover:*

- *Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a designated provider/facility 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.*

If the patient is an enrolled dependent minor child, the transportation and lodging expenses of two companions will be covered.

The cancer, congenital heart disease, bariatric and transplant programs offer a combined *overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and reimbursed under the plan in connection with all qualified procedures.*

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

Lodging

- *A per diem rate, up to $50 per day, for the patient or the caregiver if the patient is in the hospital.*
- *A per diem rate, up to $100 per day, for the patient and one caregiver. When the patient is a child, two persons may accompany the child.*

Examples of items that are not covered include groceries; alcoholic beverages; personal or cleaning supplies; meals; over-the-counter dressings or medical supplies; deposits; utilities and furniture rentals when billed separately from the rent payment; and phone calls, newspapers or movie rentals.

Note that reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the plan participant if the reimbursement exceeds the per diem rate.

(continued)

For more information about UHC's bariatric surgery provisions, call 888-936-7246.

Remember: You must notify Personal Health Support if you seek the services described here, or if you seek out-of-network care. If you do not, benefits for covered services will be reduced to 50% of eligible expenses.

Note that the travel and lodging assistance program does not apply to Fertility Solutions or the Comprehensive Kidney Solution (CKS) program.

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

TRAVEL AND LODGING ASSISTANCE PROGRAM *(continued)*

Transportation

- *Automobile mileage (reimbursed at the Internal Revenue Service (IRS) medical rate) for the most direct route between the patient's home and the designated facility,*
- *Taxi fares (not including limos or car services),*
- *Economy or coach airfare, trains, boat or bus transport,*
- *Parking and tolls.*

If you have questions regarding the Travel and Lodging Assistance Program, call 800-842-0843.

Gender Dysphoria (Transgender Surgery and Gender Dysphoria Treatments)

The UHC plans provide benefits for certain services related to gender dysphoria (transgender surgery and gender dysphoria treatments). Benefits are in accordance with UHC guidelines, which are based on World Professional Association for Transgender Health Association (WPATH) recommendations.

To be eligible for gender dysphoria benefits, you must meet all UHC requirements. Note that the transportation and lodging benefits outlined earlier in this section do not apply. For a complete list of covered services, as well as information about requirements and coverage details, call UHC.

Hormone therapy related to gender dysphoria may be covered by your medical plan or by the CVS Caremark prescription drug benefit. Check with both plans for more information.

ABOUT GENDER DYSPHORIA

Gender dysphoria is a disorder that is characterized by the following diagnostic criteria classified in the most current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

- *A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:*
  - *A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).*
  - *A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).*
  - *A strong desire for the primary and/or secondary sex characteristics of the other gender.*
  - *A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).*
  - *A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).*
  - *A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).*
- *The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.*

Diagnostic criteria for children:

- *A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):*
  - *A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).*
  - *In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.*

(continued)

You must notify Personal Health Support as soon as the possibility for any surgery related to gender dysphoria arises or if you seek out-of-network care. ***If you do not, benefits for covered services will be reduced to 50% of eligible expenses.***

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

ABOUT GENDER DYSPHORIA *(continued)*

- *A strong preference for cross-gender roles in make-believe play or fantasy play.*
- *A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.*
- *A strong preference for playmates of the other gender.*
- *In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.*
- *A strong dislike of ones' sexual anatomy.*

• *A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.*

In addition, the condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Claims Procedures

In-Network

If you visit a Choice Plus network provider/facility (an Options PPO provider/facility with the Out-of-Area plan), you do not have to file a claim form. Simply show your medical ID card. Note that a network provider/facility may request payment for any required deductible, coinsurance or charges for services that may or may not be covered.

Out-of-Network

If your plan provides out-of-network coverage (or for the Out-of-Area plan, if you visit a provider/facility that does not participate in the Options PPO), follow these steps to file a claim.

1. ***Be sure that you know your benefits.*** In order to get the most out of your plan, it's important to understand what is and is not covered, as well as how the plan pays benefits.
2. ***Get an itemized bill.*** Be sure the bill includes:
   - Name, phone number, address and tax ID number of the service provider/facility;
   - Patient's full name as well as Social Security or member ID number;
   - Employee's Social Security or member ID number;
   - Date of service;
   - Description of the service/supply rendered;
   - Procedure code;
   - Amount charged; and
   - Diagnosis or nature of illness.

   Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.
3. ***Keep a copy of your itemized bill.*** Because you must submit originals, it's important to keep a copy for your records. Once your claim is received, itemized bills cannot be returned.
4. ***Complete a claim form.*** Make sure all information is completed properly and then date and sign the form. Claim forms are available online at www.myuhc.com under *Claims & Accounts* or by calling UHC.
5. ***Attach your itemized bill(s) to the claim form and mail them.*** Once you have completed and obtained all necessary information, mail the materials to the address on the form:

   UnitedHealthcare
   P.O. Box 740809
   Atlanta, GA 30374

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

Separate claim forms must be filed for each covered dependent. Be sure to submit all bills for covered health services. ***All claims must be filed no later than 24 months after the date the supplies or services were rendered.***

Once your claim is processed, you may check its status and/or view or print an *Explanation of Benefits* (EOB) by going to www.myuhc.com. Your EOB lists:

- Provider's/facility's charge and the allowable amount;
- Coinsurance and deductible amounts, if any, that you're required to pay;
- Reason for any denial or partial payment;
- Total benefits payable; and
- How much you owe.

You may also request a paper copy of your EOB by calling UHC.

Claims Appeal

If a claim is denied, you will receive a written explanation. You have the right to request a review of the claim by contacting UHC at:

UnitedHealthcare Appeals
P.O. Box 30432
Salt Lake City, UT 84131-0432

Please see *Applying for Benefits* in the *Administrative* section for details or call UHC.

COORDINATION OF BENEFITS

The UHC plans include non-duplication coordination of benefits (COB). The non-duplication COB provision provides payment up to the normal reimbursement level under the plan. This means your combined benefits from all plans will equal, but never exceed, the amount that would normally be payable from your company-sponsored plan when there is no COB with another plan.

See the Administrative *section for more information about COB.*

SUBROGATION PROVISIONS

The UHC plans include subrogation provisions. Subrogation applies if you receive payment from a third party that is held liable for any injury that required medical care. In this case, you may be required to reimburse your plan for claim payments.

See the Administrative *section for more information about subrogation.*

UHC HSA Advantage Plans

The company offers two health savings account (HSA)-eligible plans through UnitedHealthcare (UHC)—UHC HSA Advantage 1 and UHC HSA Advantage 2. Deductibles and other cost-sharing arrangements (i.e., coinsurance and out-of-pocket maximums) vary by plan and coverage level.

When you elect a UHC HSA Advantage plan, you are eligible for an HSA. The company makes an annual lump-sum contribution to your HSA in January. Company contributions vary by plan and coverage level. You also can make contributions. The maximum amount you and the company combined can contribute is subject to an annual federal limit.

You *always* own the money in your HSA. ***Any unused money carries over to the next year and may earn interest—there are no "use-it-or-lose-it" rules.*** And if you leave the company, the money in your HSA belongs to you. (For detailed information about HSAs, see the *Health Savings Account* section.)

While federal regulations prohibit anyone who is making or receiving contributions to an HSA from having other health care coverage, including through a health care flexible spending account (FSA), if applicable, eligible employees do have the option of enrolling in a limited purpose dental and vision FSA, which can be used to pay for eligible dental and vision expenses. For more information, see the *Flexible Spending Accounts* section of this handbook, if applicable.

Note also that while this regulation applies to Medicare Part A, Part B and/or Part D, as well as TRICARE, since the HSA Advantage plans are not linked to an HSA; Medicare/TRICARE participants can elect an HSA Advantage plan *without funding an HSA.* In this case, you can use your HSA Advantage plan to pay for eligible expenses incurred by you and your dependents. As long as you are not funding your HSA, it is not considered other health care coverage.

How the Plans Work

Here is a brief overview of how the plans work. The pages that follow illustrate the similarities and differences between the two UHC HSA Advantage plans.

- The federal government regulates the design of health plans with HSAs.
- Covered expenses are subject to a calendar-year deductible, with the following exceptions:
  - ***Routine in-network preventive care,*** which is covered at 100% in-network (no out-of-pocket cost). In compliance with the ACA, this coverage extends to include Women's Health Services, certain preventive supplements and smoking-/tobacco-cessation prescriptions (as defined by CVS Caremark); and
  - ***Prescription drugs on the federal Treasury Guidance list,*** specifically:
    - ***Generic preventive prescription drugs*** to treat chronic conditions, including high cholesterol, high blood pressure and asthma, which are covered at 100% (no out-of-pocket cost);
    - ***Oral and insulin diabetic medications*** (and supplies, if purchased at the same time), which are covered at 100% (again, no out-of-pocket cost).

(continued)

As part of the *Medicare Prescription Drug, Improvement and Modernization Act,* which was enacted by Congress in 2003, HSAs are designed to help individuals save for qualified health care expenses on a tax-advantaged basis.

Both you and the company are allowed to make contributions to an account that you own, which you use to save for future or pay for current health care expenses. Any money you elect to contribute to your HSA is deducted from your paycheck before taxes, which lowers your annual taxable income and allows you to pay for out-of-pocket costs with pre-tax dollars. For information about the HSAs, see the *Health Savings Account* section.

Note that if you elect medical coverage with an HSA Advantage plan and do not participate in an HSA (either because you elect not to or because your Medicare or TRICARE status makes you ineligible), you can elect a health care FSA and not be limited to only dental and vision expenses.

Will you soon be eligible for Medicare? See *Approaching Age 65? Be Sure to Understand Your Medical Coverage Options* in the *Medical* or *Health Savings Account* section to learn why it's wise to consult your tax advisor before making any decisions about your post-65 medical coverage, such as whether or not to enroll in Medicare Part A when you are first eligible.

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

Note: To avoid extra steps, your pharmacist must submit the charges for the insulin/medication first (before the supplies). If the supplies are submitted first, you will be charged for them. Should this happen, you'll need to ask your pharmacist to reprocess the charges in the appropriate order before you pick up your medications/supplies or call CVS Caremark Customer Care toll-free at 866-329-4023 to request that the charges be reprocessed; and

- ***Brand-name preventive prescription drugs***—including those used to treat high blood pressure, cardiovascular diseases, osteoporosis and mental health disorders (subject to coinsurance).

To review the Treasury Guidance list, go to www.caremark.com or call CVS Caremark at 866-329-4023.

- Electing a PCP is recommended, but not required.
- The plans are network-based, meaning you choose whether to visit a Choice Plus network provider/facility (in New England, you also have access to the Harvard Pilgrim network) and receive the highest level of benefits, or visit an out-of-network provider/facility and pay more out-of-pocket.
- The deductible, which resets each January 1, can be satisfied by one family member or a combination of family members. **If you have family coverage, you must satisfy the family deductible before benefits are payable.**
- After you meet the applicable deductible, the plans pay a percentage of eligible expenses. Both plans cover in-network services at a higher percentage. You pay the remainder of the charges until you reach the calendar-year in-network or out-of-network out-of-pocket maximum (both of which include the applicable deductible and coinsurance for all eligible services and supplies). If you reach the out-of-pocket maximum, the plans cover eligible expenses at 100% in-network (up to negotiated amounts out-of-network, if applicable; see *How Eligible Expenses Are Paid Out-of-Network* earlier in this section for more information) for the remainder of the calendar year.
- ***Contact information:*** www.myuhc.com, 800-638-8884.

REMINDER

The HSA Advantage plans have both in-network and out-of-network deductibles and out-of-pocket maximums. Claims for services you receive in-network do not apply to the out-of-network deductible or out-of-pocket maximum, and vice versa.

To qualify for maximum benefits, you must call UHC before any scheduled inpatient admission or certain outpatient procedures. For more information, see *Personal Heath Support* earlier in this section.

Note that while the family in-network calendar-year out-of-pocket maximum for UHC HSA Advantage 1 is $8,200, the most any one individual family member needs to spend to satisfy his/her share of the out-of-pocket maximum is $7,150.

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ABOUT THE COMPANY'S HSA CONTRIBUTION AND THE CALENDAR-YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

For New Hires

If, as a new hire, your UHC HSA Advantage plan coverage becomes effective after January 1, the company's lump-sum contribution to your HSA is pro-rated for that year. For details, see *For New Hires* in the *Health Savings Account* section.

In terms of the plan's deductible and out-of-pocket maximum, the entire calendar-year deductible and out-of-pocket maximum apply regardless of when your coverage with a UHC HSA Advantage plan becomes effective; they are not pro-rated.

If You Have a Change in Status During the Year

If, as the result of a qualified change in status that occurs after January 1 and before December 1, your coverage level *increases* (such as from employee only to employee plus family), the company contribution to your HSA is adjusted to match your new coverage level and prorated to reflect your new coverage level for the rest of the year. For details, see the *Health Savings Account* section. In this case, any eligible expenses incurred to date by you and/or your covered dependents prior to your change in status continue to apply toward your new calendar-year deductible and out-of-pocket maximum.

If your qualified change in status results in your coverage level *decreasing* (such as from employee and family to employee only), any company HSA contribution you have received that is in excess of the company contribution amount for your new coverage level remains in your HSA. In this case, any expenses your previously covered dependent(s) had incurred do *not* apply toward your new deductible or out-of-pocket maximum.

For example, assume you start the year with family coverage and meet the UHC HSA Advantage 1 plan's in-network family deductible of $4,200 in June ($1,000 in expenses for you, $1,000 for your spouse and $2,200 for your child). On July 12, your child turns 26 and is removed from your coverage. At that time, your coverage level is adjusted to the employee and spouse level, which has a $3,150 in-network deductible. Since your child's expenses no longer apply toward your deductible, and your and your spouse's eligible expenses are $2,000, you will not have met your new deductible amount. In this case, you and your spouse will need to incur and pay for an additional $1,150 in eligible expenses in order to meet your new deductible.

Likewise, your child's expenses will no longer apply toward your out-of-pocket maximum. Since your new out-of-pocket maximum decreases from $8,200 to $6,150, you and your spouse will need to pay an additional $4,150 in coinsurance toward the cost of eligible expenses to reach your new out-of-pocket maximum.

If you have questions about how a change in status affects your deductible or out-of-pocket maximum, contact UHC at 800-638-8884. If you have questions about how a change in status affects contributions to your HSA, see the *Health Savings Account* section or call Fidelity at 800-544-3716.

With the exception of telehealth visits related to COVID, which are covered at 100% with no out-of-pocket cost, coverage as shown in this chart applies to both in-person and telehealth visits. For more information, see *Telehealth and Virtual Visits,* earlier in this section.

UHC HSA Advantage 1

Medical

UHC HSA Advantage 1 Summary of Benefits Chart

This chart provides only a summary of your benefits with UHC HSA Advantage 1. A list of limitations and exclusions can be found at the end of this section. The plan only covers care provided by health care professionals or facilities licensed, certified or otherwise qualified under state law to provide health care services.

Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. For more details on covered health services, go to www.myuhc.com or call 800-638-8884.

UHC HSA Advantage 1		
Plan Features	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Calendar-Year Deductible[3,4] (see footnote 3 below for important information regarding family coverage)	• Employee only: $2,100 • Employee and spouse: $3,150 • Employee and child(ren): $3,150 • Employee and family: $4,200	• Employee only: $2,600 • Employee and spouse: $3,900 • Employee and child(ren): $3,900 • Employee and family: $5,200
Company HSA Contribution for 2021[5] (available to employees who are eligible to receive or make contributions to an HSA; see *Contributions to Your HSA* in the *Health Savings Account* section for information regarding the annual maximum amount you can contribute)	• Employee only: $750 • Employee and spouse: $1,125 • Employee and child(ren): $1,125 • Employee and family: $1,500 (Amounts shown will be prorated for new hires)	
Coinsurance	80%	60%
Calendar-Year Out-of-Pocket Maximum[4] (includes deductible and coinsurance for all eligible services and supplies)	• Employee only: $4,100 • Employee and spouse: $6,150 • Employee and child(ren): $6,150 • Employee and family: $8,200	• Employee only: $5,100 • Employee and spouse: $7,650 • Employee and child(ren): $7,650 • Employee and family: $10,200
Covered Services: Preventive Care[6]	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Adult Routine Physical Exam (see footnote 6 below for information regarding ACA guidelines)	Covered at 100%	Covered at 60% after deductible
Routine Preventive Lab Tests, Including Fecal DNA (see footnote 6 below for information regarding ACA guidelines)	Covered at 100%	Covered at 60% after deductible
Well-Woman Exam (see footnote 6 below for information regarding ACA guidelines)	*Primary care doctor:* Covered at 100% *Specialist:* Covered at 100%	Covered at 60% after deductible

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] With only a few exceptions (ACA-required preventive health services, in-network routine preventive care and preventive prescription drugs on the Treasury Guidance list), covered expenses are subject to a deductible, which can be satisfied by one family member or a combination of family members. **If you have family coverage, you must satisfy the family deductible before benefits are payable.** Regardless of whether you visit an in-network or an out-of-network provider/facility, the plan begins paying benefits only after you satisfy the applicable deductible.

[4] If you reach the out-of-pocket maximum, the plan generally pays 100% of the rest of your covered charges, up to the negotiated charge for each service, for the remainder of that calendar year. Note that the following do not count toward your deductible or out-of-pocket maximum:

- Charges for services that are not covered by the plan or exceed plan limitations;
- Charges in excess of the negotiated amount for provider charges or any negotiated amount for facility charges;
- Charges that are not payable because you did not comply with the plan's prenotification requirements; and
- Any penalty you pay if your provider prescribes—or you request—a preferred brand-name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available. For more information, see the *CVS Caremark Prescription Drug Coverage* section.

While the family in-network calendar-year out-of-pocket maximum is $8,200, the most any one individual family member needs to spend to satisfy his/her share of the out-of-pocket maximum is $7,150.

[5] The company's HSA contribution represents the company's total annual lump-sum contribution and can be used for in-network or out-of-network services. In other words, the company does not make an in-network contribution and an out-of-network contribution.

[6] Benefits are calculated on a **calendar-year** basis; you do not need to wait 12 months from the date of your last eligible preventive care visit to schedule your next visit. Lab tests and screenings are covered according to age and gender recommendations of the U.S. Preventive Services Task Force (USPSTF) and/or the guidelines supported by the Health Resources and Services Administration, as determined by UHC. Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), as determined by UHC. **Note that to be considered routine preventive care, your exam and/or associated lab tests *cannot* be related to the diagnosis or treatment of an illness or injury.** For more information, call UHC.

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UHC HSA Advantage 1		
Covered Services: Preventive Care[1]	**In-Network Benefits**[2]	**Out-of-Network Benefits**[3]
Routine Mammogram (Including 3D) (beginning at age 40 or as recommended by your physician; see footnote 1 below for information regarding ACA guidelines)	Covered at 100%	Covered at 60% after deductible
Women's Health Services (Including Breast Pumps) (see footnote 1 below for information regarding ACA guidelines)	Covered at 100% *Note:* Contact UHC for a list of covered services	Covered at 60% after deductible
Well-Child Care (from birth through age 18; see footnote 1 below for information regarding ACA guidelines)	Covered at 100%	Covered at 60% after deductible
Immunizations (see footnote 1 below for information regarding ACIP guidelines) *Adults:* Includes an annual flu shot and tetanus/diphtheria booster once every 10 years *Children:* Includes age-appropriate immunizations	Covered at 100%	Covered at 60% after deductible
Preventive Nutritional Counseling	Covered at 100% Preventive nutritional counseling is limited to 2 visits per calendar year (in- and out-of-network combined). Note that nutritional counseling necessary for improving a diagnosed medical condition also is covered; see later in this chart for details	Covered at 60% after deductible
Covered Services: Inpatient Care	**In-Network Benefits**[2]	**Out-of-Network Benefits**[3]
Inpatient Hospital Care[4] (includes semi-private room and special services in a general hospital; chronic disease hospital; inpatient mental health or substance-related and addictive disorders treatment facility; or rehabilitation hospital)	Covered at 80% after deductible	Covered at 60% after deductible, subject to Personal Health Support prenotification requirements
Inpatient Physician Services (includes assistant surgeon)	Covered at 80% after deductible	Covered at 60% after deductible
Inpatient Surgery[4] (includes pre- and post-operative care, anesthesia and endoscopic exams)	Covered at 80% after deductible	Covered at 60% after deductible
Covered Services: Outpatient Care	**In-Network Benefits**[2]	**Out-of-Network Benefits**[3]
Physician's Office Services (includes second surgical opinions as well as emergency or urgent care) *Note:* Services such as lab tests or x-rays provided in an office setting are covered separately; see *Outpatient Diagnostic Services*	Covered at 80% after deductible *Allergy testing:* Covered at 80% after deductible *Allergy shots (including serum) with or without an office visit:* Covered at 80% after deductible	Covered at 60% after deductible

[1] Benefits are calculated on a **calendar-year** basis; you do not need to wait 12 months from the date of your last eligible preventive care visit to schedule your next visit. Lab tests and screenings are covered according to age and gender recommendations of the U.S. Preventive Services Task Force (USPSTF) and/or the guidelines supported by the Health Resources and Services Administration, as determined by UHC. Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), as determined by UHC. **Note that to be considered routine preventive care, your exam and/or associated lab tests *cannot* be related to the diagnosis or treatment of an illness or injury.** For more information, call UHC.

[2] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[3] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[4] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

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UHC HSA Advantage 1		
Covered Services: Outpatient Care	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Prostate-Specific Antigen (PSA) Test	Covered at 100%	Covered at 60% after deductible
Outpatient Diagnostic Services[3] (includes simple lab tests, x-rays and genetic testing as well as complex services, such as MRIs, MRAs (magnetic resonance angiography), CT scans, PET scans and nuclear medicine provided in a hospital, physician's office or other setting)	Covered at 80% after deductible	Covered at 60% after deductible
Emergency Room[3] (an *emergency* generally means medical care and treatment provided after the sudden onset of a medical condition that places your health or bodily function in serious jeopardy. See *Emergency and Urgent Care* earlier in this section for a complete definition)	*Emergency room fee, emergency room doctor's services, treatment and tests received in an emergency room:* Covered at 80% after in-network deductible *Note:* You must notify the plan within 48 hours or on the next business day (whichever comes first)	
Emergency Room–Non-Emergency[3]	Covered at 80% after in-network deductible	
Short-Term Rehabilitative Therapy[3] (includes physical therapy, speech therapy (restorative only), occupational therapy, pulmonary therapy or cardiac rehabilitation)	Covered at 80% after deductible	Covered at 60% after deductible
	Limited to 90 visits per calendar year (in- and out-of-network combined) per therapy	
	Note: Services must be performed by a licensed therapy provider and be under the direction of a physician. Benefits are based on the allowed charge for short-term rehabilitative therapy by a physical therapist; at a general, chronic disease or rehabilitative hospital or community health center or in a doctor's office	
Outpatient Surgery and Anesthesia[3]	Covered at 80% after deductible	Covered at 60% after deductible
Drug Tests	Covered at 80% after deductible	Covered at 60% after deductible
	Note: Includes definitive drug tests (to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug) and presumptive drug tests (to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result). Each type of test limited to 18 per calendar year, plus an additional six tests of either type combined	
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Acupuncture (available for the treatment of chronic pain or nausea only)	Covered at 80% after deductible	Covered at 60% after deductible
Ambulance Services (must be provided by a licensed professional ambulance)	*Emergency cases:* Covered at 80% after in-network deductible	
	Note: In an emergency, coverage is for licensed ambulance service to the nearest hospital where emergency health services can be performed. Ambulance service by air is covered in an emergency if ground transportation is impossible or would put life or health in serious jeopardy. Under special circumstances, UHC may pay benefits for emergency air transportation to a hospital that is not the closest facility	
	Non-emergency cases[3]: Covered at 60% after out-of-network deductible	
	Note: If you request non-emergency ambulance services, you must notify Personal Health Support as soon as possible prior to the transport. If Personal Health Support is not notified, no benefits will be paid (you will be responsible for all charges)	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

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UHC HSA Advantage 1		
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Bariatric Surgery[3]	Covered at 80% after deductible	Covered at 60% after deductible
	Note: To be eligible, you must meet the requirements of UHC's clinical policy. ***You must also must also complete one call with Bariatric Resources Services (BRS) nurse by calling 888-936-7246 prior to surgery.*** For more information, see *UHC Bariatric Surgery Centers of Excellence* earlier in this section	
Cellular Therapy and Gene Therapy[3] (cellular therapy (the administration of living whole cells into a patient for the treatment of disease) and gene therapy (therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease) are covered when ordered by a physician)	Covered at 80% after deductible	Covered at 60% after deductible
Chemotherapy and Radiation Therapy	Covered at 80% after deductible	Covered at 60% after deductible
Chiropractor Services (includes manipulative and osteopathic manipulative therapy)	Covered at 80% after deductible	Covered at 60% after deductible
	Limited to 20 visits per calendar year, in- and out-of-network combined	
	Note: Services must be received through the American Chiropractic Network	
Cochlear Implants	Covered at 80% after deductible	Covered at 60% after deductible
Durable Medical Equipment[3] (rental or purchase with Personal Health Support review; includes oxygen and items related to the management and treatment of diabetes)	Covered at 80% after deductible	Covered at 60% after deductible
	Note: You must notify UHC before obtaining any single item that costs more than $1,000 (purchase, rental, repair or replacement). If you do not, benefits are reduced to 50% of eligible expenses	
Enteral Nutrition (must be the required source of nutrition and/or prescribed to treat inborn errors of metabolism)	Covered at 80% after deductible	Covered at 60% after deductible
Family Planning (includes FDA-approved oral, injectable and emergency contraceptives for women; Depo-Provera; diaphragms; IUDs; and voluntary sterilization for women)	Covered at 100% in compliance with the ACA	Covered at 60% after deductible
	Note: Contact UHC for details	
	Contraceptive drugs are covered under your prescription drug benefit when prescribed by a physician. You may fill any ongoing maintenance prescriptions using the CVS Caremark Maintenance Choice program. See the *CVS Caremark Prescription Drug Program* section for details	
Gender Dysphoria (Transgender Surgery[3] and Gender Dysphoria Treatments) (see earlier in this section for a description)	Covered at 80% after deductible	Covered at 60% after deductible
	Note: To be eligible for benefits, you must meet all UHC requirements. For information about the requirements and coverage details, contact UHC at 800-638-8884	
Hearing Care (includes services by an audiologist)	*Hearing aid exams:* Covered at 80% after deductible	Covered at 60% after deductible
	Hearing aids, supplies and services: Covered at 80% after deductible, up to $3,000 every three calendar years (combined with out-of-network)	*Hearing aids, supplies and services:* Covered at 60% after deductible, up to $3,000 every three calendar years (combined with in-network)
	Note: If you do not have access to a network provider within a 30-mile radius of your home zip code, you may be eligible to receive in-network benefits with an out-of-network provider/facility. For more information, call UHC. For a description of benefits, see *Limitations* later in this section	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

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UHC HSA Advantage 1		
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Hemodialysis and Peritoneal Dialysis	Covered at 80% after deductible	Not covered
Home Health Care[3]	Covered at 80% after deductible	Covered at 60% after deductible
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section	
Hospice Services[3] (includes respite care in the home or a nursing home, and other covered services and supplies, when received from a licensed hospice agency)	Covered at 80% after deductible *Bereavement counseling:* Covered at 80% after deductible	Covered at 60% after deductible
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section	
Infertility Services[3]	Covered at 80% after deductible	Covered at 60% after deductible
	Limited to $25,000 per lifetime for medical services that are related to infertility (in- and out-of-network combined) and $10,000 per lifetime for prescription drugs that are related to infertility and covered by the CVS Caremark prescription drug program. Only charges for the following apply toward the $25,000 medical services lifetime maximum: Surgeon, assistant surgeon, anesthesia, lab tests and specific injections. Physician office visits for the treatment of infertility are covered as other office visits and do not apply toward the lifetime maximum. Benefits also include access to the Fertility Solutions program, which provides support to members who are beginning infertility services. ***While you are welcome to take full advantage of this program, at a minimum, you must complete one initial call with a Fertility Solutions nurse by calling 866-774-4626 in order for UHC and CVS Caremark to cover eligible medical services and prescription drugs***. For a description of the Fertility Solutions program, see *Fertility Solutions* earlier in this section. See also *Limitations and Exclusions* for more information regarding services that are and are not covered	
Newborn Inpatient Care	*Newborn exam, physician charges for circumcision and newborn care:* Covered at 80% after deductible after baby's separate deductible	Covered at 60% after deductible
	Note: A newborn is subject to his/her own deductible; newborn care is not provided under the mother's policy and/or deductible. You must call the Raytheon Benefit Center at 800-358-1231 within 31 days of the birth date to enroll your newborn for coverage, including if you already have family coverage. Dependent verification is required	
Nutritional Counseling (necessary for improving a diagnosed medical condition)	Covered at 80% after deductible	Covered at 60% after deductible
	Note: Diagnosis-based nutritional counseling is limited to 3 visits per condition per lifetime (in- and out-of-network combined)	
Orthoptic Therapy (techniques aimed at correcting and improving binocular, oculomotor, visual processing and perceptual disorders)	Covered at 80% after deductible	Covered at 60% after deductible
Podiatry	Covered at 80% after deductible *Diagnostic tests and prescribed orthotics:* Covered at 80% after deductible	Covered at 60% after deductible
	Note: For a description of limitations and exclusions related to orthotics, see *Limitations* and *Exclusions* later in this section	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

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UHC HSA Advantage 1		
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Pregnancy and Maternity Care	Certain services and supplies covered at 100%; others covered at 80% after deductible. For more information, see *Pregnancy and Maternity Care* earlier in this section	Covered at 60% after deductible[3]
Prosthetic Devices[3]	Covered at 80% after deductible	Covered at 60% after deductible
	Note: Subject to plan review; rental or purchase must meet clinical requirements	
Skilled Nursing Facility[3]	Covered at 80% after deductible	Covered at 60% after deductible
	Limited to 120 days per calendar year (combined with inpatient rehabilitation facility; in- and out-of-network combined)	
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section	
Mental Health (Including Applied Behavior Analysis (ABA) Therapy) And Substance-Related and Addictive Disorders Treatment	**In-Network Benefits[1]**	**In-Network Benefits[1]**
Outpatient Care[3]	Covered at 80% after deductible	Covered at 60% after deductible
	Note: For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral Health *before* receiving care For more information about covered services and prenotification requirements, refer to *Mental Health and Substance-Related and Addictive Disorders Coverage* earlier in this section. For a description of ABA therapy, refer to *Treating Autism Spectrum Disorders (ASD)* earlier in this section. For a description of limitations and exclusions related to all services, see *Limitations and Exclusions* later in this section	
Inpatient Hospital Care[3]	Covered at 80% after deductible	Covered at 60% after deductible
	Note: For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral Health *before* receiving care For more information about covered services and prenotification requirements, refer to *Mental Health and Substance-Related and Addictive Disorders Coverage* earlier in this section. For a description of ABA therapy, refer to *Treating Autism Spectrum Disorders (ASD)* earlier in this section. For a description of limitations and exclusions related to all services, see *Limitations and Exclusions* later in this section	
Prescription Drugs		
Retail	Administered by CVS Caremark. See the *CVS Caremark Prescription Drug Program* section for details	
Mail Order	Administered by CVS Caremark. See the *CVS Caremark Prescription Drug Program* section for details	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

With the exception of telehealth visits related to COVID, which are covered at 100% with no out-of-pocket cost, coverage as shown in this chart applies to both in-person and telehealth visits. For more information, see *Telehealth and Virtual Visits,* earlier in this section.

UHC HSA Advantage 2 Summary of Benefits Chart

This chart provides only a summary of your benefits with UHC HSA Advantage 2. A list of limitations and exclusions can be found at the end of this section. The plan only covers care provided by health care professionals or facilities licensed, certified or otherwise qualified under state law to provide health care services.

Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. For more details on covered health services, go to www.myuhc.com or call 800-638-8884.

UHC HSA Advantage 2		
Plan Features	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Calendar-Year Deductible[3,4] (see footnote 3 below for important information regarding family coverage)	• Employee only: $1,600 • Employee and spouse: $2,950 • Employee and child(ren): $2,950 • Employee and family: $3,200	• Employee only: $2,100 • Employee and spouse: $3,150 • Employee and child(ren): $3,150 • Employee and family: $4,200
Company HSA Contribution for 2021[5] (available to employees who are eligible to receive or make contributions to an HSA; see *Contributions to Your HSA* in the *Health Savings Account* section for information regarding the annual maximum amount you can contribute)	• Employee only: $500 • Employee and spouse: $750 • Employee and child(ren): $750 • Employee and family: $1,000 (Amounts shown will be prorated for new hires)	
Coinsurance	90%	70%
Calendar-Year Out-of-Pocket Maximum[4] (includes deductible and coinsurance for all eligible services and supplies)	• Employee only: $3,100 • Employee and spouse: $4,150 • Employee and child(ren): $4,150 • Employee and family: $5,200	• Employee only: $3,600 • Employee and spouse: $5,400 • Employee and child(ren): $5,400 • Employee and family: $7,200
Covered Services: Preventive Care[6]	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Adult Routine Physical Exam (see footnote 6 below for information regarding ACA guidelines)	Covered at 100%	Covered at 70% after deductible
Routine Preventive Lab Tests, Including Fecal DNA (see footnote 6 below for information regarding ACA guidelines)	Covered at 100%	Covered at 70% after deductible
Well-Woman Exam (see footnote 6 below for information regarding ACA guidelines)	*Primary care doctor:* Covered at 100% *Specialist:* Covered at 100%	Covered at 70% after deductible

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] With only a few exceptions (ACA-required preventive health services, in-network routine preventive care and preventive prescription drugs on the Treasury Guidance list), covered expenses are subject to a deductible, which can be satisfied by one family member or a combination of family members. **If you have family coverage, you must satisfy the family deductible before benefits are payable.** Regardless of whether you visit an in-network or an out-of-network provide/facility, the plan begins paying benefits only after you satisfy the applicable deductible.

[4] If you reach the out-of-pocket maximum, the plan generally pays 100% of the rest of your covered charges, up to the negotiated charge for each service, for the remainder of that calendar year. Note that the following do not count toward your deductible or out-of-pocket maximum:

- Charges for services that are not covered by the plan or exceed plan limitations;
- Charges in excess of the negotiated amount for provider charges or any negotiated amount for facility charges;
- Charges that are not payable because you did not comply with the plan's prenotification requirements; and
- Any penalty you pay if your provider prescribes—or you request—a preferred brand-name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available. For more information, see the *CVS Caremark Prescription Drug Coverage* section.

[5] The company's HSA contribution represents the company's total annual lump-sum contribution and can be used for in-network or out-of-network services. In other words, the company does not make an in-network contribution and an out-of-network contribution.

[6] Benefits are calculated on a **calendar-year** basis; you do not need to wait 12 months from the date of your last eligible preventive care visit to schedule your next visit. Lab tests and screenings are covered according to age and gender recommendations of the U.S. Preventive Services Task Force (USPSTF) and/or the guidelines supported by the Health Resources and Services Administration, as determined by UHC. Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), as determined by UHC. **Note that to be considered routine preventive care, your exam and/or associated lab tests *cannot* be related to the diagnosis or treatment of an illness or injury.** For more information, call UHC.

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UHC HSA Advantage 2		
Covered Services: Preventive Care[1]	**In-Network Benefits**[2]	**Out-of-Network Benefits**[3]
Routine Mammogram (Including 3D) (beginning at age 40 or as recommended by your physician; see footnote 1 below for information regarding ACA guidelines)	Covered at 100%	Covered at 70% after deductible
Women's Health Services (Including Breast Pumps) (see footnote 1 below for information regarding ACA guidelines)	Covered at 100% *Note:* Contact UHC for a list of covered services	Covered at 70% after deductible
Well-Child Care (from birth through age 18; see footnote 1 below for information regarding ACA guidelines)	Covered at 100%	Covered at 70% after deductible
Immunizations (see footnote 1 below for information regarding ACIP guidelines) *Adults:* Includes an annual flu shot and tetanus/diphtheria booster once every 10 years *Children:* Includes age-appropriate immunizations	Covered at 100%	Covered at 70% after deductible
Preventive Nutritional Counseling	Covered at 100% Preventive nutritional counseling is limited to 2 visits per calendar year (in- and out-of-network combined). Nutritional counseling necessary for improving a diagnosed medical condition also is covered; see later in this chart for details	Covered at 70% after deductible
Covered Services: Inpatient Care	**In-Network Benefits**[2]	**Out-of-Network Benefits**[3]
Inpatient Hospital Care[4] (includes semi-private room and special services in a general hospital; chronic disease hospital; inpatient mental health or substance-related and addictive disorders treatment facility; or rehabilitation hospital)	Covered at 90% after deductible	Covered at 70% after deductible, subject to Personal Health Support prenotification requirements
Inpatient Physician Services (includes assistant surgeon)	Covered at 90% after deductible	Covered at 70% after deductible
Inpatient Surgery[4] (includes pre- and post-operative care, anesthesia and endoscopic exams)	Covered at 90% after deductible	Covered at 70% after deductible
Covered Services: Outpatient Care	**In-Network Benefits**[2]	**Out-of-Network Benefits**[3]
Physician's Office Services (includes second surgical opinions as well as emergency or urgent care) *Note:* Services such as lab tests or x-rays provided in an office setting are covered separately; see *Outpatient Diagnostic Services*	Covered at 90% after deductible *Allergy testing:* Covered at 90% after deductible *Allergy shots (including serum) with or without an office visit:* Covered at 90% after deductible	Covered at 70% after deductible

[1] Benefits are calculated on a **calendar-year** basis; you do not need to wait 12 months from the date of your last eligible preventive care visit to schedule your next visit. Lab tests and screenings are covered according to age and gender recommendations of the U.S. Preventive Services Task Force (USPSTF) and/or the guidelines supported by the Health Resources and Services Administration, as determined by UHC. Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), as determined by UHC. **Note that to be considered routine preventive care, your exam and/or associated lab tests *cannot* be related to the diagnosis or treatment of an illness or injury.** For more information, call UHC.

[2] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[3] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[4] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

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UHC HSA Advantage 2		
Covered Services: Outpatient Care	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Prostate-Specific Antigen (PSA) Test	Covered at 100%	Covered at 70% after deductible
Outpatient Diagnostic Services[3] (includes simple lab tests, x-rays and genetic testing as well as complex services, such as MRIs, MRAs (magnetic resonance angiography), CT scans, PET scans and nuclear medicine provided in a hospital, physician's office or other setting)	Covered at 90% after deductible	Covered at 70% after deductible
Emergency Room[3] (an *emergency* generally means medical care and treatment provided after the sudden onset of a medical condition that places your health or bodily function in serious jeopardy. See *Emergency and Urgent Care* earlier in this section for a complete definition)	*Emergency room fee, emergency room doctor's services, treatment and tests received in an emergency room:* Covered at 90% after in-network deductible *Note:* You must notify the plan within 48 hours or on the next business day (whichever comes first)	
Emergency Room–Non-Emergency[3]	Covered at 90% after in-network deductible	
Short-Term Rehabilitative Therapy[3] (includes physical therapy, speech therapy (restorative only), occupational therapy, pulmonary therapy or cardiac rehabilitation)	Covered at 90% after deductible	Covered at 70% after deductible
	Limited to 90 visits per calendar year (in-and out-of-network combined) per therapy	
	Note: Services must be performed by a licensed therapy provider and be under the direction of a physician. Benefits are based on the allowed charge for short-term rehabilitative therapy by a physical therapist; at a general, chronic disease or rehabilitative hospital or community health center or in a doctor's office	
Outpatient Surgery and Anesthesia[3]	Covered at 90% after deductible	Covered at 70% after deductible
Drug Tests	Covered at 90% after deductible	Covered at 70% after deductible
	Note: Includes definitive drug tests (to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug) and presumptive drug tests (to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result. Each type of test limited to 18 per calendar year, plus an additional six tests of either type combined	
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Acupuncture (available for the treatment of chronic pain or nausea only)	Covered at 90% after deductible	Covered at 70% after deductible
	Emergency cases: Covered at 90% after in-network deductible	
Ambulance Services (must be provided by a licensed professional ambulance)	*Note:* In an emergency, coverage is for licensed ambulance service to the nearest hospital where emergency health services can be performed. Ambulance service by air is covered in an emergency if ground transportation is impossible or would put life or health in serious jeopardy. Under special circumstances, UHC may pay benefits for emergency air transportation to a hospital that is not the closest facility	
	Non-emergency cases[3]: Covered at 70% after out-of-network deductible	
	Note: If you request non-emergency ambulance services, you must notify Personal Health Support as soon as possible prior to the transport. If Personal Health Support is not notified, no benefits will be paid (you will be responsible for all charges)	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

(continued)

UHC HSA Advantage 2		
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Bariatric Surgery[3]	Covered at 90% after deductible	Covered at 70% after deductible
	Note: To be eligible, you must meet the requirements of UHC's clinical policy. ***You must also must also complete one call with Bariatric Resources Services (BRS) nurse by calling 888-936-7246 prior to surgery.*** For more information, see *UHC Bariatric Surgery Centers of Excellence* earlier in this section	
Cellular Therapy and Gene Therapy[3] (cellular therapy (the administration of living whole cells into a patient for the treatment of disease) and gene therapy (therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease) are covered when ordered by a physician)	Covered at 90% after deductible	Covered at 70% after deductible
Chemotherapy and Radiation Therapy	Covered at 90% after deductible	Covered at 70% after deductible
Chiropractor Services (includes manipulative and osteopathic manipulative therapy)	Covered at 90% after deductible	Covered at 70% after deductible
	Limited to 20 visits per calendar year, in- and out-of-network combined	
	Note: Services must be received through the American Chiropractic Network	
Cochlear Implants	Covered at 90% after deductible	Covered at 70% after deductible
Durable Medical Equipment[3] (rental or purchase with Personal Health Support review; includes oxygen and items related to the management and treatment of diabetes)	Covered at 90% after deductible	Covered at 70% after deductible
	Note: You must notify UHC before obtaining any single item that costs more than $1,000 (purchase, rental, repair or replacement). If you do not, benefits are reduced to 50% of eligible expenses	
Enteral Nutrition (must be the required source of nutrition and/or prescribed to treat inborn errors of metabolism)	Covered at 90% after deductible	Covered at 70% after deductible
Family Planning (includes FDA-approved oral, injectable and emergency contraceptives for women; Depo-Provera; diaphragms; IUDs; and voluntary sterilization for women)	Covered at 100% in compliance with the ACA	Covered at 70% after deductible
	Note: Contact UHC for details	
	Contraceptive drugs are covered under your prescription drug benefit when prescribed by a physician. You may fill any ongoing maintenance prescriptions using the CVS Caremark Maintenance Choice program. See the *CVS Caremark Drug Program* section for details	
Gender Dysphoria (Transgender Surgery[3] and Gender Dysphoria Treatments) (see earlier in this section for a description)	Covered at 90% after deductible	Covered at 70% after deductible
	Note: To be eligible for benefits, you must meet all UHC requirements. For information about the requirements and coverage details, contact UHC at 800-638-8884	
Hearing Care (includes services by an audiologist)	*Hearing aid exams:* Covered at 90% after deductible	Covered at 70% after deductible
	Hearing aids, supplies and services: Covered at 90% after deductible, up to $3,000 every three calendar years (combined with out-of-network)	*Hearing aids, supplies and services:* Covered at 70% after deductible, up to $3,000 every three calendar years (combined with in-network)
	Note: If you do not have access to a network provider within a 30-mile radius of your home zip code, you may be eligible to receive in-network benefits with an out-of-network provider/facility. For more information, call UHC. For a description of benefits, see *Limitations* later in this section	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

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UHC HSA Advantage 2		
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Hemodialysis and Peritoneal Dialysis	Covered at 90% after deductible	Not covered
Home Health Care[3]	Covered at 90% after deductible	Covered at 70% after deductible
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section	
Hospice Services[3] (includes respite care in the home or a nursing home, and other covered services and supplies, when received from a licensed hospice agency)	Covered at 90% after deductible *Bereavement counseling:* Covered at 90% after deductible	Covered at 70% after deductible
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section	
Infertility Services[3]	Covered at 90% after deductible	Covered at 70% after deductible
	Limited to $25,000 per lifetime for medical services that are related to infertility (in- and out-of-network combined) and $10,000 per lifetime for prescription drugs that are related to infertility and covered by the CVS Caremark prescription drug program. Only charges for the following apply toward the $25,000 medical services lifetime maximum: Surgeon, assistant surgeon, anesthesia, lab tests and specific injections. Physician office visits for the treatment of infertility are covered as other office visits and do not apply toward the lifetime maximum. Benefits also include access to the Fertility Solutions program, which provides support to members who are beginning infertility services. ***While you are welcome to take full advantage of this program, at a minimum, you must complete one initial call with a Fertility Solutions nurse by calling 866-774-4626 in order for UHC and CVS Caremark to cover eligible medical services and prescription drugs***. For a description of the Fertility Solutions program, see *Fertility Solutions* earlier in this section. See also *Limitations and Exclusions* for more information regarding services that are and are not covered	
Newborn Inpatient Care	*Newborn exam, physician charges for circumcision and newborn care:* Covered at 90% after deductible after baby's separate deductible	Covered at 70% after deductible[3]
	Note: A newborn is subject to his/her own deductible; newborn care is not provided under the mother's policy and/or deductible. You must call the Raytheon Benefit Center at 800-358-1231 within 31 days of the birth date to enroll your newborn for coverage, including if you already have family coverage. Dependent verification is required	
Nutritional Counseling (necessary for improving a diagnosed medical condition)	Covered at 90% after deductible	Covered at 70% after deductible
	Note: Diagnosis-based nutritional counseling is limited to 3 visits per condition per lifetime (in- and out-of-network combined)	
Orthoptic Therapy (techniques aimed at correcting and improving binocular, oculomotor, visual processing and perceptual disorders)	Covered at 90% after deductible	Covered at 70% after deductible
Podiatry	Covered at 90% after deductible *Diagnostic tests and prescribed orthotics:* Covered at 90% after deductible	Covered at 70% after deductible
	Note: For a description of limitations and exclusions related to orthotics, see *Limitations* and *Exclusions* later in this section	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

(continued)

UHC HSA Advantage 2		
Other Covered Services	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Pregnancy and Maternity Care	Certain services and supplies covered at 100%; others covered at 90% after deductible. For more information, see *Pregnancy and Maternity Care* earlier in this section	Covered at 70% after deductible[3]
Prosthetic Devices[3]	Covered at 90% after deductible	Covered at 70% after deductible
	Note: Subject to plan review; rental or purchase must meet clinical requirements	
Skilled Nursing Facility[3]	Covered at 90% after deductible	Covered at 70% after deductible
	Limited to 120 days per calendar year (combined with inpatient rehabilitation facility; in- and out-of-network combined) *Note:* Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section	
Mental Health (Including Applied Behavior Analysis (ABA) Therapy) And Substance-Related and Addictive Disorders Treatment	**In-Network Benefits[1]**	**Out-of-Network Benefits[2]**
Outpatient Care[3]	Covered at 90% after deductible	Covered at 70% after deductible
	Note: For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral Health *before* receiving care For more information about covered services and prenotification requirements, refer to *Mental Health and Substance-Related and Addictive Disorders Coverage* earlier in this section. For a description of ABA therapy, refer to *Treating Autism Spectrum Disorders (ASD)* earlier in this section. For a description of limitations and exclusions related to all services, see *Limitations and Exclusions* later in this section	
Inpatient Hospital Care[3]	Covered at 90% after deductible`	Covered at 70% after deductible
	Note: For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral Health *before* receiving care For more information about covered services and prenotification requirements, refer to *Mental Health and Substance-Related and Addictive Disorders Coverage* earlier in this section. For a description of ABA therapy, refer to *Treating Autism Spectrum Disorders (ASD)* earlier in this section. For a description of limitations and exclusions related to all services, see *Limitations and Exclusions* later in this section	
Prescription Drugs		
Retail	Administered by CVS Caremark. See the *CVS Caremark Prescription Drug Program* section for details	
Mail Order	Administered by CVS Caremark. See the *CVS Caremark Prescription Drug Program* section for details	

[1] Care must be provided by a Choice Plus network provider/facility. **It is your responsibility to confirm that you are using a network provider/visiting a network facility.** The only exception is for services that meet UHC's definition of an emergency, as defined in *Emergency and Urgent Care* earlier in this section.

[2] All coverage is based on the negotiated charge (defined earlier) for a particular covered health service or procedure.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

UnitedHealthcare Out-of-Area Plan

If you live in an area where a fully developed network is not available, medical coverage is available through the UnitedHealthcare (UHC) Out-of-Area plan. You make all decisions regarding where, when and how to receive your medical care. It's up to you as a health care consumer to select a provider/facility as well as to ensure that treatment is provided in the most appropriate and cost-effective manner.

How the Plan Works

- Electing a primary care physician (PCP) is recommended, but not required.
- Because the Out-of-Area plan is not network-based, coverage is provided at the same benefit level regardless of your choice of provider/facility or location within the United States. However, you can save money when you use a provider/facility in the Options Preferred Provider Organization (PPO), which is available nationwide. (See the box below for details.)
- Eligible preventive-care services (as identified by the ACA under the Preventive Care Services benefit) are covered at 100% with no out-of-pocket expense. In compliance with the ACA, this coverage extends to include Women's Health Services (as defined by UHC).
- For all other covered services, you generally have to meet a calendar-year deductible before the plan pays benefits. (See the sidebar for information about the deductible.)
- Once you meet the deductible, the plan pays 80% of negotiated charges for most covered health services and supplies. You pay the remaining 20%, up to the calendar-year out-of-pocket maximum.
- If you reach the out-of-pocket maximum, the plan pays 100% (up to negotiated amounts) of your covered charges for the remainder of that calendar year.
- ***Contact information:*** www.myuhc.com, 800-638-8884.

UNITEDHEALTHCARE OPTIONS PPO—SAVING YOU TIME AND MONEY

To help you take advantage of lower costs for your care when possible, the Out-of-Area plan offers access to the UnitedHealthcare Options Preferred Provider Organization (PPO)—a network of physicians, specialists and health care providers/facilities that has negotiated discounted rates for covered health services.

When you use a provider/facility that participates in the Options PPO, you enjoy several advantages, including:

- **Lower costs for your care.** *You pay less when you use a PPO provider because your coinsurance (the percentage you pay) is based on a lower fee. And, if your provider/facility charges more than the negotiated charge, you are* ***not*** *required to pay the difference (called "balance billing").*
- **No claims forms to file.** *When you use a PPO provide /facility, your doctor or health care facility files your claims for you, saving you time. You will receive a statement of what the plan paid and the coinsurance you owe, based on the lower PPO negotiated fee.*
- **Flexibility to choose who you see.** *You always have the option of seeing the doctor, specialist or other health care provider you wish. This means that you can continue to see the medical providers/facilities you currently use, whether or not they participate in the PPO.*

UnitedHealthcare Options PPO network providers/facilities are available in most major metropolitan areas. To find participating providers/facilities online, go to www.myuhc.com.

When you receive certain services such as hospitalization, you are responsible for ensuring prenotification policies are followed. For more information, see *Personal Health Support* earlier in this section.

If you do not satisfy any part of the deductible during the first three quarters of the calendar year (January through September), any deductible met or partially met during the last quarter of the calendar year (October to December) is carried over and applied to the appropriate deductible for the following calendar year, provided that you remain in the same plan.

UnitedHealthcare (UHC)
www.myuhc.com
800-638-8884

With the exception of telehealth visits related to COVID, which are covered at 100% with no out-of-pocket cost, coverage as shown in this chart applies to both in-person and telehealth visits. For more information, see *Telehealth and Virtual Visits,* earlier in this section.

UnitedHealthcare Out-of-Area Plan

Medical

UnitedHealthcare Out-of-Area Plan Summary of Benefits Chart

This chart provides only a summary of your benefits under the UHC Out-of-Area plan. A list of limitations and exclusions can be found at the end of this section. Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. For more details on covered health services, go to www.myuhc.com or call 800-638-8884.

UnitedHealthcare Out-of-Area[1]	
Plan Features	**Benefits**
Calendar-Year Deductible[2,3]	$ 200 per individual $ 400 per family
Calendar-Year Out-of-Pocket Maximum[3] (includes deductible)	$2,500 per individual $5,000 per family
Covered Services: Preventive Care[4]	**Benefits**
Adult Routine Physical Exam (see footnote 4 below for information regarding ACA guidelines)	Covered at 100%
Routine Preventive Lab Tests, Including Fecal DNA (see footnote 4 below for information regarding ACA guidelines)	Covered at 100%
Well-Woman Exam (see footnote 4 below for information regarding ACA guidelines)	*Primary care doctor and specialist:* Covered at 100%
Routine Mammogram (Including 3D) (beginning at age 40 or as recommended by your physician; see footnote 4 below for information regarding ACA guidelines)	Covered at 100%
Women's Health Services (Including Breast Pumps) (see footnote 4 below for information regarding ACA guidelines)	Covered at 100% *Note:* Contact UHC for a list of covered services
Well-Child Care (from birth through age 18; see footnote 4 below for information regarding ACA guidelines)	Covered at 100%
Immunizations (see footnote 2 below for information regarding ACIP guidelines) *Adults:* Includes an annual flu shot and tetanus/diphtheria booster once every 10 years *Children:* Includes age-appropriate immunizations	Covered at 100%

[1] All coverage is based on the negotiated charge for a particular covered health service or procedure.

[2] Once more than two family members pay eligible expenses toward the deductible that equal the family deductible, no more deductibles are required for any family member's claim during the rest of that calendar year. In addition, if you do not satisfy any part of the deductible during the first three quarters of the calendar year (January to September), any deductible met or partially met during the last quarter of the calendar year (October to December) is carried over and applied to the deductible for the following calendar year.

[3] If you reach the out-of-pocket maximum, the plan generally pays 100% of the rest of your covered charges, up to the negotiated charge for each service, for the remainder of that calendar year. Note that the following do not count toward your deductible or out-of-pocket maximum:

- Charges for services that are not covered by the plan or exceed plan limitations;
- Charges in excess of the negotiated amount for provider charges or any negotiated amount for facility charges;
- Charges that are not payable because you did not comply with the plan's prenotification requirements; and
- Any penalty you pay if your provider prescribes—or you request—a preferred brand-name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available. For more information, see the *CVS Caremark Prescription Drug Coverage* section.

[4] Benefits are calculated on a **calendar-year basis;** you do not need to wait 12 months from the date of your last eligible preventive care visit to schedule your next visit. Lab tests and screenings are covered according to age and gender recommendations of the U.S. Preventive Services Task Force (USPSTF) and/or the guidelines supported by the Health Resources and Services Administration, as determined by UHC. Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), as determined by UHC. **Note that to be considered routine preventive care, your exam and/or associated lab tests *cannot* be related to the diagnosis or treatment of an illness or injury.** For more information, call UHC.

(continued)

UnitedHealthcare Out-of-Area[1]	
Covered Services: Preventive Care[2]	**Benefits**
Preventive Nutritional Counseling	Covered at 100%
	Preventive nutritional counseling is limited to 2 visits per calendar year. Nutritional counseling necessary for improving a diagnosed medical condition also is covered; see later in this chart for details
Covered Services: Inpatient Care	**Benefits**
Inpatient Hospital Care[3] (includes semi-private room and special services in a general hospital; chronic disease hospital; inpatient mental health or substance-related and addictive disorders treatment facility; or rehabilitation hospital)	Covered at 80% after deductible, subject to Personal Health Support prenotification requirements
Inpatient Physician Services (includes assistant surgeon)	Covered at 80% after deductible
Inpatient Surgery[3] (includes pre- and post-operative care, anesthesia and endoscopic exams)	Covered at 80% after deductible, subject to Personal Health Support prenotification requirements
Covered Services: Outpatient Care	**Benefits**
Physician's Office Services (includes second surgical opinions as well as emergency or urgent care)	Covered at 80% after deductible
Note: Services such as lab tests or x-rays provided in an office setting are covered separately; see *Outpatient Diagnostic Services*	*Allergy testing:* Covered at 80% after deductible
	Allergy shots (including serum) with or without an office visit: Covered at 80% after deductible
Prostate-Specific Antigen (PSA) Test	Covered at 100%
Outpatient Diagnostic Services[3] (includes simple lab tests, x-rays and genetic testing as well as complex services, such as MRIs, MRAs (magnetic resonance angiography), CT scans, PET scans and nuclear medicine provided in a hospital, physician's office or other setting)	Covered at 80% after deductible
Emergency Room[3] (an *emergency* generally means medical care and treatment provided after the sudden onset of a medical condition that places your health or bodily function in serious jeopardy. See *Emergency and Urgent Care* earlier in this section for a complete definition)	*Emergency room fee, emergency room doctor's services, treatment and tests received in an emergency room:* Covered at 80% after deductible
	Note: You must notify the plan within 48 hours or on the next business day (whichever comes first)
Emergency Room–Non-Emergency[3]	Covered at 80% after deductible
Short-Term Rehabilitative Therapy[3] (includes physical therapy, speech therapy (restorative only), occupational therapy, pulmonary therapy or cardiac rehabilitation)	Covered at 80% after deductible
	Limited to 90 visits per calendar year per therapy
	Note: Services must be performed by a licensed therapy provider and be under the direction of a physician. Benefits are based on the allowed charge for short-term rehabilitative therapy by a physical therapist; at a general, chronic disease or rehabilitative hospital or community health center or in a doctor's office
Outpatient Surgery and Anesthesia[3]	Covered at 80% after deductible, subject to Personal Health Support prenotification requirements

[1] All coverage is based on the negotiated charge for a particular covered health service or procedure.

[2] Benefits are calculated on a **calendar-year basis;** you do not need to wait 12 months from the date of your last eligible preventive care visit to schedule your next visit. Lab tests and screenings are covered according to age and gender recommendations of the U.S. Preventive Services Task Force (USPSTF) and/or the guidelines supported by the Health Resources and Services Administration, as determined by UHC. Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), as determined by UHC. **Note that to be considered routine preventive care, your exam and/or associated lab tests *cannot* be related to the diagnosis or treatment of an illness or injury.** For more information, call UHC.

[3] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

(continued)

UnitedHealthcare Out-of-Area[1]	
Covered Services: Outpatient Care	**Benefits**
Drug Tests	Covered at 80% after deductible
	Note: Includes definitive drug tests (to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug) and presumptive drug tests (to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result). Each type of test limited to 18 per calendar year, plus an additional six tests of either type combined
Other Covered Services	**Benefits**
Acupuncture (available for the treatment of chronic pain or nausea only)	Covered at 80% after deductible
Ambulance Services (must be provided by a licensed professional ambulance)	*Emergency and non-emergency*[2]*:* Covered at 80% after deductible
	Note: In an emergency, coverage is for licensed ambulance service to the nearest hospital where emergency health services can be performed. Ambulance service by air is covered in an emergency if ground transportation is impossible or would put life or health in serious jeopardy. Under special circumstances, UHC may pay benefits for emergency air transportation to a hospital that is not the closest facility. If you request non-emergency ambulance services, you must notify Personal Health Support as soon as possible prior to the transport. If Personal Health Support is not notified, no benefits will be paid (you will be responsible for all charges)
Bariatric Surgery[2]	Covered at 80% after deductible
	Note: To be eligible, you must meet the requirements of UHC's clinical policy. ***You must also must also complete one call with Bariatric Resources Services (BRS) nurse by calling 888-936-7246 prior to surgery.*** For more information, see *UHC Bariatric Surgery Centers of Excellence* earlier in this section
Cellular Therapy and Gene Therapy[2] (cellular therapy (the administration of living whole cells into a patient for the treatment of disease) and gene therapy (therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease) are covered when ordered by a physician)	Covered at 80% after deductible
Chemotherapy and Radiation Therapy	Covered at 80% after deductible
Chiropractor Services (includes manipulative and osteopathic manipulative therapy)	Covered at 80% after deductible
	Limited to 20 visits per calendar year
	Note: Services must be received through the American Chiropractic Network
Cochlear Implants	Covered at 80% after deductible
Durable Medical Equipment[2] (rental or purchase with Personal Health Support review; includes oxygen and items related to the management and treatment of diabetes)	Covered at 80% after deductible
	Note: You must notify UHC before obtaining any single item that costs more than $1,000 (purchase, rental, repair or replacement). If you do not, benefits are reduced to 50% of eligible expenses
Enteral Nutrition (must be the required source of nutrition and/or prescribed to treat inborn errors of metabolism)	Covered at 80% after deductible

[1] All coverage is based on the negotiated charge for a particular covered health service or procedure.

[2] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

(continued)

UnitedHealthcare Out-of-Area[1]	
Other Covered Services	**Benefits**
Family Planning (includes FDA-approved oral, injectable and emergency contraceptives for women; Depo-Provera; diaphragms; IUDs; and voluntary sterilization for women)	Covered at 100% in compliance with the ACA
	Note: Contact UHC for details
	Contraceptive drugs are covered under your prescription drug benefit when prescribed by a physician. You may fill any ongoing maintenance prescriptions using the CVS Caremark Maintenance Choice program. See the *CVS Caremark Prescription Drug Program* section for details
Gender Dysphoria (Transgender Surgery[2] and Gender Dysphoria Treatments) (see earlier in this section for a description)	Covered at 80% after deductible
	Note: To be eligible for benefits, you must meet all UHC requirements. For information about the requirements and coverage details, contact UHC at 800-638-8884
Hearing Care	Not covered
Hemodialysis and Peritoneal Dialysis	Covered at 80% after deductible
Home Health Care[2]	Covered at 80% after deductible
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section
Hospice Services[2] (includes respite care in the home or a nursing home, and other covered services and supplies, when received from a licensed hospice agency)	Covered at 80% after deductible
	Bereavement counseling: Covered at 80% after deductible
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section
Infertility Services[2]	Covered at 80% after deductible
	Limited to $25,000 per lifetime for medical services that are related to infertility (in- and out-of-network combined) and $10,000 per lifetime for prescription drugs that are related to infertility and covered by the CVS Caremark prescription drug program. Only charges for the following apply toward the $25,000 medical services lifetime maximum: Surgeon, assistant surgeon, anesthesia, lab tests and specific injections. Physician office visits for the treatment of infertility are covered as other office visits and do not apply toward the lifetime maximum. Benefits also include access to the Fertility Solutions program, which provides support to members who are beginning infertility services. ***While you are welcome to take full advantage of this program, at a minimum, you must complete one initial call with a Fertility Solutions nurse by calling 866-774-4626 in order for UHC and CVS Caremark to cover eligible medical services and prescription drugs***. For a description of the Fertility Solutions program, see *Fertility Solutions* earlier in this section. See also *Limitations and Exclusions* for more information regarding services that are and are not covered
Newborn Inpatient Care	*Newborn exam, physician charges for circumcision and newborn care:* Covered at 80% after baby's separate deductible
	Note: A newborn is subject to his/her own deductible; newborn care is not provided under the mother's policy and/or deductible. You must call the Raytheon Benefit Center at 800-358-1231 within 31 days of the birth date to enroll your newborn for coverage, including if you already have family coverage. Note that dependent eligibility verification, such as a birth certificate, is required
Nutritional Counseling (necessary for improving a diagnosed medical condition)	Covered at 80% after deductible
	Note: Diagnosis-based nutritional counseling is limited to 3 visits per condition per lifetime

[1] All coverage is based on the negotiated charge for a particular covered health service or procedure.

[2] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

(continued)

UnitedHealthcare Out-of-Area[1]	
Other Covered Services	**Benefits**
Orthoptic Therapy (techniques aimed at correcting and improving binocular, oculomotor, visual processing and perceptual disorders)	Covered at 80% after deductible
Podiatry	Covered at 80% after deductible
	Diagnostic tests and prescribed orthotics: Covered at 80% after deductible
	Note: For a description of limitations and exclusions related to orthotics, see *Limitations* and *Exclusions* later in this section
Pregnancy and Maternity Care	Certain services and supplies covered at 100%; others covered at 80% after deductible. For more information, see *Pregnancy and Maternity Care earlier* in this section[2]
Prosthetic Devices[2]	Covered at 80% after deductible
	Note: Subject to plan review; rental or purchase must meet clinical requirements
Skilled Nursing Facility[2]	Covered at 80% after deductible
	Limited to 120 days per calendar year (combined with inpatient rehabilitation facility)
	Note: Custodial services are not covered. For more information about eligible services, refer to *Alternative Care Settings* earlier in this section
Mental Health (Including Applied Behavior Analysis (ABA) Therapy) and Substance-Related And Addictive Disorders Treatment	**Benefits**
Outpatient Care[2]	Covered at 80% after deductible
	Note: For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral Health before receiving care For more information about covered services and prenotification requirements, refer to *Mental Health and Substance-Related and Addictive Disorders Coverage* earlier in this section. For a description of ABA therapy, refer to *Treating Autism Spectrum Disorders (ASD)* earlier in this section. For a description of limitations and exclusions related to all services, see *Limitations and Exclusions* later in this section
Inpatient Hospital Care[2]	Covered at 80% after deductible
	Note: For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral Health before receiving care For more information about covered services and prenotification requirements, refer to *Mental Health and Substance-Related and Addictive Disorders Coverage* earlier in this section. For a description of ABA therapy, refer to *Treating Autism Spectrum Disorders (ASD)* earlier in this section. For a description of limitations and exclusions related to all services, see *Limitations and Exclusions* later in this section
Prescription Drugs	**Benefits**
Retail	Administered by CVS Caremark. See the *CVS Caremark Prescription Drug Program* section for details
Mail Order	Administered by CVS Caremark. See the *CVS Caremark Prescription Drug Program* section for details

[1] All coverage is based on the negotiated charge for a particular covered health service or procedure.

[2] For more information about prenotification requirements, see *Personal Health Support* earlier in this section.

Limitations and Exclusions

The following limitations and exclusions apply to the UHC plans. To qualify for the highest level of benefits for UHC HSA Advantage 1 and UHC HSA Advantage 2, all services and supplies must generally be received through the Choice Plus network (and, in New England, the Passport Connect program). ***Note that any references to out-of-network do not apply to the Out-of-Area plan.***

COVERED HEALTH SERVICES

Covered health services *are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance use disorder or their symptoms. Covered health services must be provided:*

- *When the UHC plan is in effect;*
- *Before an individual's coverage with the UHC plan ends; and*
- *Only when the person who receives services is a covered person and meets all eligibility requirements specified in the UHC plan.*

A covered health service must meet each of the following criteria:

- *It is supported by national medical standards of practice;*
- *It is consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes and is based on trials that meet the following designs:*
  - *Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received); or*
  - *Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group);*
- *It is the most cost-effective method and yields a similar outcome to other available alternatives; and*
- *It is a health service or supply that is described in the plan documents, and that is not excluded under general exclusions.*

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

Limitations

- Benefits for ***acupuncture*** are available for the treatment of chronic pain and nausea ***only;*** services must meet UHC guidelines. Services must be provided by a licensed provider (DO, MD, DSS) qualified in the use of acupuncture or an acupuncturist licensed by the state or certified by the National Commission of Acupuncturists.
- With the exception of the Out-of-Area plan, UHC covers charges by a licensed or certified ***audiologist*** for physician-prescribed hearing evaluations to determine the location of a disease within the auditory system as well as for validation or organicity tests to confirm an organic hearing problem.

  Audiologist charges for services relating to prescription hearing aids or basic hearing evaluations are not covered.
- UHC pays benefits for psychiatric services for ***autism spectrum disorders (ASD)*** 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.

Final Coverage Determined by UHC

As the claims fiduciary, UHC makes the final decision as to whether or not a particular service is covered, and for covered services, the benefit payable. For questions about what is and is not covered under your plan, call UHC. For information about how to appeal a denied claim, see *Applying for Benefits* in the *Administrative* section.

By enrolling in a UHC plan, you agree to allow all providers to give UHC needed information about your care. UHC keeps all such information strictly confidential. If a provider requires specific authorization to release records, you must provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.

Limitations *(continued)*

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

- Applied Behavior Analysis (ABA) therapy (see *Treating Autism Spectrum Disorders (ASD)* earlier in this section for a description);
- Crisis intervention;
- Diagnostic evaluations and assessment;
- Individual, family, therapeutic group and provider-based case management services;
- Medication management;
- Referral services; and
- Treatment planning.

Benefits include inpatient partial hospitalization/day treatment and services at a residential treatment facility. Outpatient benefits include those for intensive outpatient treatment.

UHC 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 UHC for referrals to providers and coordination of care.

- ***Breast pumps*** must be purchased from a UHC network supplier.
- Benefits for ***dental services*** are only available in the event of an accidental injury. For benefits to be paid, *all* of the following must be true:
  - Benefits are available only for the treatment of a sound, natural tooth. Before the plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, or that it has no decay, has no filling on more than two surfaces, has no gum disease associated with bone loss, has no root canal therapy, is not a dental implant and functions normally in chewing and speech;
  - Treatment is necessary because of accidental damage to the tooth;
  - The dental damage did not occur as a result of normal activities of daily living or extraordinary use of the teeth;
  - The dental services are received from a doctor of dental surgery (DDS) or doctor of medical dentistry (DMD); *and*
  - The dental damage is severe enough that initial contact with a physician or dentist occurred 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.)

  Dental services for final treatment to repair the damage caused by accidental injury must be started within three months of the accident (or if not a covered person at the time of the accident, within three months of coverage under the plan) unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident (or if not a covered person at the time of the accident, within 12 months of coverage under the plan).

  UHC pays for treatment of accidental injury only for:
  - Emergency examination;
  - Endodontic (root canal) treatment;
  - Extractions;
  - Necessary diagnostic x-rays;
  - Post-traumatic crowns if such are the only clinically acceptable treatment;
  - Prefabricated post and core;
  - Replacement of lost teeth due to the injury by implant, dentures or bridges;
  - Simple minimal restorative procedures (fillings); and
  - Temporary splinting of teeth.

UHC defines autism spectrum disorders as conditions marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Limitations *(continued)*

- UHC pays for ***durable medical equipment (DME)*** that is:
  - Ordered or provided by a physician for outpatient use, primarily in a home setting;
  - Used for medical purposes;
  - Not consumable or disposable except as needed for the effective use of DME (note that urinary catheters are covered);
  - Not of use to a person in the absence of a disease or disability; and
  - Durable enough to withstand repeated use.

  If more than one piece of DME can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the plan will pay only the amount that the plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost. Benefits are provided for a single unit of DME (e.g., one insulin pump) and for repairs of that unit.

  Examples of DME include, but are not limited to:

  - Braces that stabilize an injured body part, including orthotic braces and necessary adjustments to shoes to accommodate braces. (Note that braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME and are a covered health service. Dental braces are excluded from coverage);
  - Burn garments;
  - Compression stockings;
  - Continuous Positive Air Pressure (CPAP) machines;
  - Cranial bands and helmets for infants;
  - Delivery pumps for tube feedings;
  - Equipment to assist with mobility, such as a standard wheelchair;
  - Equipment for the treatment of chronic or acute respiratory failure or conditions;
  - External cochlear devices and systems. UHC also covers inpatient or outpatient surgery to place a cochlear implant;
  - Insulin pumps, including wireless pumps, such as Omnipod, and all related necessary supplies as described in the plan documents;
  - Lymphedema stockings for the arm (as required by the *Women's Health and Cancer Rights Act of 1998);*
  - Mechanical equipment necessary to treat chronic or acute respiratory failure (note that air conditioners, humidifiers, dehumidifiers, air purifiers and filters or personal comfort items are not covered);
  - Negative pressure wound therapy pumps (wound vacuum);
  - Orthotic appliances and devices, including foot orthotics, shoe orthotics, shoes or any braces, are covered only if prescribed by a physician for a medical purpose and are custom-manufactured or custom-fitted to the individual covered person;
  - Ostomy bags and related supplies;
  - Other prescribed medical and disposable supplies, such as ace bandages, diabetic strips and syringes;
  - Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks);
  - Standard hospital-type beds; and
  - Urinary catheters.

Note that any references to out-of-network do not apply to the Out-of-Area plan.

You must notify UHC before obtaining any single item of DME (including oxygen and items related to the management and treatment of diabetes) from an in- or out-of-network provider that costs more than $1,000 (purchase, rental, repair or replacement of DME). If you do not notify UHC, benefits are reduced to 50% of eligible expenses.

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Limitations *(continued)*

UHC also covers tubings, nasal cannulas, connectors and masks used in connection with DME. UHC will decide if the equipment should be rented or purchased. For example, CPAP machines must first be rented, not purchased. You must rent or purchase the DME from the vendor UHC identifies or directly from the prescribing network physician.

The benefits described here apply to external DME, and not any device, appliance, pump, machine, stimulator or monitor that is fully implanted into the body. Benefits for implantable devices are provided under the applicable medical/surgical covered health service categories.

At UHC'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 anytime and are not subject to the three-year timeline for replacement.

Prenotification Required. You must notify UHC before obtaining any single item of DME from an in- or out-of-network provider that costs more than $1,000 (purchase, rental, repair or replacement of DME). ***If you do not notify UHC, benefits are reduced to 50% of eligible expenses.***

Note: The Out-of-Area plan does not cover hearing care or hearing aids.

- ***Enteral nutrition*** is covered when it is the required source of nutrition and/or prescribed to treat inborn errors of metabolism.
- With the exception of the Out-of-Area plan, UHC covers ***hearing aids*** that are required for the correction of a hearing impairment (a reduction in the ability to perceive sound, which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

  Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. Note that if more than one type of hearing aid can meet your functional needs, benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the plan will pay only the amount that the plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

  Benefits do not include bone-anchored hearing aids. Bone-anchored hearing aids are covered under the applicable medical/surgical covered health services categories of the plan documents 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.

  All hearing aids, supplies and repairs combined are subject to a $3,000 maximum per person every three calendar years (in-and out-of-network combined).

- ***Infertility*** coverage is limited to $25,000 per lifetime for any treatments covered by your medical plan (in- and out-of-network combined) and $10,000 per lifetime for prescription drugs that are related to infertility and covered by your prescription drug program.

  For a description of covered services and limitations, see *Infertility Services* earlier in this section. Note that certain infertility treatment-related services are not covered. For details, see *Exclusions* later in this section.

Limitations *(continued)*

- Covered expenses for ***multiple surgical procedures***—which occur when you receive more than one surgical procedure during the same operative session—are generally limited as follows:
  - Covered expenses for a secondary procedure are limited to a lesser percentage of the covered expense that would have been performed during a separate operative session; and
  - Covered expenses for any subsequent procedure are limited to a lesser percentage of the covered expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

  The Multiple Procedure Policy is intended to address multiple surgeries and separate procedures performed by the same provider on the same patient in the same operative session. Multiple procedure reductions apply to additional procedures by the same provider on the same day, including bilateral procedures, based on the medical/surgical "package" associated with the Current Procedural Terminology (CPT) codes billed.
- ***Nutritional counseling as preventive care*** is covered at 100% up to two in-network visits per person per calendar year (covered services received out-of-network are subject to coinsurance and deductible). These counseling sessions are in addition to the three individual sessions that are covered when a medical condition requires a special diet.
- ***Nutritional counseling for medical conditions requiring a special diet*** is limited to three individual sessions with a registered dietician for each medical condition per lifetime. Examples include:
  - Coronary artery disease;
  - Congestive heart failure;
  - Diabetes mellitus;
  - Gout (a form of arthritis);
  - Hyperlipidemia (excess of fatty substances in the blood);
  - Phenylketonuria (a genetic disorder diagnosed at infancy);
  - Renal failure; and
  - Severe obstructive airway disease.

  These counseling sessions are in addition to the two in-network visits per person per calendar year covered at 100% as preventive care (covered services received out-of-network are subject to deductible and coinsurance).
- ***Oral contraceptives*** are covered through the CVS Caremark prescription drug program.
- ***Orthognathic surgery*** is covered only for the treatment of an acute, traumatic injury, tumor, cancer, congenital anomaly or obstructive sleep apnea.
- ***Ostomy supplies*** include pouches, face plates, belts, irrigation sleeves, bags, ostomy irrigation catheters and skin barriers. Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items not specifically listed as covered.
- UHC covers ***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.

  If more than one prosthetic device can meet a covered person's 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.

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

Note that any references to out-of-network do not apply to the Out-of-Area plan.

Note that 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 or physical changes (i.e., weight gain/loss, child's growth, etc.) as verified by the doctor occur sooner than the five-year time-frame.

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.

UHC does not cover the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect; or the replacement of lost or stolen prosthetic devices.

Coverage is subject to UHC review; and any rental or purchase must meet clinical requirements.

- ***Reconstructive procedures*** are covered when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. *Improving or restoring function* means that the organ or body part is made to work better.

  Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry.

  With the exception of certain procedures related to gender dysphoria, cosmetic procedures are not covered.
- Benefits for ***reconstructive surgery*** are available only to correct or repair damage following an injury or disease.
- ***Rehabilitation benefits*** (outpatient physical, occupational, speech (restorative only), pulmonary rehabilitation and cardiac rehabilitation therapy) may be denied or shortened for a covered person who is not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.
- Benefits for ***reproductive services*** are provided for voluntary sterilization; surgical, non-surgical or drug-induced pregnancy termination; health services and associated expenses for elective abortion; fetal reduction surgery; and contraceptive supplies and services. Benefits are not provided for surrogate parenting; the reversal of voluntary sterilization; or artificial reproductive treatments for gender or trait selection.
- ***Spinal treatment,*** manipulative and osteopathic manipulative therapy is eligible for coverage when provided by a chiropractor who is part of the American Chiropractic Network. Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or manipulative treatment, or if goals have previously been met.
- UHC covers diagnostic and surgical treatment of conditions affecting the ***temporomandibular joint (TMJ)*** when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of acute traumatic injury, tumor, cancer or congenital anomaly.

  Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, arthrocentesis and trigger-point injections.

  Benefits are provided for surgical treatment if:

  – There is clearly demonstrated radiographic evidence of significant joint abnormality;

  – Non-surgical treatment has failed to adequately resolve the symptoms; and

  – Pain or dysfunction is moderate or severe.

  Benefits for surgical services include arthrocentesis, arthroscopy, arthoplasty, arthrotomy, as well as open or closed reduction of dislocations.

  Benefits for an inpatient stay in a hospital and hospital-based physician services are described in the plan documents.

Oral appliances for TMJ or any TMJ treatment that is dental in nature are not covered by UHC, but may be covered by your dental plan (check with UHC for details).

- Indwelling and intermittent ***urinary catheters*** are covered for incontinence or retention. Benefits are limited to the following urologic supplies related to indwelling catheters: urinary drainage bag and insertion tray (kit), anchoring device and irrigation tubing set.

Exclusions

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES

UHC does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of or given in connection with medical, surgical, diagnostic, psychiatric, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UHC makes a determination regarding coverage in a particular case, are determined to be:

- *Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the* American Hospital Formulary Service, *or the* United States Pharmacopoeia Dispensing Information, *as appropriate for the proposed use; or*
- *Subject to review and approval by any institutional review board for the proposed use; or*
- *The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or*
- *Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.*

Unproven services *are health services that, according to prevailing medical research, do not have a beneficial effect on health outcomes and are not based on well-conducted randomized controlled trials or well-conducted cohort studies.*

In a randomized trial, *two or more treatments are compared to each other, and the patients are not allowed to choose which treatments they receive. In a cohort study, patients who receive study treatment are compared to a group of patients who receive standard therapy. In both cases, the comparison group must be nearly identical to the study treatment group.*

If you have a sickness or injury that UHC may, in its judgment, deem an experimental, investigational or unproven service covered under the plan for treating a sickness or condition if it is determined by UHC that the experimental, investigational or unproven service at the time of the determination:

- *Is proved to be safe and promising; and*
- *Is provided in a clinically controlled research setting; and*
- *Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.*

Coverage may be denied even if the service has received FDA approval but has not yet been deemed a proven treatment by UHC.

Coverage for Clinical Trials for Treatment of Cancer or Other Diseases

Effective for plan years beginning on or after January 1, 2014, all group health plans that are not grandfathered under the ACA *must provide members with cancer and other diseases who qualify to participate in an* approved clinical trial *with coverage for* routine patient costs*.*

This ACA *mandate expands any existing clinical trial coverage to include preventive and Phase IV trials that involve monitoring the effectiveness of the device or drug that is part of the trial.*

Routine patient costs *are all medically necessary health care services provided for the purposes of the trial, including those provided by doctors, diagnostic or laboratory tests, and other services that are consistent with the customary standard of patient care and would be otherwise covered by the medical plan if the member was not a trial participant.*

Routine patient costs do **not** *include the actual device, equipment or drug that is being studied as part of the clinical trial. Also excluded are items or services that are not used in the direct clinical management of the patient, such as those solely to satisfy data collection and analysis needs, or items and services clearly inconsistent with accepted standards of care for the particular disease or condition.*

Members may qualify for an approved clinical trial *if:*

- *They meet the trial's protocols,* and
- *A participating provider deems the member eligible and refers him/her to the trial as appropriate for the purpose of the trial, consistent with the member's benefit plan documents.*

Members also can provide UHC with medical and scientific information to establish that their participation in the trial is appropriate and consistent with the trial protocol.

Note that any references to out-of-network do not apply to the Out-of-Area plan.

UHC defines sickness to include physical illness, disease or pregnancy. Note that the term sickness includes mental illness, or substance-related and addictive disorders, regardless of the cause or origin of the mental illness, or substance-related and addictive disorder.

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Exclusions *(continued)*

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

- ***Acupressure.***
- ***Adoption or surrogacy.***
- ***Alternative treatments,*** such as art therapy, music therapy, dance therapy, horseback therapy and other forms as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to non-manipulative osteopathic care as allowed in the plan documents.
- ***Aromatherapy.***
- ***Artificial reproductive treatments*** for gender or trait selection.
- ***Autopsies*** and other coroner services and transportation services for a corpse.
- Services or supplies received ***before an employee or his or her dependent becomes covered*** under the plan.
- ***Biofeedback.***
- ***Breast reduction surgery*** that is determined to be a cosmetic procedure. This exclusion does not apply to breast reduction surgery that:
  - The claims administrator determines is requested to treat a physiologic functional impairment;
  - Is covered by the *Women's Health and Cancer Rights Act of 1998;* or
  - Meets UHC's Personal Health Support guidelines.
- ***Charges for missed appointments;*** room or facility reservations; completion of claim forms; record processing or services; or supplies or equipment that are advertised by the provider as free.
- ***Charges for which a provider waives the deductible or coinsurance amounts.***
- ***Charges prohibited by federal anti-kickback or self-referral statutes.***
- ***Chelation therapy,*** except to treat heavy metal poisoning.
- Services ordered or delivered by a ***Christian Science practitioner.***
- Charges made by a hospital for ***confinement in a special area of the hospital that provides non-acute care,*** by whatever name called, including but not limited to the type of care given by the following facilities:
  - Adult or child day care center;
  - Ambulatory surgical center;
  - Birth center;
  - Halfway house;
  - Hospice;
  - Skilled nursing facility;
  - Treatment center;
  - Vocational rehabilitation center; and
  - Any other area of a hospital that renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.

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

Exclusions *(continued)*

- Services for a surgical procedure to ***correct refraction errors of the eye,*** including radial keratotomy, laser surgery and any confinement, treatment, services or supplies in connection with or related to the surgery.
- ***Cosmetic surgery or treatment.*** These are procedures or services (surgery or treatment) primarily to change or improve appearance without significantly improving physiological function. Examples include pharmacological regimens; nutritional procedures or treatments; tattoo or scar removal, or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); replacement of an existing intact breast implant if the earlier breast implant was performed as a cosmetic procedure (Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy; see *reconstructive surgery* in the *Limitations* section for further details); varicose vein treatment of the lower extremities (including vein stripping, ligation and sclerotherapy); and treatment of benign gynecomastia (abnormal breast enlargement in males). It does not matter whether or not it is for psychological or emotional reasons. Note: Certain cosmetic procedures are covered to treat gender dysphoria; see the entry for gender dysphoria later in this section.
- ***Custodial or maintenance care.*** This is care made up of services and supplies that meet one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; and/or
  - Care that does not seek a cure, or can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

  Care that meets one of these conditions is custodial care regardless of any of the following:
  - Who recommends, provides or directs the care;
  - Where the care is provided; and
  - Whether or not the patient or another caregiver can be or is being trained to care for himself/herself.
- With the exception of accident-related dental services described under *Limitations* earlier in this section, UHC does not cover the following ***dental services:***
  - Dental care that is required to treat the effects of a medical condition but that is not necessary to directly treat the medical condition. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication, and any treatment to improve the ability to chew or speak;
  - Endodontics; periodontal treatment or surgery; and restoration and replacement of teeth;
  - Diagnosis or treatment of or related to the teeth or gums, or to the jawbones unless due to accidental injury. Examples include extractions (including wisdom teeth); restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes;
  - Preventive dental care;
  - Services to improve dental clinical outcomes;
  - Dental implants, bone grafts (unless due to accidental injury) and other implant-related procedures;
  - Dental braces (orthodontics); and
  - Dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.
- Expenses incurred by a dependent if the ***dependent is also a company employee*** and has coverage for the same services under his/her company-sponsored plan.

Exclusions *(continued)*

- ***Diagnostic tests*** that are delivered in other than a physician's office or health care facility, and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests.
- ***Domiciliary care,*** meaning living arrangements designed to meet the needs of people who cannot live independently, but do not require skilled nursing facility services.
- Services provided by a ***doula*** or other labor aide.
- The following ***durable medical equipment (DME)*** services are not covered:
  - Devices used specifically as safety items or to affect performance in sports-related activities;
  - Orthotic appliances and devices, including, but not limited to foot orthotics, shoe orthotics, shoes or any braces that can be obtained without a physician's order. Note that orthotic appliances and devices are covered only if prescribed by a physician for a medical purpose and are custom-manufactured or custom-fitted to the individual covered person;
  - Blood pressure cuff/monitor;
  - Enuresis alarm;
  - Home coagulation testing equipment;
  - Non-wearable external defibrillator;
  - Trusses;
  - Ultrasonic nebulizers;
  - Devices and computers to assist in communication and speech, except for dedicated speech-generating devices and tracheo-esophageal voice devices; and
  - Oral appliances for snoring.

  This exclusion does not apply to insulin pumps, breast prosthesis, mastectomy bras and lymphedema stockings for which benefits are provided.
- ***Ecological or environmental medicine,*** including diagnosis and for treatment.
- ***Education, training and bed and board while confined in an institution*** that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- ***Elective services*** received outside the U.S.
- Expenses for health services and supplies that ***exceed eligible expenses*** or any specific limitation in this Summary Plan Description.
- Any ***expense submitted more than 24 months after the date the service*** or supply was received.
- ***Excision or elimination of hanging skin*** on any part of the body. Examples include abdominoplasty and other procedures or surgery to remove fatty tissue, such as panniculectomy, thighplasty, brachioplasty or mastopexy. The exception is if a covered person has had bariatric surgery (as described under *UHC Bariatric Surgery Centers of Excellence* earlier in this section) and requires excess skin to be removed. Any procedure to remove excess skin must meet UHC's medical criteria guidelines.
- ***Eyeglasses, contact lenses and eye refractions,*** unless required due to an accidental injury or following cataract surgery.
- ***Food*** of any kind, unless it is prescribed to treat inborn errors of metabolism, such as phenylketonuria (PKU), and/or is the required source of nutrition. Foods that are not covered include:
  - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
  - Oral vitamins and minerals;
  - Meals you can order from a menu, for an additional charge, during an inpatient stay;

Note that any references to out-of-network do not apply to the Out-of-Area plan.

Exclusions *(continued)*

- Other dietary and electrolyte supplements;
- Infant formula available over the counter; and
- Other nutritional and electrolyte formulas.

- ***Foot care,*** including the following:
  - Routine foot care, except when needed for severe systemic disease. Routine foot care services that are not covered include cutting or removal of corns and calluses, nail trimming or cutting, and debriding (removal of dead skin or underlying tissue);
  - Hygienic and preventive foot care. Examples include cleaning and soaking the feet, applying skin creams in order to maintain skin tone, and other services that are performed when there is not a localized sickness, injury or symptom involving the foot;
  - Treatment of flat feet, except foot orthotics for flat feet when prescribed by a physician and custom manufactured or custom fitted to the individual covered person;
  - Treatment of subluxation (joint or bone dislocation) of the foot;
  - Shoes (standard or custom not prescribed by a physician for diabetes or other systemic diseases), lifts and wedges; and
  - Foot orthotics or shoe orthotics that are not prescribed by a physician.
- ***Foreign language and sign-language services.***
- ***Full-body scans and EBCT (heart scans).***
- Certain services related to ***gender dysphoria,*** including the following cosmetic procedures:
  - Abdominoplasty;
  - Blepharoplasty;
  - Breast enlargement, including augmentation mammoplasty and breast implants;
  - Body contouring, such as lipoplasty;*
  - Brow lift;
  - Calf implants;
  - Cheek, chin, and nose implants;
  - Face lift,* forehead lift, or neck tightening;
  - Facial bone remodeling for facial feminizations;*
  - Hair removal;*
  - Hair transplantation;
  - Injection of fillers or neurotoxins;
  - Lip augmentation;
  - Lip reduction;
  - Liposuction;*
  - Mastopexy;
  - Pectoral implants for chest masculinization;
  - Rhinoplasty;
  - Skin resurfacing;
  - Thyroid cartilage reduction, reduction thyroid chondroplasty, trachea shave (removal or reduction of the Adam's Apple);
  - Voice modification surgery;
  - Voice lessons and voice therapy.

* Body contouring, such as lipoplasty, facial bone remodeling, face lift, facial hair removal for facial feminizations, hair removal for genital surgery and liposuction to reduce fat in hips, thighs and buttocks are covered for persons who complete genital surgery.

Exclusions *(continued)*

- ***Growth hormone therapy,*** except in some cases related to gender dysphoria.
- ***Habilitative services*** for maintenance/preventive treatment.
- Membership costs for ***health clubs,*** weight loss clinics and similar programs.
- ***Health education classes,*** such as those for asthma, birthing, parenting, prenatal, smoking/tobacco cessation or weight control.
- ***Hemodialysis and peritoneal dialysis*** are not covered out-of-network.
- ***Herbal medicine,*** holistic or homeopathic care, including drugs.
- Treatment of ***hyperhidrosis (excessive sweating).***
- ***Hypnotism.***
- The following ***infertility treatment-related services:***
  - Cryopreservation and other forms of preservation of reproductive materials;
  - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue;
  - Embryo or oocyte accumulation (defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes);
  - Donor services and non-medical costs of oocyte or sperm donation, such as donor agency fees;
  - Ovulation predictor kits;
  - Fees for the use of a gestational carrier or surrogate;
  - Pregnancy services for a gestational carrier (a woman who agrees to have a couple's fertilized egg implanted in her uterus. A gestational carrier carries the pregnancy for the couple, who usually has to adopt the child. The carrier does not provide the egg and is therefore not biologically related to the child) or surrogate (a woman who becomes pregnant usually by artificial insemination or surgical implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman) who is not covered by the plan;
  - Reversal of voluntary sterilization;
  - In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of infertility;
  - Artificial reproductive treatments for gender or trait selection;
  - Infertility treatment following the reversal of voluntary sterilization (tubal reversal, reanastomosis, vasectomy reversal/vasovasostomy or vasoepididymostomy).
- ***Intracellular micronutrient testing.***
- Upper and lower ***jawbone surgery,*** except as required for direct treatment of acute traumatic injury, tumor, cancer or congenital anomaly.
- ***Liposuction,*** except in some cases related to gender dysphoria.
- Surgical correction or other treatment of ***malocclusion.***
- ***Manipulative treatment*** to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies.
- ***Massage therapy.***
- ***Mechanical or animal organ transplants,*** except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

Note that any references to out-of-network do not apply to the Out-of-Area plan.

Exclusions *(continued)*

- Services, supplies, ***medical care or treatment given by one of the following members of the employee's immediate family:***
  - The employee's spouse; or
  - The child, brother, sister, parent or grandparent of either the employee or the employee's spouse.
- ***Megavitamin and nutrition-based therapy.***
- The following ***mental health (including Autism Spectrum Disorder (ASD) services)/substance-related and addictive disorders*** services are not covered:
  - Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association;*
  - Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*
  - Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, gambling disorder and paraphilic disorder;
  - Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*
  - Habilitative services, which are health care services that help a person keep, learn or improve skills and functioning for daily living, such as non-restorative ABA speech therapy;
  - Non-medical 24-hour withdrawal management as per the American Society of Addiction Medicine (ASAM);
  - High-intensity residential care as per ASAM;
  - Transitional living services for mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in the ASAM criteria, and are either:
    - Sober-living arrangements, such as drug-free housing or alcohol/drug halfway houses, that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. Sober-living arrangements may be used as an addition to ambulatory treatment when that treatment does not offer the intensity and structure needed to help with recovery; or
    - Supervised living arrangements, such as facilities, group homes and supervised apartments, that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be used as an addition to treatment when that treatment does not offer the intensity and structure needed to help with recovery;
  - Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges) and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the mental health/substance-related and addictive disorders administrator;
  - Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements, unless pre-authorized by the mental health/substance-related and addictive disorders administrator;

Exclusions *(continued)*

- Services for a patient who has repeatedly and intentionally not complied with treatment recommendations;
- Routine use of psychological testing without specific authorization; or
- Services and supplies for the diagnosis or treatment of mental illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the mental health/substance-related and addictive disorders administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective, or are not consistent with:
  - Prevailing national standards of clinical practice for the treatment of such conditions;
  - Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; or
  - The mental health/substance-related and addictive disorders administrator's level of care guidelines as modified from time to time;
- Treatment that is not clinically appropriate for the patient's mental illness, substance use disorder or condition, based on generally accepted standards of medical practice and benchmarks;
- Mental health services as treatments for V-code conditions as listed in the current edition of the *Diagnostic and Statistical Manual of American Psychiatric Association;*
- Mental health services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
- Treatments for the primary diagnosis of learning disabilities;
- Educational/behavioral services that are focused on primary building skills and capabilities in communication, social interaction and learning;
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes;
- Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act;*
- Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*
- Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*
- Methadone treatment as maintenance for drug addiction;
- Intensive behavioral therapies other than Applied Behavior Analysis (ABA) therapy for Autism Spectrum Disorders (ASD);
- Any treatments or other specialized services designed for Autism Spectrum Disorders that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered experimental, investigational or unproven services.

- Services for which coverage is available while on active ***military duty*** and for treatment of military service-related disabilities when the covered person is legally entitled to other coverage and facilities are reasonably accessible.
- Services or supplies that are ***not covered health services,*** including any confinement or treatment given in connection with a service or supply that is not covered by UHC.
- Services and supplies for which the covered person is ***not legally required to pay.***

Note that any references to out-of-network do not apply to the Out-of-Area plan.

Intensive behavioral therapy is an umbrella term for a variety of outpatient behavioral interventions that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with an ASD. The most common intensive behavioral therapy is Applied Behavior Analysis (ABA) therapy.

Exclusions *(continued)*

- ***Occupational injury or sickness,*** meaning an injury or sickness that is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- ***Oral contraceptives*** (check with your prescription drug plan for any available oral contraceptive coverage).
- Examinations or treatment ***ordered by a court*** in connection with legal proceedings, unless such examinations or treatment otherwise qualifies as a covered health service.
- Services given by a ***pastoral counselor.***
- ***Personal convenience or comfort items,*** including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, dehumidifiers, humidifiers, saunas and hot tubs, beauty/barber service, guest service, air purifiers and filters, batteries and battery charger, ergonomically correct chairs, non-hospital beds and comfort beds, devices and computers to assist in communication and speech, and home remodeling to accommodate a health need, including, but not limited to, ramps, swimming pools, elevators, handrails and stair glides.
- ***Phototherapy devices*** used to treat Seasonal Affective Disorder.
- ***Physical conditioning programs,*** such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion of general motivation.
- Benefits are not provided by UHC for the following types of ***prescription drugs:***
  - Prescription drugs for outpatient use that are filled by a prescription order or refill;
  - Self-administered or self-infused medications. Note that this exclusion does ***not*** apply to medications that, due to their characteristics (as determined by UHC), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion also does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to covered persons for self-infusion;
  - Non-injectable medications given in a physician's office, except as required in an emergency; and
  - Over-the-counter drugs and treatments.
- ***Prescription medications or products approved by the U.S. Food and Drug Administration (FDA)*** administered in connection with a covered health service by a physician and/or new dosage forms are excluded until the date they are reviewed by UHC.
- ***Private-duty nursing services,*** while confined in a facility.
- Services ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that ***provider is not actively involved in the covered person's medical care*** prior to ordering the service or after the service is received. (This exclusion does not apply to mammography testing.)
- Charges by a ***provider who is sanctioned under a federal program*** for reason of fraud, abuse or medical competency.
- ***Psychosurgery*** (lobotomy).
- Services for, or related to, the ***removal of an organ or tissue from a person for transplantation*** into another person, unless the transplant recipient is a covered person under the plan and is undergoing a covered transplant.
- ***Respite care.*** This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which benefits are described in the plan documents.

Exclusions *(continued)*

- ***Rest cures.***
- ***Reversal of voluntary sterilization.***
- ***Rolfing*** (holistic tissue massage).
- ***Sales tax.***
- ***Sensitivity training,*** education training therapy or treatment for an education requirement.
- Expenses for health ***services and supplies that are received after the date your coverage under the UHC plan ends,*** including health services for medical conditions that began before the date the covered person's coverage under the UHC plan ends. UHC will provide benefits for an inpatient confinement through the date of discharge if the patient was confined prior to the patient's termination date.
- ***Services covered by another plan,*** except as described under *Coordination of Benefits* in the *Administrative* section.
- ***Services ordered by a provider who is not actively involved in your care*** before order the service or after the service is received. Note that this exclusion does not apply to mammography testing.
- ***Services performed at a diagnostic facility (hospital or otherwise) without a written order from a provider.***
- ***Services performed by a provider with the employee's same legal residence.***
- ***Services performed by an unlicensed provider*** or one who is operating outside the scope of his/her license.
- Rehabilitation services and manipulative treatment to improve general physical condition that are provided to reduce potential risk factors, where ***significant therapeutic improvement is not expected,*** including but not limited to routine, long-term or maintenance/preventive treatment.
- Physiological modalities and procedures that result in ***similar or redundant therapeutic effects*** when performed on the same body region during the same visit or office encounter.
- Treatment of smoking/tobacco dependency, including services and supplies for ***smoking-/tobacco cessation.***
- Medical and surgical treatment of ***snoring,*** except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded.
- ***Speech therapy*** for non-restorative purposes.
- ***Spinal treatment*** to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies, or for maintenance/preventive manipulative treatment.
- ***Standby services*** required of a physician.
- ***Storage of blood,*** umbilical cord or other material for use in a covered health service, except if needed for an imminent surgery.
- ***Toupees, hair transplants, hair weaving or any drug,*** if such drug is used in connection with baldness.
- ***Travel and/or lodging expenses*** of a physician or a patient, except as specified in *Disease Management Programs* earlier in this section.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or ***treatment for purposes of education, career, employment, school, camp, travel*** outside the United States, insurance, marriage or adoption, medical research, judicial or administrative proceedings or orders; for obtaining or maintaining a license of any kind; or as the result of incarceration.

Exclusions *(continued)*

- ***Treatment received while confined in a state, federal or Veterans Affairs hospital*** for which charges are not imposed.
- UHC does not provide coverage for the following ***vision care*** services:
  - Routine vision exam, including refractive examinations to determine the need for vision correction.
  - Purchase cost and associated fitting charges for eyeglasses or contact lenses.
  - Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
  - Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy.
- Services given by ***volunteers*** or persons who do not normally charge for their services.
- Services or supplies that are received as a result of ***war*** or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to covered persons who are civilians injured or otherwise affected by war or any act of war or terrorism in a non-war zone.
- ***Weight reduction or control,*** unless there is a diagnosis of morbid obesity and the services meet UHC's Personal Health Support guidelines (in this case, only surgical treatment is covered). The following treatments for obesity are not covered: nonsurgical treatment, even if for morbid obesity, and surgical treatment of obesity unless there is a diagnosis of morbid obesity. For information regarding UHC's clinical policy, call 888-936-7246. UHC also does not provide benefits for any weight-loss programs, whether or not they are under medical supervision or for medical reasons.
- ***Wigs,*** except when needed for hair loss due to cancer treatment or alopecia areata.
- Treatment of ***wisdom teeth.***

Kaiser Permanente HSA Advantage Plan (California)

Kaiser Permanente, a California nonprofit corporation (Kaiser Foundation Health Plan, Inc.), administers an HSA Advantage plan that is available to employees in California.

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

- Routine care with your own personal plan physician,
- Hospital care,
- Laboratory and pharmacy services,
- Urgent care and emergency services, and
- Other benefits as described in the *Evidence of Coverage* booklet.

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

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

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

Choosing a Primary Care Physician (PCP)

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

To find Kaiser Permanente providers and locations:

- Go to www.kp.org/locations. Use the doctor and location search to learn about each practitioner's gender, certifications, specialties, languages, interests and more. If you don't choose a PCP, Kaiser Permanente can select one for you,
- Go to *Desktop Benefits* at https://raytheon.benefitcenter.com and click on the *My Resources* tab and *Benefit Provider Contacts,* or
- If you are a member, call Member Services.

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

This section provides a brief summary of the Kaiser Permanente HSA Advantage plan available in California. For detailed information about the plan, refer to the *Evidence of Coverage* booklet, which describes covered services, any limitations and special programs that may be offered—or call the Member Services number on your medical ID card. To view the *Evidence of Coverage* booklet, go to https://my.kp.org/raytheon (for a hard copy, call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

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KAISER PERMANENTE: HEALTH FOR THE 21ST CENTURY

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

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

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

REMINDER: NON-PREVENTIVE PHONE AND VIDEO VISITS SUBJECT TO THE DEDUCTIBLE

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

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

After your visit, you'll receive a bill for any deductible amount you owe. If you have more questions about this change, call Member Services. For more information about phone and video visits, go to kp.org/getcare.

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

PARTNERING WITH TARGET STORES IN SOUTHERN CALIFORNIA

To make routine care and other services more convenient, Kaiser Permanente partners with Target throughout southern California to offer Target Clinics. When you visit a Target Clinic, you pay the same copay as you would pay at a Kaiser Permanente facility.

Kaiser Permanente members, and as well as Target guests who are not members, can visit clinics for a wide range of services, including:

- *Treatment for minor illnesses, such as cold and flu;*
- *Care for chronic illnesses, such as diabetes and high blood pressure;*
- *Child and adolescent care (starting at 2 weeks old);*
- *Video consultations with doctors and other providers;*
- *Vaccinations;*
- *Women's health services; and*
- *Basic dermatology services.*

Clinics are open seven days a week and are operated by Kaiser Permanente's Southern California Permanente Medical Group. Clinics are staffed with Kaiser Permanente nurse practitioners and licensed vocational nurses (LVNs). Kaiser Permanente physicians also have a physical presence in some locations.

For more information, call Member Services.

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ABOUT THE *EVIDENCE OF COVERAGE* BOOKLET

This section of Your Benefits Handbook *provides only a brief summary of the Kaiser Permanente HSA Advantage plan available in California. For additional information about the plan, including details about:*

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

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

BEHAVIORAL HEALTH TREATMENT FOR PERVASIVE DEVELOPMENTAL DISORDER (PDD) AND AUTISM SPECTRUM DISORDER (ASD)

The Kaiser Permanente HSA Advantage plan available in California covers evidence-based behavioral health treatment, such as Applied Behavior Analysis (ABA) for members diagnosed with Pervasive Developmental Disorder (PDD) or Autism Spectrum Disorder (ASD). Medically necessary services can be provided in the member's home, clinic or other community-based non-educational setting.

Covered services include those that develop or restore, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet criteria established by Kaiser Permanente, including that:

- *Services are provided inside the service area;*
- *Treatment is prescribed by a plan physician, or is developed by a plan provider who is a psychologist; and*
- *Treatment is provided under a treatment plan prescribed and administered by a plan provider who is a qualified autism service provider (as defined by Kaiser Permanente).*

The treatment plan must:

- *Utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism;*
- *Have measurable goals over a specific timeline. The qualified autism service provider must review the treatment plan—and make modifications whenever appropriate—no less than once every six months.*

In addition, the qualified autism service provider must follow certain Kaiser Permanente criteria. For example, the intervention plan must include the service type, number of hours and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the member's progress is evaluated and reported. Coverage for intensive behavioral intervention services ends when the treatment goals and objectives are achieved or deemed to be no longer appropriate.

Note that the treatment plan cannot be used for purposes of providing (or for the reimbursement of) respite care, day care, or educational services, or to reimburse a parent for participating in the treatment program.

For a complete description of covered services, view the Evidence of Coverage *booklet.*

About Limitations, Exclusions and Administrative Information

Please note that this section does not provide a description of Kaiser Permanente's limitations, exclusions or administrative information, including post-service claims and appeals, coordination of benefits (COB) provisions and subrogation provisions. Be sure to review the Kaiser Permanente *Evidence of Coverage* booklet for this information.

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When you elect the Kaiser Permanente HSA Advantage plan, you are eligible for a health savings account (HSA). The company makes an annual lump-sum contribution to your HSA in January. Company contributions vary by coverage level. You also can make contributions. The maximum amount you and the company combined can contribute is subject to an annual federal limit.

You *always* own the money in your HSA. ***Any unused money carries over to the next year and may earn interest—there are no "use-it-or-lose-it" rules.*** And if you leave the company, the money in your HSA belongs to you. (For detailed information about HSAs, see the section *Health Savings Account.)*

While federal regulations prohibit anyone who is making or receiving contributions to an HSA from having other health care coverage, including through a health care flexible spending account (FSA), if applicable, eligible employees do have the option of enrolling in a limited purpose dental and vision FSA, which can be used to pay for eligible dental and vision expenses. For more information, see the *Flexible Spending Accounts* section of this handbook, if applicable.

Note also that while this regulation applies to Medicare Part A, Part B and/or Part D, as well as TRICARE, since the HSA Advantage plan is not linked to an HSA, Medicare/TRICARE participants can elect an HSA Advantage plan *without funding an HSA.* In this case, you can use your HSA Advantage plan to pay for eligible expenses incurred by you and your dependents. As long as you are not funding your HSA, it is not considered other health care coverage.

How the Plan Works

Here is a brief overview of how the plan works. The pages that follow provide a *Summary of Benefits* chart for the plan.

- The federal government regulates the design of health plans with HSAs.
- Most covered expenses—including most prescription drugs—are subject to a calendar-year deductible, which resets each January 1. There are two exceptions:
  - ***Routine in-network preventive care,*** which is covered at 100% in-network (no deductible, no coinsurance, no out-of-pocket cost). In compliance with the *Affordable Care Act* (ACA), this coverage extends to include Women's Health Services, certain preventive supplements and tobacco-cessation prescriptions (as defined by Kaiser Permanente); and
  - ***Preventive prescription drugs,*** which are covered at 100% (again, no deductible, no coinsurance, no out-of-pocket cost).
- The deductible can be satisfied by one family member or a combination of family members. ***Note that if you have employee and spouse, employee and child(ren) or employee and family coverage, each individual is limited to a $2,800 individual deductible. You do not have to satisfy the family deductible before benefits for that individual are payable.***
- After you meet the deductible, the plan pays a percentage of eligible expenses. You pay the remainder of the charges until you reach the calendar-year out-of-pocket maximum (which includes the deductible and coinsurance for all eligible services and supplies). If you reach the out-of-pocket maximum, the plan covers eligible expenses at 100% for the remainder of the calendar year. ***Note that if you have employee***

(continued)

As part of the *Medicare Prescription Drug, Improvement and Modernization Act,* which was enacted by Congress in 2003, HSAs are designed to help individuals save for qualified health care expenses on a tax-advantaged basis.

Both you and the company are allowed to make contributions to an account that you own, which you use to save for future or pay for current health care expenses. Any money you elect to contribute to your HSA is deducted from your paycheck before federal taxes, which lowers your annual taxable income and allows you to pay for out-of-pocket costs with pre-tax dollars. Note that while California does not offer pre-tax savings on HSA contributions, you still save on the federal tax. For information about the HSAs, see the section *Health Savings Account.*

Note that if you elect medical coverage with an HSA Advantage plan and do not participate in an HSA (either because you elect not to or because your Medicare or TRICARE status makes you ineligible), you can elect a health care FSA, if applicable, and not be limited to only dental and vision expenses.

Will you soon be eligible for Medicare? See *Approaching Age 65? Be Sure to Understand Your Medical Coverage Options* in the *Medical* or *Health Savings Account* section to learn why it's wise to consult your tax advisor before making any decisions about your post-65 medical coverage, such as whether or not to enroll in Medicare Part A when you are first eligible.

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and spouse, employee and child(ren) or employee and family coverage, each individual is limited to a $4,100 individual out-of-pocket maximum. You do not have to satisfy the family out-of-pocket maximum before benefits for that individual are payable.

- Again, care obtained outside the Kaiser Permanente network is generally covered only in emergencies, as defined by the plan. In certain unusual circumstances, your PCP may refer you to an out-of-network specialist. Unless your PCP receives authorization from the plan, any care you receive outside the network will not be covered.
- Kaiser Permanente provides prescription drug coverage for this plan. The *CVS Caremark Prescription Drug Program* section does not apply to the Kaiser Permanente HSA Advantage plan.

For detailed information about the plan, refer to the *Evidence of Coverage* booklet—which describes covered services, any limitations and special programs that may be offered—or call Member Services. To view the *Evidence of Coverage,* go to https://my.kp.org/raytheon (for a hard copy, simply return the postcard you will receive after you enroll or call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

If you need emergency or urgent medical care whether at home or while traveling anywhere in the world, follow the procedures on your identification card in order to receive maximum benefits from the plan.

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ABOUT THE COMPANY'S HSA CONTRIBUTION AND THE CALENDAR-YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

For New Hires

If, as a new hire, your Kaiser Permanente HSA Advantage plan coverage becomes effective after January 1, the company's lump-sum contribution to your HSA is pro-rated for that year. For details, see *For New Hires* in the *Health Savings Account* section.

In terms of the plan's deductible and out-of-pocket maximum, the entire calendar-year deductible and out-of-pocket maximum apply regardless of when your coverage with the Kaiser Permanente HSA Advantage plan becomes effective; they are not pro-rated.

If You Have a Change in Status During the Year

If, as the result of a qualified change in status that occurs after January 1 and before December 1, your coverage level *increases* (such as from employee only to employee and family), the company contribution to your HSA is adjusted to match your new coverage level and prorated to reflect your new coverage level for the rest of the year. For details, see the section *Health Savings Account.* In this case, any eligible expenses incurred to date by you and/or your covered dependents prior to your change in status continue to apply toward your new calendar-year deductible and out-of-pocket maximum.

If your qualified change in status results in your coverage level *decreasing* (such as from employee and family to employee only), any company HSA contribution you have received that is in excess of the company contribution amount for your new coverage level remains in your HSA. In this case, any expenses your previously covered dependent had incurred do *not* apply toward your deductible or out-of-pocket maximum.

For example, assume you start the year with family coverage and meet the family deductible of $4,200 (or $2,800 per individual) in June ($1,000 in expenses for you, $1,000 for your spouse and $2,200 for your child). On July 12, your child turns 26 and is removed from your coverage. Since your child's expenses will no longer apply toward your deductible, and your and your spouse's eligible expenses are $2,000, you and your spouse will need to incur and pay for an additional $2,200 combined (or $1,800 for one individual) in eligible expenses in order to meet your deductible. Likewise, since your child's expenses will no longer apply toward your out-of-pocket maximum, you and your spouse will need to incur and pay for an additional $5,350 combined (or $3,100 for one individual) in coinsurance toward the cost of eligible expenses to reach the plan's $7,350 combined (or $4,100 individual) out-of-pocket maximum.

If you have questions about how a change in status affects your deductible or out-of-pocket maximum, contact Kaiser Permanente. If you have questions about how a change in status affects contributions to your HSA, contact Fidelity at 800-544-3716.

Kaiser Permanente
https://my.kp.org/raytheon
800-464-4000

Kaiser Permanente HSA Advantage Plan (California) Summary of Benefits Chart

This chart provides only a summary of your benefits with the Kaiser Permanente HSA Advantage plan available in California. Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. Care obtained outside the Kaiser Permanente network is generally covered only in emergencies, as defined by the plan. Kaiser Permanente provides prescription drug coverage for this plan. The *CVS Caremark Prescription Drug Program* section does not apply to the Kaiser Permanente HSA Advantage plan.

For detailed information about the plan, refer to the *Evidence of Coverage* booklet—which describes covered services, any limitations and special programs that may be offered—or call Member Services. To view the *Evidence of Coverage* booklet, go to https://my.kp.org/raytheon (for a hard copy, call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

Kaiser Permanente HSA Advantage (California)	
Plan Features	**Benefits***
Calendar-Year Deductible	• Employee only: $2,100 • Employee and spouse: $4,200 ($2,800 individual) • Employee and child(ren): $4,200 ($2,800 individual) • Employee and family: $4,200 ($2,800 individual)
Company HSA Contribution for 2021 (available to employees who are eligible to receive or make contributions to an HSA; see *Contributions to Your HSA* in the *Health Savings Account* section for information regarding the annual maximum amount you can contribute)	• Employee only: $750 • Employee and spouse: $1,125 • Employee and child(ren): $1,125 • Employee and family: $1,500 (Amounts shown will be prorated for new hires)
Coinsurance	80%
Calendar-Year Out-of-Pocket Maximum	• Employee only: $4,100 • Employee and spouse: $7,350 ($4,100 individual) • Employee and child(ren): $7,350 ($4,100 individual) • Employee and family: $7,350 ($4,100 individual)
Covered Services: Preventive Care**	**Benefits***
Preventive Care Services Covered services include: • Routine physical maintenance exams, including well-woman exams • Scheduled routine prenatal exams • Well-child exams for children 0-23 months • Health education counseling programs • Immunizations • Routine preventive imaging and laboratory services • Blood pressure screening for all adults • Cholesterol screening • Colorectal cancer screening for adults over 50 • Type 2 diabetes screening for adults with high blood pressure • Mammograms every one to two years for women over 40 • Cervical cancer screening for sexually active women • Osteoporosis screening for women over 60, depending on risk factors • Immunizations for children from birth to 18 years • Obesity screening and counseling for children Note: If you receive any other covered services during a visit that includes preventive care services on the list, you will pay the applicable cost share for those other services. Note that this list is subject to change at any time; go to www.kp.org/prevention for a complete list	Covered at 100% (the deductible does not apply)

*All care must be coordinated by your PCP, unless otherwise noted.

**Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. For detailed information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

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Kaiser Permanente HSA Advantage (California)	
Covered Services*	**Benefits****
Inpatient Hospital Care Including Inpatient Surgery and Inpatient Physician Services	Covered at 80% after deductible
Outpatient Surgery and Anesthesia	Covered at 80% after deductible
Emergency Room For important information about emergency services, see the *Evidence of Coverage* booklet or call Member Services	Covered at 80% after deductible Note that while prior authorization is not required for non-plan providers in the case of emergency or out-of-area urgent care, prior authorization is required for any post-stabilization care
Ambulance Services	Covered at 80% after deductible
Physician's Services	*Office visits:* Covered at 80% after deductible *Scheduled non-preventive phone and video visits:* Covered at 100% after deductible (for details, see *Non-Preventive Phone and Video Visits Now Subject to the Deductible* earlier in this section)
Outpatient Diagnostic Services	Covered at 80% after deductible
Hearing Care	*Exam:* Covered at 100% (deductible does not apply) *Hearing Aid:* Not covered
Hemodialysis, Chemotherapy, Radiation Therapy	*Hemodialysis:* Covered at 80% after deductible *Chemotherapy and radiation therapy:* Covered at 100% after deductible
Short-Term Rehabilitative Therapy	Covered at 80% after deductible Benefits include physical therapy, speech/language therapy (restorative only), occupational therapy or an organized program of these combined services
Nutritional Counseling with a Registered Dietician	*Individual or group session:* Covered at 80% after deductible
Chiropractor Services***	After you satisfy the deductible, covered at at 100% after $15 copayment, limited to 20 visits per calendar year
Podiatry	Covered at 80% after deductible
Family Planning (including Depo-Provera injections, diaphragms and IUDs when supplied by physician)	*Family planning visits:* Covered at 100% (the deductible doesn't apply) *Contraceptive drugs and devices:* Covered at 100% (the deductible doesn't apply)
Emergency or Urgent Care in a Physician's Office	Covered at 80% after deductible
Oxygen and Durable Medical Equipment	Covered at 80% after deductible when arranged by Kaiser Permanente
Hospice Services, Including Bereavement Services	*Hospice:* Covered at 100% after deductible *Bereavement:* Covered at 80% after deductible (includes services provided to the family or primary care person following the death of the hospice patient and other covered services and supplies, when billed by an approved hospice provider)
Transgender Services (includes sexual reassignment surgery, mastectomy/chest reconstruction, behavioral health care and hormone therapy)	Covered at 80% after deductible

*For more information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

**All care must be coordinated by your PCP, unless otherwise noted.

***Kaiser Permanente contracts with American Specialty Health (ASH) for chiropractic services. You can obtain services from any participating ASH plan chiropractor without a referral from your Kaiser Permanente plan physician. Your ASH chiropractor coordinates authorization of all services and claims with ASH directly; you simply pay your copayment at each visit. You can obtain a listing of participating chiropractors by calling the ASH Member Services Department at 800-972-4226 or going to www.ashcompanies.com.

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Kaiser Permanente HSA Advantage (California)	
Nursing Services*	**Benefits****
Skilled Nursing Facility	Covered at 80% after deductible, limited to 120 days per benefit period
Home Health Care	Covered at 100% after the deductible when prescribed by a plan physician within the service area, up to 3 visits per day and a maximum of 120 visits per calendar year
Mental Health (Including Applied Behavior Analysis (ABA) Therapy) and Substance Abuse Treatment*	**Benefits****
Hospital Admission	*Mental health:* Covered at 80% after deductible *Substance abuse (detoxification):* Covered at 80% after deductible *Substance abuse (residential rehabilitation):* Covered at 80% after deductible **Note:** Inpatient care must be authorized in advance; contact your plan's Member Services number to find out how to obtain services
Outpatient Care	*Mental health:* Covered at 80% after deductible for individual or group sessions *Substance abuse:* Covered at 80% after deductible for individual or group sessions
Prescription Drugs*	**Benefits****
Retail***	*At a Kaiser Permanente pharmacy:* *Generic:* After you meet the deductible, you pay 20% up to $50 per prescription for up to a 100-day supply *Brand-name:* After you meet the deductible, you pay 20% up to $100 per prescription for up to a 100-day supply *Specialty drugs:* After you meet the deductible, you pay 20% up to $200 per prescription for up to a 30-day supply *Preventive drugs:* You pay $0
Mail Order***	*At a Kaiser Permanente pharmacy:* *Generic:* After you meet the deductible, you pay 20% up to $50 per prescription for up to a 100-day supply *Brand-name:* After you meet the deductible, you pay 20% up to $100 per prescription for up to a 100-day supply *Specialty drugs:* Not available via mail order *Preventive drugs:* You pay $0

*For more information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

**All care must be coordinated by your PCP, unless otherwise noted.

***Coverage includes biopharmaceutical drugs approved for our commercial formulary or if a Kaiser Permanente physician writes an exception based on medical necessity.

Kaiser Permanente HSA Advantage Plan (Colorado)

Kaiser Permanente, a Colorado nonprofit corporation (Kaiser Foundation Health Plan, Inc.), administers an HSA Advantage plan that is available to employees in Colorado.

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

- Routine care with your own personal plan physician,
- Hospital care,
- Laboratory and pharmacy services,
- Urgent care and emergency services, and
- Other benefits as described in the *Evidence of Coverage* booklet.

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

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

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

Choosing a Primary Care Physician (PCP)

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

To find Kaiser Permanente providers and locations:

- Go to www.kp.org/locations. Use the doctor and location search to learn about each practitioner's gender, certifications, specialties, languages, interests and more. If you don't choose a PCP, Kaiser Permanente can select one for you,
- Go to *Desktop Benefits* at https://raytheon.benefitcenter.com and click on the *My Resources* tab and *Benefit Provider Contacts,* or
- If you are a member, call Member Services.

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

This section provides a brief summary of the Kaiser Permanente HSA Advantage plan available in Colorado. For detailed information about the plan, refer to the *Evidence of Coverage* booklet, which describes covered services, any limitations and special programs that may be offered—or call the Member Services number on your medical ID card. To view the *Evidence of Coverage* booklet, go to https://my.kp.org/raytheon (for a hard copy, call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

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303-338-3800

KAISER PERMANENTE: HEALTH FOR THE 21ST CENTURY

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

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

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

REMINDER: NON-PREVENTIVE PHONE AND VIDEO VISITS SUBJECT TO THE DEDUCTIBLE

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

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

After your visit, you'll receive a bill for any deductible amount you owe. If you have more questions about this change, call Member Services. For more information about phone and video visits, go to kp.org/getcare.

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

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ABOUT THE *EVIDENCE OF COVERAGE* BOOKLET

This section of Your Benefits Handbook *provides only a brief summary of the Kaiser Permanente HSA Advantage plan available in Colorado. For additional information about the plan, including details about:*

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

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

BEHAVIORAL HEALTH TREATMENT FOR AUTISM SPECTRUM DISORDER (ASD)

For children under the age of 19, the plan covers the following therapies for the treatment of Autism Spectrum Disorders (ASD) when prescribed by a plan physician as medically necessary:

- *Evaluation and assessment services (including diagnosis);*
- *Applied Behavior Analysis (ABA), including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers (no visit limits);*
- *Habilitative or rehabilitative care, including occupational therapy, speech therapy and physical therapy;*
- *Therapeutic care, including occupational therapy, speech therapy, physical therapy and ABA therapy as long as services are provided by a speech language pathologist, registered occupational therapist, licensed physical therapist or autism services provider;*
- *Psychological care, including family counseling;*
- *Pharmacy care/medication; and*
- *Psychiatric care.*

Services are covered the same as other mental health services; benefits are subject to the general terms of the policy.

About Limitations, Exclusions and Administrative Information

Please note that this section does not provide a description of Kaiser Permanente's limitations, exclusions or administrative information, including post-service claims and appeals, coordination of benefits (COB) provisions and subrogation provisions. Be sure to review the Kaiser Permanente *Evidence of Coverage* booklet for this information.

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When you elect the Kaiser Permanente HSA Advantage plan, you are eligible for a health savings account (HSA). The company makes an annual lump-sum contribution to your HSA in January. Company contributions vary by coverage level. You also can make contributions. The maximum amount you and the company combined can contribute is subject to an annual federal limit.

You *always* own the money in your HSA. ***Any unused money carries over to the next year and may earn interest—there are no "use-it-or-lose-it" rules.*** And if you leave the company, the money in your HSA belongs to you. (For detailed information about HSAs, see the section *Health Savings Account.)*

While federal regulations prohibit anyone who is making or receiving contributions to an HSA from having other health care coverage, including through a health care flexible spending account (FSA), if applicable, eligible employees do have the option of enrolling in a limited purpose dental and vision FSA, which can be used to pay for eligible dental and vision expenses. For more information, see the *Flexible Spending Accounts* section of this handbook, if applicable.

Note also that while this regulation applies to Medicare Part A, Part B and/or Part D, as well as TRICARE, since the HSA Advantage plan is not linked to an HSA, Medicare/TRICARE participants can elect an HSA Advantage plan *without funding an HSA.* In this case, you can use your HSA Advantage plan to pay for eligible expenses incurred by you and your dependents. As long as you are not funding your HSA, it is not considered other health care coverage.

How the Plan Works

Here is a brief overview of how the plan works. The pages that follow provide a *Summary of Benefits* chart for the plan.

- The federal government regulates the design of health plans with HSAs.
- Most covered expenses—including most prescription drugs—are subject to a calendar-year deductible, which resets each January 1. There are two exceptions:
  - ***Routine in-network preventive care,*** which is covered at 100% in-network (no deductible, no coinsurance, no out-of-pocket cost). In compliance with the *Affordable Care Act* (ACA), this coverage extends to include Women's Health Services, certain preventive supplements and tobacco-cessation prescriptions (as defined by Kaiser Permanente); and
  - ***Preventive prescription drugs,*** which are covered at 100% (again, no deductible, no coinsurance, no out-of-pocket cost).
- The deductible can be satisfied by one family member or a combination of family members. **If you have family coverage, you must satisfy the family deductible before benefits are payable.**
- After you meet the deductible, the plan pays a percentage of eligible expenses. You pay the remainder of the charges until you reach the calendar-year out-of-pocket maximum (which includes the deductible and coinsurance for all eligible services and supplies). If you reach the out-of-pocket maximum, the plan covers eligible expenses at 100% for the remainder of the calendar year.

(continued)

As part of the *Medicare Prescription Drug, Improvement and Modernization Act,* which was enacted by Congress in 2003, HSAs are designed to help individuals save for qualified health care expenses on a tax-advantaged basis.

Both you and the company are allowed to make contributions to an account that you own, which you use to save for future or pay for current health care expenses. Any money you elect to contribute to your HSA is deducted from your paycheck before federal taxes, which lowers your annual taxable income and allows you to pay for out-of-pocket costs with pre-tax dollars. For information about the HSAs, see the section *Health Savings Account.*

Note that if you elect medical coverage with an HSA Advantage plan and do not participate in an HSA (either because you elect not to or because your Medicare or TRICARE status makes you ineligible), you can elect a health care FSA, if applicable, and not be limited to only dental and vision expenses.

Will you soon be eligible for Medicare? See *Approaching Age 65? Be Sure to Understand Your Medical Coverage Options* in the *Medical* or *Health Savings Account* section to learn why it's wise to consult your tax advisor before making any decisions about your post-65 medical coverage, such as whether or not to enroll in Medicare Part A when you are first eligible.

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- Again, care obtained outside the Kaiser Permanente network is generally covered only in emergencies, as defined by the plan. In certain unusual circumstances, your PCP may refer you to an out-of-network specialist. Unless your PCP receives authorization from the plan, any care you receive outside the network will not be covered.
- Kaiser Permanente provides prescription drug coverage for this plan. The *CVS Caremark Prescription Drug Program* section does not apply to the Kaiser Permanente HSA Advantage plan.

For detailed information about the plan, refer to the *Evidence of Coverage* booklet—which describes covered services, any limitations and special programs that may be offered—or call Member Services. To view the *Evidence of Coverage,* go to https://my.kp.org/raytheon (for a hard copy, simply return the postcard you will receive after you enroll or call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

If you need emergency or urgent medical care whether at home or while traveling anywhere in the world, follow the procedures on your identification card in order to receive maximum benefits from the plan.

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ABOUT THE COMPANY'S HSA CONTRIBUTION AND THE CALENDAR-YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

For New Hires

If, as a new hire, your Kaiser Permanente HSA Advantage plan coverage becomes effective after January 1, the company's lump-sum contribution to your HSA is pro-rated for that year. For details, see *For New Hires* in the *Health Savings Account* section.

In terms of the plan's deductible and out-of-pocket maximum, the entire calendar-year deductible and out-of-pocket maximum apply regardless of when your coverage with the Kaiser Permanente HSA Advantage plan becomes effective; they are not pro-rated.

If You Have a Change in Status During the Year

If, as the result of a qualified change in status that occurs after January 1 and before December 1, your coverage level *increases* (such as from employee only to employee and family), the company contribution to your HSA is adjusted to match your new coverage level and prorated to reflect your new coverage level for the rest of the year. For details, see the section *Health Savings Account.* In this case, any eligible expenses incurred to date by you and/or your covered dependents prior to your change in status continue to apply toward your new calendar-year deductible and out-of-pocket maximum.

If your qualified change in status results in your coverage level *decreasing* (such as from employee plus family to employee only), any company HSA contribution you have received that is in excess of the company contribution amount for your new coverage level remains in your HSA. In this case, any expenses your previously covered dependent had incurred do *not* apply toward your deductible or out-of-pocket maximum.

For example, assume you start the year with family coverage and meet the family deductible of $4,200 in June ($1,000 in expenses for you, $1,000 for your spouse and $2,200 for your child). On July 12, your child turns 26 and is removed from your coverage. Since your child's expenses will no longer apply toward your deductible, and your and your spouse's eligible expenses are $2,000, you and your spouse will need to incur and pay for an additional $2,200 in eligible expenses in order to meet your deductible. Likewise, since your child's expenses will no longer apply toward your out-of-pocket maximum, you and your spouse will need to incur and pay for an additional $5,350 in coinsurance toward the cost of eligible expenses to reach the plan's $7,350 out-of-pocket maximum.

If you have questions about how a change in status affects your deductible or out-of-pocket maximum, contact Kaiser Permanente. If you have questions about how a change in status affects contributions to your HSA, contact Fidelity at 800-544-3716.

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Kaiser Permanente HSA Advantage Plan (Colorado) Summary of Benefits Chart

This chart provides only a summary of your benefits with the Kaiser Permanente HSA Advantage plan available in Colorado. Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. Care obtained outside the Kaiser Permanente network is generally covered only in emergencies, as defined by the plan. Kaiser Permanente provides prescription drug coverage for this plan. The *CVS Caremark Prescription Drug Program* section does not apply to the Kaiser Permanente HSA Advantage plan.

For detailed information about the plan, refer to the *Evidence of Coverage* booklet—which describes covered services, any limitations and special programs that may be offered—or call Member Services. To view the *Evidence of Coverage* booklet, go to https://my.kp.org/raytheon (for a hard copy, call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

Kaiser Permanente HSA Advantage (Colorado)	
Plan Features	**Benefits***
Calendar-Year Deductible	• Employee only: $2,100 • Employee and spouse: $4,200 • Employee and child(ren): $4,200 • Employee and family: $4,200
Company HSA Contribution for 2021 (available to employees who are eligible to receive or make contributions to an HSA; see *Contributions to Your HSA* in the *Health Savings Account* section for information regarding the annual maximum amount you can contribute)	• Employee only: $750 • Employee and spouse: $1,125 • Employee and child(ren): $1,125 • Employee and family: $1,500 (Amounts shown will be prorated for new hires)
Coinsurance	80%
Calendar-Year Out-of-Pocket Maximum	• Employee only: $4,100 • Employee and spouse: $7,350 • Employee and child(ren): $7,350 • Employee and family: $7,350
Covered Services: Preventive Care**	**Benefits***
Preventive Care Services Covered services include: • Routine physical maintenance exams, including well-woman exams • Scheduled routine prenatal services (note that prenatal exams are subject to the deductible and coinsurance) • Well-child exams for children 0-23 months • Health education counseling programs • Immunizations • Routine preventive imaging and laboratory services • Blood pressure screening for all adults • Cholesterol screening • Colorectal cancer screening for adults over 50 • Type 2 diabetes screening for adults with high blood pressure • Mammograms every one to two years for women over 40 • Cervical cancer screening for sexually active women • Osteoporosis screening for women over 60, depending on risk factors • Immunizations for children from birth to 18 years • Obesity screening and counseling for children	Covered at 100% (the deductible does not apply) Note: If you receive any other covered services during a visit that includes preventive care services on the list, you will pay the applicable cost share for those other services. Note that this list is subject to change at any time; go to www.kp.org/prevention for a complete list

*All care must be coordinated by your PCP, unless otherwise noted.

**Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. For detailed information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

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Kaiser Permanente HSA Advantage (Colorado)	
Covered Services*	**Benefits****
Inpatient Hospital Care Including Inpatient Surgery and Inpatient Physician Services	Covered at 80% after deductible
Outpatient Surgery and Anesthesia	Covered at 80% after deductible
Emergency Room For important information about emergency services, including prior authorization requirements, see the *Evidence of Coverage* booklet or call Member Services	Covered at 80% after deductible
Ambulance Services	Covered at 80% after deductible
Physician's Services	*Office visits:* Covered at 80% after deductible *Scheduled non-preventive phone and video visits:* Covered at 100% after deductible (for details, see *Non-Preventive Phone and Video Visits Now Subject to the Deductible* earlier in this section)
Outpatient Diagnostic Services	Covered at 80% after deductible
Hearing Care	*Exam:* Covered at 80% after deductible *Hearing Aid:* Limited to $1,000 every 12 months per aid for adults (No limit for minors; cost for minors accrues to the plan's out-of-pocket maximum)
Hemodialysis, Chemotherapy, Radiation Therapy	Covered at 80% after deductible
Short-Term Rehabilitative and Habilitative Therapy	Covered at 80% after deductible, limited to medically necessary therapy authorized by a plan physician, 90-visit limit for physical, occupational and speech therapy combined *Note:* Benefits are provided based on the allowed charge for short-term rehabilitative therapy by a physical therapist, general, chronic disease or rehabilitation hospital or community health center or in a doctor's office. The claims administrator must determine that your condition can be reasonably expected to improve significantly within 60 days of the first therapy visit; note that this limit does not apply to habilitative therapy as it relates to behavioral health treatment for Autism Spectrum Disorder (ASD). Benefits include physical therapy, speech/language therapy (restorative only except in cases of behavioral health treatment for ASD), occupational therapy or an organized program of these combined services
Nutritional Counseling with a Registered Dietician	*Individual or group session:* Covered at 80% after deductible
Chiropractor Services***	Covered at 80% after deductible, limited to 20 visits per calendar year
Podiatry	Covered at 80% after deductible
Family Planning (including Depo-Provera injections, diaphragms and IUDs when supplied by physician)	*Family planning visits:* Covered at 100% (the deductible doesn't apply) Note: Prescription copayments and coinsurance apply
Emergency or Urgent Care in a Physician's Office	Covered at 80% after deductible
Oxygen and Durable Medical Equipment (rental or purchase with medical necessity review; must meet medical necessity criteria)	Covered at 80% after deductible when arranged by Kaiser Permanente. Must be in accordance with formulary guidelines for durable medical equipment

*For more information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

**All care must be coordinated by your PCP, unless otherwise noted.

***Kaiser Permanente contracts with American Specialty Health (ASH) for chiropractic services. You can obtain services from any participating ASH plan chiropractor without a referral from your Kaiser Permanente plan physician. Your ASH chiropractor coordinates authorization of all services and claims with ASH directly; you simply pay your copayment at each visit. You can obtain a listing of participating chiropractors by calling the ASH Member Services Department at 800-972-4226 or going to www.ashcompanies.com.

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Kaiser Permanente HSA Advantage (Colorado)	
Covered Services*	**Benefits****
Hospice Services, Including Bereavement Services	Covered at 80% after deductible in a plan facility
Transgender Services (includes sexual reassignment surgery, mastectomy/chest reconstruction, behavioral health care and hormone therapy)	Covered at 80% after deductible
Nursing Services*	**Benefits****
Skilled Nursing Facility	Covered at 80% after deductible, limited to 120 days per benefit period
Home Health Care	Covered at 80% after the deductible when prescribed by a plan physician within the service area
Mental Health (Including Applied Behavior Analysis (ABA) Therapy) and Substance Abuse Treatment*	**Benefits****
Hospital Admission	*Mental health:* Covered at 80% after deductible *Substance abuse (detoxification):* Covered at 80% after deductible *Substance abuse (residential rehabilitation):* Covered at 80% after deductible **Note:** Inpatient care must be authorized in advance; contact Member Services to find out how to obtain services
Outpatient Care	*Mental health:* Covered at 80% after deductible for individual or group sessions *Substance abuse:* Covered at 80% after deductible for individual or group sessions
Prescription Drugs*	**Benefits****
Retail***	*At a Kaiser Permanente pharmacy:* *Generic:* After you meet the deductible, you pay 20% for up to a 30-day supply *Brand-name:* After you meet the deductible, you pay 20% for up to a 30-day supply *Specialty drugs:* After you meet the deductible, you pay 20% for up to a 30-day supply *Preventive drugs:* You pay $0
Mail Order***	*At a Kaiser Permanente pharmacy:* *Generic:* After you meet the deductible, you pay 20% for up to a 90-day supply *Brand-name:* After you meet the deductible, you pay 20% for up to a 90-day supply *Specialty drugs:* Not available via mail order *Preventive drugs:* You pay $0

*For more information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

**All care must be coordinated by your PCP, unless otherwise noted.

***Coverage includes biopharmaceutical drugs approved for our commercial formulary or if a Kaiser Permanente physician writes an exception based on medical necessity.

Kaiser Permanente HSA Advantage Plan (Mid-Atlantic States)

Kaiser Permanente, a nonprofit corporation (Kaiser Foundation Health Plan, Inc.), administers an HSA Advantage plan that is available to employees in the mid-Atlantic states.

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

- Routine care with your own personal plan physician,
- Hospital care,
- Laboratory and pharmacy services,
- Urgent care and emergency services, and
- Other benefits as described in the *Evidence of Coverage* booklet.

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

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

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

Choosing a Primary Care Physician (PCP)

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

To find Kaiser Permanente providers and locations:

- Go to www.kp.org/locations. Use the doctor and location search to learn about each practitioner's gender, certifications, specialties, languages, interests and more. If you don't choose a PCP, Kaiser Permanente can select one for you,
- Go to *Desktop Benefits* at https://raytheon.benefitcenter.com and click on the *My Resources* tab and *Benefit Provider Contacts,* or
- If you are a member, call Member Services.

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

This section provides a brief summary of the Kaiser Permanente HSA Advantage plan available in the mid-Atlantic states. For detailed information about the plan, refer to the *Evidence of Coverage* booklet, which describes covered services, any limitations and special programs that may be offered—or call the Member Services number on your medical ID card. To view the *Evidence of Coverage* booklet, go to https://my.kp.org/raytheon (for a hard copy, call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

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

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

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

REMINDER: NON-PREVENTIVE PHONE AND VIDEO VISITS SUBJECT TO THE DEDUCTIBLE

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

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

After your visit, you'll receive a bill for any deductible amount you owe. If you have more questions about this change, call Member Services. For more information about phone and video visits, go to kp.org/getcare.

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

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ABOUT THE *EVIDENCE OF COVERAGE* BOOKLET

This section of Your Benefits Handbook *provides only a brief summary of the Kaiser Permanente HSA Advantage plan available in the mid-Atlantic states. For additional information about the plan, including details about:*

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

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

AUTISM SPECTRUM DISORDER (ASD)

Kaiser Permanente covers services for the diagnosis and treatment of Autism Spectrum Disorder (ASD) for dependent children, age 2 through 10. ASD means any pervasive developmental disorder, including:

- *Autistic disorder;*
- *Asperger's Syndrome;*
- *Rett Syndrome;*
- *Childhood disintegrative disorder; or*
- *Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the* Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For purposes of this benefit, diagnosis of ASD means medically necessary assessments, evaluations or tests to diagnose whether an individual has ASD. The diagnosis of ASD shall be made by a plan provider or a licensed psychologist who determines the care, including behavioral health treatments and therapeutic care to be medically necessary.

Treatment for ASD must be identified in a treatment plan and may include the following services:

- *Behavioral health treatment;*
- *Pharmacy care;*
- *Psychiatric and psychological care;*
- *Therapeutic care; and*
- *Applied Behavior Analysis (ABA) therapy, when provided or supervised by a board certified behavior analyst licensed by the Virginia Board of Medicine.*

The prescribing practitioner must be independent of the provider of ABA therapy. A treatment plan means a plan for the treatment of ASD developed by a plan provider pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

About Limitations, Exclusions and Administrative Information

Please note that this section does not provide a description of Kaiser Permanente's limitations, exclusions or administrative information, including post-service claims and appeals, coordination of benefits (COB) provisions and subrogation provisions. Be sure to review the Kaiser Permanente *Evidence of Coverage* booklet for this information.

ABA therapy is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

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When you elect the Kaiser Permanente HSA Advantage plan, you are eligible for a health savings account (HSA). The company makes an annual lump-sum contribution to your HSA in January. Company contributions vary by coverage level. You also can make contributions. The maximum amount you and the company combined can contribute is subject to an annual federal limit.

You *always* own the money in your HSA. ***Any unused money carries over to the next year and may earn interest—there are no "use-it-or-lose-it" rules.*** And if you leave the company, the money in your HSA belongs to you. (For detailed information about HSAs, see the section *Health Savings Account.)*

While federal regulations prohibit anyone who is making or receiving contributions to an HSA from having other health care coverage, including through a health care flexible spending account (FSA), if applicable, eligible employees do have the option of enrolling in a limited purpose dental and vision FSA, which can be used to pay for eligible dental and vision expenses. For more information, see the *Flexible Spending Accounts* section of this handbook, if applicable.

Note also that while this regulation applies to Medicare Part A, Part B and/or Part D, as well as TRICARE, since the HSA Advantage plan is not linked to an HSA, Medicare/TRICARE participants can elect an HSA Advantage plan *without funding an HSA.* In this case, you can use your HSA Advantage plan to pay for eligible expenses incurred by you and your dependents. As long as you are not funding your HSA, it is not considered other health care coverage.

How the Plan Works

Here is a brief overview of how the plan works. The pages that follow provide a *Summary of Benefits* chart for the plan.

- The federal government regulates the design of health plans with HSAs.
- Most covered expenses—including most prescription drugs—are subject to a calendar-year deductible, which resets each January 1. There are two exceptions:
  - ***Routine in-network preventive care,*** which is covered at 100% in-network (no deductible, no coinsurance, no out-of-pocket cost). In compliance with the *Affordable Care Act* (ACA), this coverage extends to include Women's Health Services, certain preventive supplements and tobacco-cessation prescriptions (as defined by Kaiser Permanente); and
  - ***Preventive prescription drugs,*** which are covered at 100% (again, no deductible, no coinsurance, no out-of-pocket cost).
- The deductible can be satisfied by one family member or a combination of family members. **If you have family coverage, you must satisfy the family deductible before benefits are payable.**
- After you meet the deductible, the plan pays a percentage of eligible expenses. You pay the remainder of the charges until you reach the calendar-year out-of-pocket maximum (which includes the deductible and coinsurance for all eligible services and supplies). If you reach the out-of-pocket maximum, the plan covers eligible expenses at 100% for the remainder of the calendar year.

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As part of the *Medicare Prescription Drug, Improvement and Modernization Act,* which was enacted by Congress in 2003, HSAs are designed to help individuals save for qualified health care expenses on a tax-advantaged basis.

Both you and the company are allowed to make contributions to an account that you own, which you use to save for future or pay for current health care expenses. Any money you elect to contribute to your HSA is deducted from your paycheck before federal taxes, which lowers your annual taxable income and allows you to pay for out-of-pocket costs with pre-tax dollars. For information about the HSAs, see the section *Health Savings Account.*

Note that if you elect medical coverage with an HSA Advantage plan and do not participate in an HSA (either because you elect not to or because your Medicare or TRICARE status makes you ineligible), you can elect a health care FSA, if applicable, and not be limited to only dental and vision expenses.

Will you soon be eligible for Medicare? See *Approaching Age 65? Be Sure to Understand Your Medical Coverage Options* in the *Medical* or *Health Savings Account* section to learn why it's wise to consult your tax advisor before making any decisions about your post-65 medical coverage, such as whether or not to enroll in Medicare Part A when you are first eligible.

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- Again, care obtained outside the Kaiser Permanente network is generally covered only in emergencies, as defined by the plan. In certain unusual circumstances, your PCP may refer you to an out-of-network specialist. Unless your PCP receives authorization from the plan, any care you receive outside the network will not be covered.
- Kaiser Permanente provides prescription drug coverage for this plan. The *CVS Caremark Prescription Drug Program* section does not apply to the Kaiser Permanente HSA Advantage plan.

For detailed information about the plan, refer to the *Evidence of Coverage* booklet—which describes covered services, any limitations and special programs that may be offered—or call Member Services. To view the *Evidence of Coverage,* go to https://my.kp.org/raytheon (for a hard copy, simply return the postcard you will receive after you enroll or call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

If you need emergency or urgent medical care whether at home or while traveling anywhere in the world, follow the procedures on your identification card in order to receive maximum benefits from the plan.

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ABOUT THE COMPANY'S HSA CONTRIBUTION AND THE CALENDAR-YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

For New Hires

If, as a new hire, your Kaiser Permanente HSA Advantage plan coverage becomes effective after January 1, the company's lump-sum contribution to your HSA is pro-rated for that year. For details, see *For New Hires* in the *Health Savings Account* section.

In terms of the plan's deductible and out-of-pocket maximum, the entire calendar-year deductible and out-of-pocket maximum apply regardless of when your coverage with the Kaiser Permanente HSA Advantage plan becomes effective; they are not pro-rated.

If You Have a Change in Status During the Year

If, as the result of a qualified change in status that occurs after January 1 and before December 1, your coverage level *increases* (such as from employee only to employee and family), the company contribution to your HSA is adjusted to match your new coverage level and prorated to reflect your new coverage level for the rest of the year. For details, see the section *Health Savings Account.* In this case, any eligible expenses incurred to date by you and/or your covered dependents prior to your change in status continue to apply toward your new calendar-year deductible. and out-of-pocket maximum.

If your qualified change in status results in your coverage level *decreasing* (such as from employee plus family to employee only), any company HSA contribution you have received that is in excess of the company contribution amount for your new coverage level remains in your HSA. In this case, any expenses your previously covered dependent had incurred do *not* apply toward your deductible or out-of-pocket maximum.

For example, assume you start the year with family coverage and meet the family deductible of $4,200 in June ($1,000 in expenses for you, $1,000 for your spouse and $2,200 for your child). On July 12, your child turns 26 and is removed from your coverage. Since your child's expenses will no longer apply toward your deductible, and your and your spouse's eligible expenses are $2,000, you and your spouse will need to incur and pay for an additional $2,200 in eligible expenses in order to meet your deductible. Likewise, since your child's expenses will no longer apply toward your out-of-pocket maximum, you and your spouse will need to incur and pay for an additional $5,350 in coinsurance toward the cost of eligible expenses to reach the plan's $7,350 out-of-pocket maximum.

If you have questions about how a change in status affects your deductible or out-of-pocket maximum, contact Kaiser Permanente. If you have questions about how a change in status affects contributions to your HSA, contact Fidelity at 800-544-3716.

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Kaiser Permanente HSA Advantage Plan (Mid-Atlantic States) Summary of Benefits Chart

This chart provides only a summary of your benefits with the Kaiser Permanente HSA Advantage plan available in the mid-Atlantic states. Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. Care obtained outside the Kaiser Permanente network is generally covered only in emergencies, as defined by the plan. Kaiser Permanente provides prescription drug coverage for this plan. The *CVS Caremark Prescription Drug Program* section does not apply to the Kaiser Permanente HSA Advantage plan.

For detailed information about the plan, refer to the *Evidence of Coverage* booklet—which describes covered services, any limitations and special programs that may be offered—or call Member Services. To view the *Evidence of Coverage* booklet, go to https://my.kp.org/raytheon (for a hard copy, call Member Services). In the case of any discrepancy between this document and the *Evidence of Coverage,* the *Evidence of Coverage* governs.

Kaiser Permanente HSA Advantage (Mid-Atlantic States)	
Plan Features	**Benefits***
Calendar-Year Deductible	• Employee only: $2,100 • Employee and spouse: $4,200 • Employee and child(ren): $4,200 • Employee and family: $4,200
Company HSA Contribution for 2021 (available to employees who are eligible to receive or make contributions to an HSA; see *Contributions to Your HSA* in the *Health Savings Account* section for information regarding the annual maximum amount you can contribute)	• Employee only: $750 • Employee and spouse: $1,125 • Employee and child(ren): $1,125 • Employee and family: $1,500 (Amounts shown will be prorated for new hires)
Coinsurance	80%
Calendar-Year Out-of-Pocket Maximum	• Employee only: $4,100 • Employee and spouse: $7,350 • Employee and child(ren): $7,350 • Employee and family: $7,350
Covered Services: Preventive Care**	**Benefits***
Preventive Care Services Covered services include: • Routine physical maintenance exams, including well-woman exams • Scheduled routine prenatal exams • Well-child exams for children 0 to 23 months • Health education counseling programs • Immunizations • Routine preventive imaging and laboratory services • Blood pressure screening for all adults • Cholesterol screening • Colorectal cancer screening for adults over 50 • Type 2 diabetes screening for adults with high blood pressure • Mammograms every one to two years for women over 40 • Cervical cancer screening for sexually active women • Osteoporosis screening for women over 60, depending on risk factors • Immunizations for children from birth to 18 years • Obesity screening and counseling for children Note: If you receive any other covered services during a visit that includes preventive care services on the list, you will pay the applicable cost share for those other services. Note that this list is subject to change at any time; go to www.kp.org/prevention for a complete list	Covered at 100% (the deductible does not apply)

*All care must be coordinated by your PCP, unless otherwise noted.

**Note that to be covered at 100%, routine preventive care (exams and associated lab tests) cannot be related to the diagnosis or treatment of an illness or injury and must comply with age and gender recommendations of the U.S. Preventive Services Task Force and/or the guidelines supported by the Health Resources and Services Administration. For detailed information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

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Kaiser Permanente HSA Advantage (Mid-Atlantic States)	
Covered Services*	**Benefits****
Inpatient Hospital Care Including Inpatient Surgery and Inpatient Physician Services	Covered at 80% after deductible
Outpatient Surgery and Anesthesia	Covered at 80% after deductible
Emergency Room For important information about emergency services, including prior authorization requirements, see the *Evidence of Coverage* booklet or call Member Services	Covered at 80% after deductible
Ambulance Services	Covered at 80% after deductible
Physician's Services	*Office visits:* Covered at 80% after deductible *Scheduled non-preventive phone and video visits:* Covered at 100% after deductible (for details, see *Non-Preventive Phone and Video Visits Now Subject to the Deductible* earlier in this section)
Outpatient Diagnostic Services	Covered at 80% after deductible
Hearing Care	*Exam:* Covered at 80% after deductible *Hearing Aid:* Limited to $1,000 per 24 months
Hemodialysis, Chemotherapy, Radiation Therapy	Covered at 80% after deductible
Short-Term Rehabilitative Therapy	Covered at 80% after deductible, limited to medically necessary therapy authorized by a plan physician (30-visit limit per calendar year for each therapy per injury, incident or condition) *Note:* Benefits are provided based on the allowed charge for short-term rehabilitative therapy by a physical therapist, general, chronic disease or rehabilitation hospital or community health center or in a doctor's office. The claims administrator must determine that your condition can be reasonably expected to improve significantly within 60 days of the first therapy visit. Benefits include physical therapy, speech/language therapy (restorative only), occupational therapy or an organized program of these combined services
Nutritional Counseling with a Registered Dietician	*Individual or group session:* Covered at 80% after deductible
Chiropractor Services* **	Covered at 80% after deductible, limited to 20 visits per calendar year
Podiatry	Covered at 80% after deductible
Family Planning (including Depo-Provera injections, diaphragms and IUDs when supplied by physician)	*Family planning visits:* Covered at 100% (the deductible doesn't apply) Note: Prescription copayments and coinsurance apply
Emergency or Urgent Care in a Physician's Office	Covered at 80% after deductible
Oxygen and Durable Medical Equipment (rental or purchase with medical necessity review; must meet medical necessity criteria)	Covered at 80% after deductible when arranged by Kaiser Permanente. Must be in accordance with formulary guidelines for durable medical equipment
Hospice Services (includes respite care up to 5 days in the home or a nursing home, and other covered services and supplies, when billed by an approved hospice provider)	Covered at 80% after deductible

*For more information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

**All care must be coordinated by your PCP, unless otherwise noted.

***Kaiser Permanente contracts with American Specialty Health (ASH) for chiropractic services. You can obtain services from any participating ASH plan chiropractor without a referral from your Kaiser Permanente plan physician. Your ASH chiropractor coordinates authorization of all services and claims with ASH directly; you simply pay your copayment at each visit. You can obtain a listing of participating chiropractors by calling the ASH Member Services Department at 800-972-4226 or going to www.ashcompanies.com.

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Kaiser Permanente HSA Advantage (Mid-Atlantic States)	
Covered Services*	**Benefits****
Bereavement Services (includes services provided to the family or primary care person following the death of the hospice patient and other covered services and supplies, when billed by an approved hospice provider)	Covered at 80% after deductible
Nursing Services*	**Benefits****
Skilled Nursing Facility	Covered at 80% after deductible, limited to 120 days per benefit period
Home Health Care	Covered at 80% after the deductible when prescribed by a plan physician within the service area
Mental Health (Including Applied Behavior Analysis (ABA) Therapy) and Substance Abuse Treatment*	**Benefits****
Hospital Admission	*Mental health:* Covered at 80% after deductible *Substance abuse (detoxification):* Covered at 80% after deductible *Substance abuse (residential rehabilitation):* Covered at 80% after deductible **Note:** Inpatient care must be authorized in advance; contact Member Services to find out how to obtain services
Outpatient Care	*Mental health:* Covered at 80% after deductible for individual or group sessions *Substance abuse:* Covered at 80% after deductible for individual or group sessions
Prescription Drugs*	**Benefits****
Retail***	*At a Kaiser Permanente pharmacy:* *Generic:* After you meet the deductible, you pay 20% for up to a 30-day supply *Formulary brand-name:* After you meet the deductible, you pay 20% for up to a 30-day supply *Non-formulary brand-name:* After you meet the deductible, you pay 20% for up to a 30-day supply *Specialty drugs:* After you meet the deductible, you pay 20% for up to a 30-day supply *Preventive drugs:* You pay $0 *Infertility prescriptions:* After you meet the deductible, you pay 50% *At a non-Kaiser Permanente-participating pharmacy:* *Generic:* After you meet the deductible, you pay 35% for up to a 30-day supply *Formulary brand-name:* After you meet the deductible, you pay 35% for up to a 30-day supply *Non-formulary brand-name:* After you meet the deductible, you pay 35% for up to a 30-day supply *Infertility prescriptions:* After you meet the deductible, you pay 50%
Mail Order***	*At a Kaiser Permanente pharmacy:* *Generic:* After you meet the deductible, you pay 20% for up to a 90-day supply of maintenance medications *Formulary brand-name:* After you meet the deductible, you pay 20% for up to for a 90-day supply of maintenance medications *Non-formulary brand-name:* After you meet the deductible, you pay 20% for up to a 90-day supply of maintenance medications *Specialty drugs:* Not available via mail order *Preventive drugs:* You pay $0 *Infertility prescriptions:* After you meet the deductible, you pay 50%

*For more information about covered services, refer to the *Evidence of Coverage* booklet or call Member Services.

**All care must be coordinated by your PCP, unless otherwise noted.

***Coverage includes biopharmaceutical drugs approved for our commercial formulary or if a Kaiser Permanente physician writes an exception based on medical necessity.

Global Choice

All eligible expatriate employees on international assignments and their eligible dependents have access to Global Choice, which provides medical and dental coverage. *(Note that your medical and dental coverage are bundled into one plan; you cannot elect only medical or dental coverage without the other.)* Administered by Cigna Global Health Benefits, Global Choice offers comprehensive worldwide coverage.

PRE-DEPARTURE MEDICAL ASSESSMENT

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

Before you leave, you will be asked to complete a 10-15 minute confidential and secure questionnaire *through Cigna's member website www.cignaenvoy.com.* ***It is in your best interest to complete this survey well in advance of your departure date so that Cigna can provide assistance and support before you arrive at your assignment.***

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

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

CIGNA GLOBAL HEALTH BENEFITS MEMBER WEBSITE

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

1. *Under "I am a Customer," select "I have not registered yet;"*
2. *Register using the information exactly as it appears on your Cigna ID card;*
3. *Answer the security questions and click* Register.

Once you have registered, you can:

- *Identify, choose and locate providers and hospitals that are Cigna Global Health Benefits–recommended or in the Cigna OAP network;*
- *Identify dentists in the Cigna Dental PPO/EPO network;*
- *Quickly and easily submit claims and check the status of your claims;*
- *Download international* Explanations of Benefits *(EOBs);*
- *Request, view and print ID cards;*
- *Review your benefits and verify eligible enrolled dependents; and*
- *Access a wide range of health care information.*

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

Cigna offers participants two dedicated phone numbers: 855-448-5733 (toll-free) or 302-797-3784. When calling from outside the United States, collect calls are accepted. Representatives are available 24 hours a day, seven days a week, year-round.

When you enroll, you will receive a *Certificate of Coverage* booklet, which describes the services that are covered, plan limitations and any special programs that may be offered. For detailed information about the plan, refer to the *Certificate of Coverage* or call Cigna. In the case of any discrepancy between this document and the *Certificate of Coverage,* the *Certificate of Coverage* governs.

Manage Your Health Benefits Anytime, Anywhere!

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

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

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

Cigna Global Health Benefits
www.cignaenvoy.com
855-448-5733 or 302-797-3784
(24/7, collect calls accepted from outside the U.S.)

TELEHEALTH OFFERS CONVENIENT ACCESS TO QUALITY HEALTH CARE

No matter where you are, Telehealth provides 24/7 access to licensed doctors who can consult on a variety of non-emergency health issues, from treating acute conditions, such as fever, rash or pain, to managing complex chronic conditions. Telehealth is an affordable and convenient alternative to doctor office or clinic visits—with no deductibles or coinsurance payments.

Appointment requests are made via the Cigna Wellbeing™ app and may be scheduled for the same day. Your initial consultation is usually with a general practitioner and is by phone or video. If the practitioner thinks you should speak with a physician in person, he/she will help you locate a provider in your area.

In addition to scheduling an appointment when you don't feel well or have medical questions, you can use Telehealth to help you prepare for an upcoming medical consultation or to review a medication plan and potential side effects.

Make the Cigna Wellbeing App Part Of Your Everyday Life

In addition to scheduling a same-day consultation with a doctor through Telehealth as described above, the Cigna Wellbeing app makes it easy for you to improve your health and wellness. For example, you can use the app to:

- *Measure and monitor your health with Cigna Health Assessments, which provide customized tips and advice for lifestyle improvements; and*
- *Manage chronic conditions, such as diabetes and cardiovascular disease.*

The app is free to Cigna Global Health Benefits members and is available from the Apple App Store℠ and Google Play.™ Be sure to download the app today!

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Global Choice–Medical

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

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

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

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

Global Choice Coverage Outside the United States

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

Global Choice covers wellness and preventive care (see *Wellness and Preventive-Care Benefits* later in this section) at 100%—with no coinsurance. For other medical services—including office visits as well as inpatient and outpatient hospital care—the plan pays 90% of covered charges and you pay the balance, up to a calendar-year out-of-pocket maximum of $1,500 per individual ($3,000 per family). There is no deductible. Once you reach the calendar-year out-of-pocket maximum, the plan pays 100%, up to reasonable and customary amounts, of the rest of your covered charges for care received outside the United States for the remainder of that calendar year.

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

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

Prior Authorization

With Global Choice, prior authorization is recommended or required for certain types of care received outside the United States. To inquire if the care you need requires prior authorization, or to receive care coordination assistance, call Cigna.

Prescription Drug Coverage

When you need to fill a prescription outside of the United States, Global Choice reimburses the cost for eligible prescription drugs at 90%. Generic and brand-name medicines are reimbursed at the same level—prescriptions filled outside the United States are not subject to a formulary.

As outlined in the *Global Choice Summary of Medical Benefits Chart,* the amount you and the plan pays varies, based on the service and if you are outside or inside the United States.

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Note that there isn't a mail-order service for prescriptions filled outside the United States—you must use a local pharmacy.

Cigna Global Health Benefits will provide direct reimbursement to those pharmacies outside the United States that will accept it. If you must pay for your prescriptions out-of-pocket, submit a claim form for reimbursement (see *Claims Procedures* later in this section for more information).

UPON YOUR RETURN TO THE UNITED STATES

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

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

If you do not take action within 30 days of your assignment end date, you will automatically receive default medical and dental coverage as follows:

- **UnitedHealthcare (UHC) HSA Advantage 2 plan at your current Global Choice coverage level,** *and*
- **Delta Dental PPO Plus Premier High Option at the employee-only coverage level.**

Whether you actively elect medical coverage with an HSA Advantage plan or default to the UHC HSA Advantage 2 plan, note the following:

- *In order to receive the company's health savings account (HSA) contribution and make your own HSA contributions, you must either have an existing HSA or open one. If you don't currently have an HSA, you must actively enroll; HSAs will not open automatically. For details, including annual contribution limits, see the* Health Savings Account *section.*
- *Since health care flexible spending accounts (FSAs) are available only to employees who do not participate in an HSA Advantage plan or participate in an HSA Advantage plan but do not fund an HSA, if you elected to participate in a health care FSA while on international assignment, your health care FSA will automatically convert to a limited purpose dental and vision FSA when you return to the U.S.*

  In addition, because moving to a position in the U.S. is considered a qualified change in status, you are eligible to make certain other changes to any FSAs (in this case, both limited purpose dental and vision, and dependent care, if applicable) for the remainder of the calendar year. For details, see the Flexible Spending Accounts *section.*

You will receive a confirmation statement shortly after the close of your 30-day enrollment period. If you wish to make any additional changes to your benefits (such as if the default coverage listed above will not meet your needs), you have 30 days from the date on your confirmation statement to do so.

For details on the benefit options available to you, see your Personalized Enrollment Worksheet *on* Desktop Benefits. Desktop Benefits *is also where you can find everything you'll need to enroll, including a description of the medical and dental plan options available to you. Questions? Call the RBC.*

MEDICAL COVERAGE FOR INTERNATIONAL BUSINESS TRAVELERS

Offered by Cigna, Medical Benefits Abroad® (MBA) provides medical coverage for U.S.-based employees who travel outside the United States for up to six months.

To review a description of how coverage works and print out an ID card, go to www.cignaenvoy.com (see your travel itinerary for login information). If you need assistance while traveling, dial the International Access Code (IAC), available at www.att.com/traveler, and then 800-243-1348 or call 302-797-3535 collect.

Global Choice Coverage Inside the United States

This section describes how Global Choice provides coverage for care received inside the United States. This applies to you when on home leave or a business trip to the United States as well as to dependents who remain at home in the United States.

In-Network Care

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

With Global Choice, it is recommended, although not required, that you choose a PCP to coordinate your care received inside the United States. Whenever you use a provider who participates in the Cigna OAP network, benefits for eligible services are paid at a higher level. Plus, you are not required to file any claim forms for in-network services.

Global Choice provides 100% in-network coverage for wellness and preventive care—with no copayment or deductible (see *Wellness and Preventive-Care Benefits* later in this section)—and office visits are covered at 100% after a $25 copayment.

When you visit a Cigna OAP provider, most other in-network care is covered either at 100% after the applicable copayment or at 90% after the calendar-year in-network deductible ($200 per individual, $400 per family).

Once more than two family members have paid eligible deductible expenses totaling $400 of eligible charges in a calendar year, any additional in-network care for any covered family member will not be subject to any further deductibles. In this case, the plan pays 90% and you pay the other 10%, known as your coinsurance, up to the calendar-year in-network out-of-pocket maximum of $1,500 per individual ($3,000 per family); note that while this does not include the deductible or prescription drug charges, it does include all copayments. Once you reach the out-of-pocket maximum, the plan pays 100% of the rest of your covered in-network charges for care received in the United States for the remainder of that calendar year.

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

Finding In-Network Health Care Providers. Using Cigna OAP network providers can help you save money on your health care expenses. To find providers in your area who participate in the network, go to www.cignaenvoy.com, click on *Physician Directory* and search for a provider within the United States. Once you have located a provider, you can learn his/her:

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

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

Out-of-Network Care

With Global Choice, you always have the option of seeing a provider or specialist who does not participate in the network. This is called *out-of-network care.*

When you seek care inside the United States with a provider that does not participate in the Cigna OAP network, you pay a larger share of the costs. Before the plan pays any out-of-network benefits, you must first incur enough eligible expenses to satisfy an out-of-network deductible ($600 per individual, $1,200 per family). Once more than two family members have paid eligible deductible expenses totaling $1,200 of eligible charges in a calendar year, any additional out-of-network care for any covered family member will not be subject to any further deductibles.

Thereafter, the plan generally pays 70% of the *maximum reimbursable charge* (defined in the next paragraph) for all covered charges, including preventive care and hospitalization. You generally pay the other 30%, up to the calendar-year out-of-network out-of-pocket maximum of $6,000 per individual ($12,000 per family).

Finding Cigna OAP Network Participating Providers

You can find Cigna OAP participating providers through www.cignaenvoy.com by clicking on *Physician Directory* and searching within the United States.

Since providers may join or leave the network at any time, you should call Cigna to check that a certain provider is still participating in the Cigna OAP network.

Applying Eligible Expenses Toward Your Deductible and Out-of-Pocket Maximum

For care received inside the United States with Global Choice, the in- and out-of-network deductibles and out-of-pocket maximums are combined. This means eligible expenses you incur in-network apply to the out-of-network deductible and out-of-pocket maximum, and vice versa. In addition, all copayments apply to both the in-network deductible and the in-network out-of-pocket maximum.

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With out-of-network care, the plan pays benefits for covered health services using a fee schedule and methodology based on Medicare's maximum reimbursable charge. The plan does not cover any charge that is above 150% of the Medicare-based fee schedule. If your out-of-network doctor or facility charges more than the maximum reimbursable charge, you are required to pay that amount in addition to the 30% coinsurance.

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

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

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

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

When you receive out-of-network care, you are responsible for initiating any prior authorization requirements by calling Cigna.

Prior Authorization Requirements

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

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

In either case, prior authorization is required for certain types of care received inside the United States. To inquire if the care you need requires prior authorization, or to receive care coordination assistance, call Cigna.

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

Prescription Drug Coverage

Prescription drug coverage for Global Choice–enrolled expatriate employees and their covered dependents filling a prescription in the United States is administered as a separate program by CVS Caremark. You will receive a CVS Caremark prescription drug card(s). For more information, see the *CVS Caremark Prescription Drug Program* section.

Other Global Choice Medical Plan Benefits

This section highlights benefits that are available to expatriate employees on international assignment and their covered dependents through the Global Choice plan. For more information about how Global Choice covers particular benefits outside or inside the United States, refer to the *Global Choice Summary of Medical Benefits Chart.*

Primary Care

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

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

Whenever you receive care at the out-of-network level, your coverage is at the lower level—even if a network provider refers you to a non-network provider. **In addition, if you seek out-of-network care for a service that requires prior authorization, *no benefits will be payable.*** To learn if a service you need requires prior authorization and to have that service authorized, call Cigna.

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

Wellness and Preventive-Care Benefits

Routine physical exams are covered at 100% with no copayment when performed outside the United States or by a Cigna OAP network physician inside the United States. If you or your covered dependent receives care inside the United States and chooses to receive a routine physical exam out-of-network, it is covered at the out-of-network level (70% after deductible). Physical exams required by a third party—such as a school, employer or camp—are not covered.

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

In addition, the plan covers related preventive-care services at 100% with no deductible, coinsurance or copayment when received outside the United States or through a Cigna OAP network provider inside the United States. (The plan covers out-of-network preventive care, generally at 70% after deductible.) Examples of services include:

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

For more information about wellness care, refer to the *Global Choice Summary of Medical Benefits Chart.*

Specialty Care

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

- Cardiologists;
- Chiropractors;
- Dermatologists;
- Ear/nose/throat doctors;
- OB/GYNs;
- Physical, speech (restorative only), occupational, cardiac rehabilitation and pulmonary therapists; and
- Podiatrists.

Benefits vary according to the type of specialist and where you seek care. For details, see the *Global Choice Summary of Medical Benefits Chart* later in this section.

Emergency Care

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

Choosing Your PCP

When you have a health care need, your PCP is generally the first person you'll call. Even though you're not required to choose a PCP to coordinate your care, it's always recommended. Your PCP is a critical member of your health care team. Seeing your PCP first helps you build a stronger relationship with your doctor and ensures you get the most effective and efficient care possible. With a PCP, you can discuss your health in a direct way and ask questions.

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

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

If emergency procedures are followed, emergency room facility charges are covered at 90% if received outside the United States or at 100% after a $150 copayment if received inside the United States (copayment is waived if admitted).

Ambulance Services

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

Family Planning Benefits

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

If you fill your prescription outside the United States, you must use a retail pharmacy and file a claim for reimbursement. (There isn't an international mail-order service.)

If you fill your prescription in the United States, see the *CVS Caremark Prescription Drug Program* section for pharmacy information.

Infertility Treatment

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

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

Maternity Care Benefits

Global Choice covers maternity care the same as any other covered medical expense.

Short-Term Therapies

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

Mental Health Care

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

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

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

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COVERAGE FOR AUTISM SPECTRUM DISORDERS (ASD)

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

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

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

LIFERESOURCES

In addition to managed mental health care through our medical plans, the company offers LifeResources, an integrated work/life and employee assistance program (EAP) provided by ComPsych® that can help with:

- *Adjusting to relocation;*
- *Dealing with stress, anxiety or depression;*
- *Marital or relationship problems;*
- *Coping with grief or loss;*
- *Managing conflicts;*
- *Parenting concerns; and*
- *Alcohol or drug issues.*

You may call LifeResources at any time, day or night, or you may request a personal online chat (which takes place on a secure website at a time you schedule with a counselor).

All calls and online chats are confidential and available to you and members of your household.

To take advantage of the services offered through LifeResources, or to learn more about the program, call LifeResources collect from outside the U.S. at +1-312-595-0074 or go to www.liferesourcesray.com (to register, the company's web ID is Raytheon).

The services of LifeResources are provided at no cost to you. Services include up to eight counseling sessions (where available) per problem per calendar year.

How LifeResources Integrates with Your Medical Coverage (Inside the United States *Only*)

If you call LifeResources with a problem that needs to be treated as a mental health and/or substance use disorder benefit under your medical plan (such as long-term counseling or inpatient care), LifeResources works to assist you. With your permission, the LifeResources specialist will contact a mental health care professional to develop an effective and appropriate treatment plan.

You may call the LifeResources number before *receiving counseling or treatment services. If you need a referral to the mental health and/or substance use disorder benefit under your medical plan, the LifeResources specialist works with you. It's important that you check your plan's precertification procedures before receiving care. Benefits provided for covered mental health and substance use disorder services are listed in the* Global Choice Summary of Medical Benefits Chart.

Note: LifeResources is not available to employees who are Re-Employed Recipients of a Pension Payment.

Inside the United States, call LifeResources at 866-640-7008 or go to liferesourcesray.com 24 hours a day, seven days a week.

When You Are Away from Home or Residence

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

If you are traveling and serious injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic. If emergency procedures are followed, emergency room facility charges are covered at 90% when received outside the United States or at 100% after a $150 copayment (waived if admitted) when received inside the United Sates. ***If emergency procedures are not followed, benefits are reduced.***

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(24/7, collect calls accepted from outside the U.S.)

Transplant Coverage

You are covered for transplants received outside the United States.

Transplants received inside the United States are covered when received at a CIGNA LIFESOURCE Transplant Network® facility. The CIGNA LIFESOURCE Transplant Network performs:

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

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

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

Note that cornea transplants are covered at the U.S. in-network level when you seek care at a participating facility that has specifically contracted with Cigna to provide those services. Cornea transplants are *not* covered at CIGNA LIFESOURCE Transplant Network facilities.

Gender Dysphoria (Transgender Surgery and Gender Dysphoria Treatments)

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

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

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Global Choice Summary of Medical Benefits Chart

This chart provides only a summary of your medical benefits with Cigna Global Health Benefits. A listing of limitations and exclusions is provided later in this section. For more information about covered health services received internationally, go to www.cignaenvoy.com or call Cigna.

Global Choice–Medical			
Benefit	**Outside the United States**	**Inside the United States**	
Calendar-Year Deductible	None	$200 individual; $400 family	$600 individual; $1,200 family
		The in- and out-of-network deductibles are combined. This means eligible expenses you incur in-network apply to the out-of-network deductible, and vice versa. Deductibles do not apply to the calendar-year out-of-pocket maximum	
Calendar-Year Out-of-Pocket Maximum (excludes certain charges as described earlier in this section)	$1,500 individual; $3,000 family	$1,500 individual; $3,000 family	$6,000 individual; $12,000 family
		The in- and out-of-network out-of-pocket maximums are combined. This means eligible expenses you incur in-network apply to the out-of-network out-of-pocket maximum, and vice versa	
Lifetime Maximum	None	None	None
Inpatient Hospital and Related Services	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Inpatient Mental Health and Substance Use Disorder Services	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
	Requires prior authorization. Call Cigna		
Professional Fees for Surgical and Medical Services	90% of covered charges	100% of covered charges after deductible has been met	70% of covered charges after deductible has been met
Outpatient or Day Case Diagnostic and Therapeutic Services	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
Outpatient or Day Case Surgery	90% of covered charge	100% of covered charges after a $100 copayment	70% of covered charges after deductible has been met
Medical Services in a Physician's Office (includes voluntary family planning and immunizations as well as urgent care)	90% of covered charges	100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met
Wellness Care*	100% of covered charges	100% of covered charges	70% of covered charges after deductible has been met
Outpatient Rehabilitation (physical therapy)	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
Outpatient Rehabilitation (speech (restorative only) occupational, cardiac, pulmonary therapy)	90% of covered charges	100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met

*Wellness care inclues:

- Preventive care, such as routine physical examinations, mammograms (including 3-D mammograms), pap tests, PSA tests, etc.;
- Additional Women's Health Services, such as breast-feeding equipment, contraceptives (including FDA-approved oral, injectable and emergency contraceptives; Depo-Provera; diaphragms; IUDs; and voluntary sterilization for women), domestic violence screenings, folic acid supplements (patients must meet age guidelines), gestational diabetes screenings and voluntary sterilization for women; and
- Well-child care.

Contact the plan for additional routine health care provided to adults and children at 100% coverage without a copayment or coinsurance.

(continued)

Global Choice–Medical			
Benefit	**Outside the United States**	**Inside the United States**	
Outpatient Mental Health and Substance Use Disorder Services	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
Accident-Related Dental Services	90% of covered charges	100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Hearing Care Exam	90% of covered charges	100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met
Hearing aids (age 24 and above, limited to $1,000 per year; under age 24, limited to $1,000 per aid, per ear, every three years)	100% of covered charges up to applicable benefit maximum	100% of covered charges up to applicable benefit maximum	100% of covered charges up to applicable benefit maximum
Vision Care Exam (one every 24 consecutive months)	90% of covered charges	100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met
Lenses and frames (combined maximum benefit of $100 every 24 consecutive months)	100% of covered charges	100% of covered charges	100% of covered charges
Chiropractic Treatment	90% of covered charges	90% of covered charges	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Acupuncture Services	90% of covered charges	100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met
Infertility Treatment (includes Zygote Intrafallopian Transfer (ZIFT) and Gamete Intrafallopian Transfer (GIFT))	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
Maternity Services (includes prenatal and postnatal care)	90% of covered charges	*Inpatient care:* 90% of covered charges after deductible has been met *Office visits:* 100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met
Emergency Room Services	90% of covered charges	100% of covered charges after a $150 copayment per visit (waived if admitted)	100% of covered charges after a $150 copayment per visit (waived if admitted)

(continued)

Global Choice–Medical			
Benefit	**Outside the United States**	**Inside the United States**	
		In-Network	**Out-of-Network**
External Prosthetics and Durable Medical Equipment	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Prescription Drugs (outpatient)	Global Choice reimburses 90% of covered charges (retail only; mail order not available)	Administered by CVS Caremark. See the *CVS Caremark Prescription Drug Program* section for details	
Home Health Care Services	90% of covered charges	100% of covered charges after a $25 copayment per visit	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Hospice Facility (inpatient or outpatient)	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Skilled Nursing Facility	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Ambulance Services (emergency only)	90% of covered charges	100% of covered charges after deductible has been met	100% of covered charges after deductible has been met
TMJ (surgery)	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
		Up to a maximum of $1,000 (in- and out-of-network combined, for care received inside the United States)	
Autism Spectrum Disorders (ASD) (includes screening, diagnosing and treating). See the *Certificate of Coverage* booklet for coverage details	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
Obesity/Bariatric Surgery	90% of covered charges	90% of covered charges after deductible has been met	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
		Up to a lifetime maximum of $10,000 (in- and out-of-network combined, for care received inside the United States)	
Cochlear Implants	90% of covered charges	*Inpatient:* 90% of covered charges after deductible has been met *Outpatient:* 100% of covered charges after a $100 copayment per visit	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		

(continued)

Global Choice–Medical			
Benefit	**Outside the United States**	**Inside the United States**	
Breast Reduction	90% of covered charges	*Inpatient:* 90% of covered charges after deductible has been met *Outpatient:* 100% of covered charges after a $100 copayment per visit	70% of covered charges after deductible has been met
	May require prior authorization. Call Cigna to confirm		
Transplant Services	90% of covered charges (you will be required to receive services at a designated CIGNA LIFESOURCE Transplant Network® facility. Procurement of organ is not covered)	90% of covered charges after deductible has been met (services must be received at a designated facility. Procurement of organ is not covered)	70% of covered charges after deductible has been met (procurement of organ is not covered)
	May require prior authorization. Call Cigna to confirm		

Global Choice–Dental

With Global Choice dental coverage, preventive and routine care is covered at 100% with no deductible. After you meet the individual or family deductible ($50/$100), the plan covers basic services (such as fillings, root canal therapy and oral surgery) at 80%, and major services (such as the installation of bridges and crowns) at 60%. The annual per person benefit maximum is $1,500 (separate lifetime maximums for orthodontia and implants apply).

Dental provider networks vary depending on if you seek care outside or inside the United States:

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

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

Global Choice–Dental	
Deductibles and Maximums (do not apply to preventive and routine care) Individual deductible Family deductible Annual benefit maximum (per person) Orthodontia maximum (per person, lifetime) Implants maximum (per person, lifetime)	 $ 50 $ 100 $1,500 $2,000 $2,000
Preventive and Routine Care (Type 1) • Oral exam and cleaning twice each calendar year (regardless of whether care is routine) • Bitewing x-ray, twice per calendar year • Full mouth x-ray, once every five years • Periodontal cleaning, once every three months following active periodontal treatment (not to be combined with preventive cleanings) • Space maintainers, fixed unilateral (limited to nonorthodontic treatment) • Topical application of sealant, per tooth, on a posterior tooth (only 1 treatment per tooth in any 3 calendar years)	Plan pays 100%
Basic Services (Type 2) • Fillings • Root canal therapy • Oral surgery and extractions • Repair of bridgework and dentures • Periodontics	After you meet the deductible, plan pays 80%
Major Services (Type 3) • Installation of bridges and dentures • Crowns and gold restorations • Reconstructive dental surgery	After you meet the deductible, plan pays 60%
Implants	After you meet the deductible, plan pays 50%
Orthodontics (including treatment for adults)	After you meet the deductible, plan pays 80%

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

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Exclusions and Limitations

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

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

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

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

Claims Procedures

Outside the United States

When you receive care from a provider who has established direct payment with Cigna Global Health Benefits, you do not have to file a claim form. Simply show your Global Choice ID card. Your provider may request payment for any required coinsurance or charges for services that are not covered.

If direct payment is not established with your provider, you pay for your care when it is received and then file a claim for reimbursement.

You can submit claims via www.cignaenvoy.com, email, fax or post, and request reimbursement in more than 80 currencies via wire transfer to your bank or with a check.

If you have any questions, call Cigna.

Prescription Drugs

If you or your covered dependents purchase prescriptions outside the United States, Cigna Global Health Benefits will provide direct reimbursement to those pharmacies that will accept it. If you must pay for the prescription drugs out of pocket, submit a claim form for reimbursement.

Cigna Global Health Benefits
www.cignaenvoy.com
855-448-5733 or 302-797-3784
(24/7, collect calls accepted from outside the U.S.)

AVAILABLE CURRENCIES

In most cases, you can receive reimbursement in the currency used to pay for care or services. International claims can be reimbursed in more than 80 currencies via check or wire transfer, when possible. If Cigna Global Health Benefits cannot send a payment in local currency, reimbursement will be made in U.S. dollars. (If a U.S.-based service cannot be paid directly to the provider, the claim will be reimbursed with a check in U.S. dollars.)

If it is necessary to make a conversion from one currency to another, Cigna Global Health Benefits uses the exchange rate in force on the date the services were incurred.

Inside the United States

If you visit a Cigna OAP network provider, you generally do not have to file a claim form. Simply show your Global Choice ID card. A network provider will not charge at the time of treatment of a covered health service, but may request payment for any required copayments, coinsurance or charges for services that are not covered.

If you visit an out-of-network provider, you may be required to file the claim yourself, as described below.

Prescription Drugs

If you or your covered dependents purchase a prescription inside the United States, your coverage is through CVS Caremark. For instructions on how to file claims, see the *CVS Caremark Prescription Drug Program* section.

Filing a Claim

Regardless of your location, follow these steps to file a claim:

1. ***Be sure that you know your benefits.*** In order to get the most out of your benefits, it's important that you understand what is and is not covered, as well as how the plan pays benefits.
2. ***Get an itemized bill.*** Be sure the bill includes:
   - Name, phone number and address of the service provider;
   - Patient's full name, address and date of birth;
   - Employee's name and address;
   - Membership ID number;
   - Date of service;
   - Description of the service/supply rendered;
   - Procedure code;
   - Amount charged; and
   - Diagnosis or nature of illness.

   Canceled checks, cash register receipts, credit card receipts or personal itemizations are ***not*** acceptable as itemized bills.
3. ***Keep a copy of your itemized bill.*** Because you must submit originals, it's important that you keep a copy for your records. Once your claim is received, itemized bills cannot be returned.
4. ***Complete a claim form.*** Make sure all information is completed properly and then date and sign the form. Claim forms are available online or by calling Cigna.
5. ***Submit your claim form.*** You can do this either online or by hard copy. If you choose to mail in your claim, be sure to attach your itemized bill(s) and send the materials to:

   Cigna Global Health Benefits
   PO Box 15050
   Wilmington, DE 19850

Ongoing Treatment

If your treatment involves several outpatient services for the same sickness or injury, Global Choice requires only one claim form every six months—as long as the itemized invoice has all the information necessary to identify the patient and the treatment rendered.

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www.cignaenvoy.com
855-448-5733 or 302-797-3784
(24/7, collect calls accepted from outside the U.S.)

Separate claim forms must be filed for each covered dependent. Be sure to submit all bills for covered health services. ***All claims must be filed no later than 365 days after the date the services or supplies were received.***

Once your international claim is processed, you can go online to check its status and/or view or print an *Explanation of Benefits* (EOB). Your EOB lists:

- Provider's charge;
- Allowable amount;
- Copayment, deductible and coinsurance amounts, if any, that you're required to pay;
- Reason for any denial or partial payment;
- Total benefits payable; and
- How much you owe.

You will receive a paper EOB for all claims.

Claims Appeal

If a claim is denied, you will receive a written explanation. You have the right to request a review of the claim by contacting:

Cigna Global Health Benefits
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850
855-448-5733 or 302-797-3784

For details, see *Applying for Benefits* in the *Administrative* section.

COORDINATION OF BENEFITS

Global Choice includes non-duplication coordination of benefits (COB). The non-duplication COB provision provides payment up to the normal reimbursement level under the plan. This means your combined benefits from all plans will equal, but never exceed, the amount that would normally be payable from your company-sponsored plan when there is no COB with another plan.

For claims incurred within the United States, you should file all claims under each plan. For claims incurred outside the United States, if you file claims with more than one plan, you must indicate, at the time of filing a claim under this plan, that you also have or will be filing your claim under another plan.

For more information about COB, see the Administrative *section or contact Cigna and request a copy of the certificate document.*

SUBROGATION/RIGHT OF REIMBURSEMENT PROVISIONS

Global Choice includes subrogation provisions. Subrogation applies if you receive payment from a third party that is held liable for any injury that required medical care. In this case, you may be required to reimburse your plan for claim payments. The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment or otherwise.

For more information about subrogation and the plan's right of reimbursement, see the Administrative *section or contact Cigna and request a copy of the certificate document.*

Medical Administrative

As Your Needs Change

If You Take a Leave of Absence

Medical Leave

If you have elected medical coverage and are on an authorized medical leave of absence, medical coverage for you and your dependents will continue for up to 24 months. You pay the premium rate in effect during your leave. If your leave is for fewer than 90 days, your deductions for medical coverage will be taken from your paycheck on a retroactive basis when you return to work. These deductions will be taken over the same number of pay periods that you were out. If your leave is for 90 days or more, you will receive a bill for the cost of medical coverage from the first day of your leave and instructions for payment.

If you participate in an HSA Advantage plan, you can make your own contributions to your HSA while you are on leave. To set up automatic contributions from your bank account, go to www.netbenefits.com/raytheon or call Fidelity Investments® at 800-544-3716. If you are on leave in January, you will receive the company's lump-sum contribution to your HSA at the same time as active employees.

After you have been on a medical leave of absence for 24 months, your employment will be administratively terminated and your medical coverage will end. You may extend your coverage under COBRA regulations (see *Extending Your Coverage* later in this section). (In addition, the company will no longer make contributions to your HSA. You can continue to make contributions to your HSA if you elect an HSA Advantage plan through COBRA.) You'll receive an administrative termination notice that explains your options and the steps you need to take to ensure your coverage continues uninterrupted.

Industrial Leave

If you're on an authorized industrial leave of absence due to an industrial injury, medical coverage for you and your dependents will continue for the duration of the leave on the same basis as a medical leave of absence, as described earlier in this section.

Family and Medical Leave

If you take an authorized family and medical leave and make arrangements to continue to pay for your medical coverage, your coverage will be continued for up to 12 weeks (or as required by state law). The amount of time off for which you are eligible may vary based on state regulations. For more information, contact your Human Resources representative.

Other Types of Leaves

If you take an authorized leave of absence other than a medical, industrial or family and medical leave, medical coverage for you and your dependents may be continued through COBRA, as defined in each applicable policy. For details about COBRA coverage, see the *Administrative* section.

If you take an authorized military leave of absence, see your local HR representative for information on continuing your benefits.

If You Are Laid Off

If you are laid off, contact your Human Resources representative for information regarding your last day of coverage.

COVID-19 Update

During the national emergency related to COVID-19, the *Coronavirus Aid, Relief and Economic Security (CARES) Act* passed by Congress in 2020 allows for the extension of certain deadlines.

For example, if you or a covered dependent is eligible to extend medical benefits through COBRA, you have until 120 days after the national emergency (or "outbreak period") ends to enroll in COBRA continuation coverage.

For details about COBRA, see the *Administrative* section. For questions related to your specific situation, call the RBC.

Raytheon Benefit Center (RBC)
800-358-1231

Coverage at Age 65

If you continue to work at the company beyond age 65, medical coverage under your company-sponsored plan will continue for you and your covered dependents. You may apply for Medicare, as described later in this section. However, regardless of whether or not you're covered by Medicare, your company-sponsored plan will pay benefits while you are covered by the plan for active employees. Then, any charges not covered by your company-sponsored plan may be eligible for payment under Medicare (if they qualify as covered Medicare expenses).

While eligible dependents age 65 and older also continue to be covered by the company-sponsored plan after they enroll for Medicare, they aren't required to enroll until after coverage under the company-sponsored plan ends. See the following section for more information.

If you participate in an HSA Advantage plan while you are enrolled in Medicare, ***note that while tax laws do not permit you to make HSA contributions or receive company contributions to your HSA, your participation in the HSA Advantage plan will continue and you may continue to use your HSA to pay for eligible expenses.***

Medicare Benefits

Medicare is divided into three parts—Part A is hospital insurance, Part B is supplemental medical insurance and Part D provides prescription drug coverage. While Medicare eligibility generally begins when you reach age 65, it's important to know that ***if you remain an active employee, you are not required to enroll in Medicare Part A, Part B or Part D when you turn 65. In addition, you do not incur any Medicare premium penalties if you wait until you leave the company to enroll in Medicare (Part A, Part B or Part D).*** If you wait until you leave the company to enroll in Medicare, you are eligible for a special enrollment period, which ends eight months from the date your employment ends or your participation in the plan for active employees ends, whichever is earlier.

Because the transition to Medicare has financial consequences, it's wise to consult your tax advisor before making any decisions about your post-65 medical coverage, such as whether or not to enroll in Medicare when you are first eligible. It's also important to know that in the majority of cases, tax advisors recommend delaying your enrollment until you leave the company.

If you do decide to enroll in Medicare, as long as you're an active employee, your company-sponsored plan remains the primary payor and Medicare is the secondary payor on any claims incurred.

For more information about making your decisions, refer to the letter the RBC will send you approximately five months before you turn 65. Questions? Call the RBC. Note that if you are disabled and receiving Medicare before age 65, contact your Social Security office when you're nearing your 65th birthday.

In the Event of Your Death

If you die while you are an active employee covered under a company-sponsored medical plan, your covered family members will have company-paid coverage for 90 days following your death. After that, they may extend their coverage under the provisions of COBRA (see *Extending Your Coverage* later in this section). Note that the 90-day period of company-paid coverage is included in your COBRA-eligible period.

Raytheon Benefit Center (RBC)
800-358-1231

Other Important Information

When Coverage Normally Ends

When Your Coverage Ends

Your company-sponsored medical coverage will end when you:

- Terminate employment. In this case, your coverage ends at 11:59:59 p.m. local time on your last day worked;
- No longer meet the plan's eligibility requirements;
- Cancel your coverage;
- Fail to make any required premium payments; or
- Commit an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact, including, but not limited to, providing false information regarding eligibility or status as a dependent.

Your coverage also will end if the plan is terminated for all employees.

When Coverage for Your Dependents Ends

Coverage for a dependent will end when:

- Your coverage ends;
- He/she no longer meets the definition of an eligible dependent, such as if you and he/she divorce or if he/she reaches age 26. In this case, coverage ends at 11:59:59 p.m. local time on the day before the event that makes him/her ineligible for coverage (i.e., the date of your divorce or the dependent's 26th birthday);
- You cancel your dependent coverage; or
- You fail to make any required premium payments.

Your dependent's coverage will also end if the plan is terminated.

Extending Your Coverage

You and your covered dependents may be eligible to extend medical coverage for up to 18 or 36 months if you experience a "qualifying event" under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA). Qualifying events include loss of a job, death, divorce or an eligible dependent reaching age 26. Under COBRA, you and/or each affected dependent may purchase coverage at 100% of the full group cost plus an additional 2% for administrative costs.

If the qualifying event is your divorce or legal separation, or if your dependent no longer qualifies for coverage under the plan, you must notify the RBC within 31 days from the last day covered to qualify for COBRA coverage. Refer to the *Administrative* section for details about COBRA coverage.

Tax Considerations

Premiums for medical coverage are paid through payroll deduction with pre-tax dollars. Since premium payments are deducted from your pay before taxes are withheld, you will not pay federal, Social Security and, in many cases, state and local income tax on this money. The actual amount of your tax savings will depend on your income tax bracket and local tax laws.

This reduction in your taxable pay may slightly impact your future Social Security benefits because you may be paying lower Social Security taxes. Generally, the tax savings you receive now far outweigh any nominal decrease in your future Social Security benefit. However, if you have any questions, you should consult a personal tax advisor.

Raytheon Benefit Center (RBC)
800-358-1231

Effect on Your Other Benefits

While pre-tax deductions reduce your pay for tax purposes, they do not have any effect on your other pay-related benefits, such as life insurance coverage or the Raytheon Savings and Investment Plan (RAYSIP). These benefits are based on your annual base pay, before any deductions are withheld.

Your Rights

This section describes your medical coverage in general terms. If any conflict arises between this description and the plan documents, or if any point is not covered, the terms of the plan document will govern in all cases. See the *Administrative* section for information related to the administration of the company's medical plans.

Health Savings Account at a glance

in this section

- When you enroll in an HSA Advantage plan, you have the opportunity to open a health savings account (HSA).

- The company makes an annual contribution to your HSA in January. The amount of the company's contribution varies by plan and coverage level. If, as a new hire, your HSA Advantage plan coverage becomes effective after January 1, the company's contribution to your HSA is pro-rated as described in the section *For New Hires*.

- You also can choose to make tax-free contributions to your HSA, lowering your taxable income. Note that state income tax laws in Alabama, California, New Hampshire, New Jersey and Tennessee differ from the federal income tax treatment of HSA contributions and earnings. You always own the money in your HSA, including the company's lump-sum contributions.

- The maximum amount you and the company combined can contribute is subject to an annual federal limit, which varies by your HSA Advantage plan coverage level. Note that if you are age 55 or older, you may make an additional $1,000 catch-up contribution to your HSA each year (including the year you turn 55).

- Note: You are not eligible to make or receive contributions to an HSA if you are enrolled in other medical coverage that is not an HSA-qualified plan, including Medicare, TRICARE, or a non-high-deductible plan or health care flexible spending account (FSA), such as may be available through your spouse's employer.

continued on next page

- Whenever you incur eligible health care expenses, you decide how to pay for them: using the money in your HSA and/or with personal funds, which will allow your HSA to grow.

- You can use the money in your HSA to pay for:
  - Covered health care expenses as defined in Section 213 of the Internal Revenue Code. This includes medical and prescription drug expenses that count toward your medical plan's deductible as well as those for which you pay coinsurance after you have satisfied the deductible;
  - Certain health expenses that an HSA Advantage plan does not cover (such as prescribed massage therapy or acupuncture) and, as such, do not count toward your deductible; and
  - Other health care expenses, such as eligible dental and vision expenses.

- Because your balance rolls over from year to year (there are no "use it or lose it" rules)—and can grow tax-free—funds in your HSA can be used to help pay for health care costs incurred in retirement, including Medicare premiums, expenses not covered by Medicare, as well as long-term care insurance premiums and eligible dental and vision expenses.

- Your HSA is portable if you leave or retire from the company.

- Fidelity Investments® administers the HSAs for the company.

- Contact information: www.netbenefits.com/raytheon, 800-544-3716.

Health Savings Account at a glance

Enrolling in a Health Savings Account (HSA)

When you enroll in a company-sponsored HSA Advantage plan—either through UnitedHealthcare (UHC) or Kaiser Permanente—you are generally eligible to make contributions to a health savings account (HSA).

The company makes an annual lump-sum contribution to your HSA in January. The amount of the company's contribution varies by plan and coverage level. If, as a new hire, your HSA Advantage plan coverage becomes effective after January 1, the company's contribution to your HSA is pro-rated as described in the section *For New Hires*.

You also can choose to make tax-free contributions to your HSA, lowering your taxable income. Note that state income tax laws in Alabama, California, New Hampshire, New Jersey and Tennessee differ from the federal income tax treatment of HSA contributions and earnings.

The maximum amount you and the company combined can contribute is subject to an annual federal limit, which varies by your HSA Advantage plan coverage level. Note that if you are age 55 or older, you may make an additional $1,000 catch-up contribution to your HSA each year (including the year you turn 55). Note that you are not eligible to make or receive contributions to an HSA if you are enrolled in other medical coverage that is not an HSA-qualified plan, including Medicare, TRICARE, or a non-high-deductible plan or health care flexible spending account (FSA), such as may be available through your spouse's employer.

You always own the money in your HSA, including the company's contributions. Your HSA balance rolls over year after year; there are no "use-it-or-lose-it" provisions. That means the money in your HSA is yours to keep until you spend it, even if you leave the company or retire.

You choose to spend the money in your HSA to pay for eligible expenses as you incur them and/or save it to pay for eligible expenses and premiums during retirement. Your HSA debit card makes it easy to access the money in your account. Plus, you don't have to submit receipts to be reimbursed for eligible expenses (just keep your receipts for tax purposes).

Fidelity Investments® administers the HSAs.

IF YOU AND YOUR SPOUSE ARE BOTH EMPLOYEES OF RAYTHEON TECHNOLOGIES AND ELIGIBLE FOR LEGACY RAYTHEON BENEFITS

If you are married to a Raytheon Technologies employee and you both are eligible for legacy Raytheon benefits, in the event either you or your spouse:

- Enrolls in an HSA Advantage plan and covers the other as a dependent, *the spouse who enrolls in the HSA Advantage plan cannot make contributions to an HSA or receive company contributions if either of you elects to participate in a health care flexible spending account (FSA). Note that you both, however, can elect to participate in a limited purpose dental and vision FSA as described under* Effects on Flexible Spending Accounts (FSAs) *later in this section.*
- Has enrolled in Medicare, *the employee not enrolled in Medicare should enroll in the HSA Advantage plan and cover the other as a dependent. By doing so, the employee enrolled in the HSA Advantage plan is eligible to make HSA contributions and receive the company's HSA contributions.*

If you enroll in an HSA Advantage plan after January 1 or if you experience a qualified change in status during the year, see *For New Hires* or *If You Have a Change in Status During the Year* later in this section for important information regarding contributions to your HSA and your HSA Advantage plan's calendar-year deductible(s) and out-of-pocket maximum(s).

IMPORTANT INFORMATION ABOUT HSAS

Coordination with Other Types of Medical Coverage

To be eligible to make and receive contributions to an HSA, the only medical coverage you (the employee) can have is through a qualified high-deductible health plan, such as an HSA Advantage plan. (Note that federal regulations allow any one who is making or receiving contributions to an HSA to carry coverage for a specific disease or illness, such as cancer coverage. If you have questions about specific additional medical coverage, call UHC at 800-638-8884 or contact Kaiser Permanente.)

This regulation means you (the employee) cannot be covered by and/or receive benefits from:

- *Your spouse's non high-deductible medical plan or health care FSA, such as may be offered through his/her employer;*
- *Medicare Part A, Part B and/or Part D;**
- *TRICARE;**
- *Medicaid;*
- *A health plan made available to retired federal employees; or*
- *The U.S. Department of Veterans Affairs (VA) or Indian Health Services (IHS) during the three months prior to you making or receiving contributions to an HSA.** Note that this is an Internal Revenue Service (IRS) exclusion and does not apply to employees who received VA or IHS preventive care, vision and/or dental services.*

You also cannot be claimed as a dependent on a tax return. In addition, note that children are not eligible to establish their own HSAs.

**If you are enrolled in Medicare or TRICARE (meaning you are not eligible to make or receive contributions to an HSA), you may enroll in an HSA Advantage plan and elect to participate in a health care FSA, if eligible. In this case, you may use your pre-tax FSA contributions to pay for eligible medical, dental and vision expenses that other benefit plans do not cover or cover only in part, including the HSA Advantage plan's deductible and coinsurance, as well as those listed in IRS Publication 502, available at www.irs.gov. Note that you have the option of enrolling in a limited purpose dental and vision FSA instead of a health care FSA. Keep in mind that, if applicable, enrollment in a health care or limited purpose dental and vision FSA is limited to the annual benefits open enrollment period or if you experience a qualified change in status. In the event of a qualified change in status, the change(s) you make must be due to and consistent with your change in status. For a description of the FSAs, see the* Flexible Spending Accounts *section, if applicable.*

***If you receive hospital and/or medical services from the VA for a* service-related disability, *you are continuously eligible to make and/or receive contributions to an HSA; the three-month period described here does not apply. In addition, as described in the above footnote, if you use the VA for non-service-related disability care, you may enroll in an HSA Advantage plan and elect to participate in either a health or a limited purpose dental and vision care FSA, if applicable.*

Effects on Flexible Spending Accounts (FSAs)

Since health care FSAs meet the IRS definition of other medical coverage, employees who are making or receiving contributions to an HSA cannot also participate in a health care FSA, either through the company, if applicable, or a spouse's employer. Note that HSA participants may use a limited purpose dental and vision FSA for eligible dental and vision expenses, if applicable. For more information about the limited purpose dental and vision FSA for HSA participants, see the Flexible Spending Accounts *section of this handbook, if applicable.*

Effects on Other Benefits

Participating in an HSA does not affect eligibility for all other company-provided benefits you are otherwise eligible for, such as dental, vision, accidental death and dismemberment insurance, disability coverage, as well as participation in LifeResources, the company's employee assistance program, and company wellness programs. To confirm your eligibility for these benefits, see the other sections of this handbook or go to Desktop Benefits.

If You and Your Spouse Are Both Employees of Raytheon Technologies and Eligible for Legacy Raytheon Benefits

If you and your spouse are both employees of Raytheon Technologies and eligible for legacy Raytheon benefits, you may each have an HSA as long as you both enroll separately in an HSA Advantage plan. If one of you enrolls in an HSA Advantage plan and covers the other, only the one who enrolls in the HSA Advantage plan can open an HSA. Before deciding, you should consider premiums, out-of-pocket costs and the company's HSA contribution associated with each option and coverage level. For more information and examples, see If You and Your Spouse Are Both Employees of Raytheon Technologies and Eligible for Legacy Raytheon Benefits *in the* Medical *section.*

The restrictions listed here do not apply to your HSA-covered dependents. That means if your HSA Advantage plan-enrolled spouse or dependent child becomes eligible for another form of medical coverage, he/she continues to remain eligible for coverage with your company-sponsored HSA Advantage plan and you may continue to use any funds in your HSA to pay for eligible expenses that your dependent incurs. For more information, contact Fidelity or call the Raytheon Benefit Center (RBC) at 800-358-1231 and follow the prompts to speak with an HSA Advantage plan expert.

If your spouse has a health care FSA through his/her employer and carries a balance for use on claims incurred in the first quarter of the following calendar year (meaning that company offers a grace period), IRS rules prohibit you from contributing to your HSA, receiving the company's lump-sum contribution to your HSA and using your HSA to pay for eligible expenses until after April 1.

Fidelity Investments
www.netbenefits.com/raytheon
800-544-3716

APPROACHING AGE 65?
BE SURE TO UNDERSTAND YOUR MEDICAL COVERAGE OPTIONS

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

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

If You Choose to Enroll in Medicare Part A and/or Part B as an Active Employee

If, in consultation with your tax advisor, you intend to enroll in Medicare Part A and/or Part B when you first become eligible, you can elect an HSA Advantage plan for the year you will become eligible and elect an HSA. In this case, you are eligible to receive the company's lump-sum contribution to your HSA in January (as long as the company's contribution is made before you enroll in Medicare) and make your own contributions (not to exceed the annual federal limit listed later in this section) until you enroll for Medicare. Note that before you enroll in Medicare, your tax advisor may suggest that you maximize your contributions to your HSA, subject to IRS proration rules (including by making a direct contribution to your HSA).

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

While all contributions to your HSA must stop once you enroll in Medicare, your participation in an HSA Advantage plan will continue automatically. For years where your Medicare status prohibits you from making or receiving contributions to your HSA, you can elect to contribute to a health care (or a limited purpose dental and vision) FSA during the benefits open enrollment period, if applicable. Note that if your spouse or dependents enroll in Medicare but you (as the employee) do not, you can continue making contributions and receiving company contributions to your HSA. You may also continue to use any funds in your HSA to pay for eligible expenses incurred by your tax dependents.

No matter which company-sponsored medical plan you participate in, as long as you're an active employee, your company-sponsored plan remains the primary payor and Medicare is the secondary payor on any claims incurred.

For more information about making your decisions, refer to the letter the RBC will send you approximately five months before you turn 65. In addition, the document available by going to https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/FS3-Enroll-in-Part-A-and-B.pdf provides detailed information on rules and guidelines. Questions? Call the RBC at 800-358-1231.

In the event the RBC is notified that you have enrolled in Medicare, the RBC will send you a letter asking you to confirm or deny your enrollment. If you:

- Confirm your Medicare enrollment, *your HSA contributions will end and Payroll will withdraw any company contributions you were not eligible to receive. To withdraw any ineligible contributions you may have made to your HSA, contact Fidelity.*
- Deny that you enrolled in Medicare, or if you do not respond to the RBC inquiry, *no changes will be made to your HSA or to your HSA contributions.*

Note that in all cases, the tax implications of your Medicare enrollment on your eligibility to receive or make HSA contributions are your responsibility. For more information, see Taxes and Penalties Associated with HSA Contributions Made in Error *later in this section.*

If you participate in Medicare Part A, B and/or D, you can elect an HSA Advantage plan *without funding an HSA.* If you currently participate in Medicare, you should not elect an HSA during open enrollment or at any other time during the year if you become eligible to make a medical plan election.

If you will enroll in Medicare during the calendar year following open enrollment, while you may elect an HSA during open enrollment, all contributions to your HSA must stop when your participation in Medicare begins.

If contributions are made to your HSA while you are enrolled in Medicare (either by the company or you), you will be subject to taxes and penalties. For more information, see *Taxes and Penalties Associated with HSA Contributions Made in Error* later in this section.

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

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800-544-3716

Contributions to Your HSA

Each year, the IRS determines the maximum amount that the combination of you and the company may contribute to HSAs.

You choose how much you want to contribute to your HSA, up to a certain limit. Contributions are deducted from your paycheck on a pre-tax basis in equal installments throughout the year. You also have the option of making a lump-sum contribution directly to your account, in which case you realize any tax savings when you file your tax return. To make a lump-sum contribution to your HSA, go to www.netbenefits.com/raytheon.

You may decrease or increase the amount of your HSA contribution (up to the annual limit) at any time through *Desktop Benefits* (from the *My Life Changes* tab, select *Change Your HSA Contribution Amount)* or by calling the RBC at 800-358-1231. Any change you request, including stopping or starting contributions, becomes effective with the next available pay period. Your new HSA contribution election amount will be deducted in equal amounts over the remaining pay periods in the year, after adjusting for any contributions you and/or the company made prior to you making the change. Note that the amount you elect to contribute via payroll deduction when you enroll remains on record until the end of the calendar year or until you make another election, whichever comes first.

The amount of the company's contribution depends upon the HSA Advantage plan and coverage level you elect, and is subject to change each year depending on general health-care costs and business needs. The company's contribution is deposited annually in January in a lump sum regardless of how much you choose to contribute.

The following chart shows HSA contribution limits for 2021.

The maximum amount you and the company combined can contribute to your HSA is subject to an annual federal limit. For 2021 limits, see the chart on this page.

2021 HSA Contribution Limits

		UHC HSA Advantage 1 Kaiser Permanente HSA Advantage Plans (The Kaiser Permanente Plans Are Available in California, Colorado and the Mid-Atlantic States)		UHC HSA Advantage 2	
Coverage Level	**Total Maximum Contribution***	**Company Contribution**	**Your Maximum Contribution***	**Company Contribution**	**Your Maximum Contribution***
Employee only	$3,600	$ 750	$2,850	$ 500	$3,100
Employee and spouse	$7,200	$1,125	$6,075	$ 750	$6,450
Employee and child(ren)	$7,200	$1,125	$6,075	$ 750	$6,450
Employee and family	$7,200	$1,500	$5,700	$1,000	$6,200

*If you are age 55 or older, you may make an additional $1,000 catch-up contribution to your HSA each year. If both you and your spouse are 55 or older, you each must have an HSA in order for both of you to be eligible to make a catch-up contribution. While you may continue to participate in an HSA Advantage plan when you enroll in Medicare Part A, Part B and/or Part D, all HSA contributions must stop.

Annual Benefits Open Enrollment

Each year during the benefits open enrollment period, you must actively elect how much you want to contribute to your HSA during the following calendar year—***your current contribution election does not carry forward.***

If you do not make an election during the annual benefits open enrollment period, your contributions will default to $0 as of the following January 1. Note that if this occurs, you can later choose to increase your contribution by calling the RBC at 800-358-1231.

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For New Hires

If your HSA Advantage plan coverage becomes effective after January 1, such as is the case for new hires, the company's contribution to your HSA is prorated based on the number of pay periods that remain in the calendar year once all the following have occurred:

- Your enrollment in an HSA Advantage plan is complete and you have provided any required dependent verification, ***and***
- You have successfully opened your HSA at Fidelity, ***and***
- Data exchanges among the Payroll, RBC and Fidelity systems are complete. Note that depending on the timing of the various data exchanges, the date used to prorate the company's HSA contribution may be delayed by one or more pay periods.

For example, if you join the company during the company's 18th biweekly pay period and enroll in individual coverage with UHC HSA Advantage 1 within 31 days of the date shown on your *Personalized Enrollment Worksheet* or of your date of hire (whichever is later), your medical coverage is effective on your first day of work. Assuming everything is in order by the 20th biweekly pay period and you do not have other health care coverage that would make you ineligible to make or receive HSA contributions (described earlier in this section), the company would contribute a pro-rated amount of $201.92 (7/26 of the total annual contribution amount, representing the number of biweekly pay periods remaining in that year, including the 20th) of the $750 annual company contribution—in a lump sum to your HSA. Note that it may take one or two pay periods for charges for medical plan premiums to go into effect. In that case, you are not charged for premiums back to the date your coverage began.

Continuing with this example (individual coverage with UHC HSA Advantage 1), in addition to being eligible to contribute the maximum employee amount for the year (for 2021, $2,850), you may choose to make up any difference between the pro-rated amount the company contributes and the total IRS maximum contribution amount for the year ($3,600 for 2021). For example, you may contribute a total of $3,398.08 to your HSA in 2021—the maximum employee contribution for your coverage level ($2,850) *plus* the remaining amount of what the company would have contributed had you been employed for the full year ($548.08). Note that to be eligible to make this additional contribution, you must enroll in an HSA by December 1 and remain covered by an HSA Advantage plan the following year.

Remember that if you are eligible to make a catch-up contribution, you may contribute an additional $1,000 to your HSA each year beyond the limits stated earlier.

In terms of the deductible(s) and out-of-pocket maximum(s) for your HSA Advantage plan, note that regardless of when your coverage with an HSA Advantage plan becomes effective, the entire calendar-year deductible(s) and out-of-pocket maximum(s) apply for the remainder of that year; they are not pro-rated.

If You Have a Change in Status During the Year

If, as the result of a qualified change in status that occurs after January 1 and before December 1, your coverage level *increases* (such as from employee only to employee plus family):

- The company's contribution to your HSA is adjusted to match your new coverage level and prorated to reflect your new coverage level for the rest of the year, and you may contribute up to the new employee maximum contribution amount.
- Any eligible expenses incurred to date by you and/or your covered dependents prior to your change in status continue to apply toward your medical plan's new calendar-year deductible and out-of-pocket maximum.

If your qualified change in status results in your coverage level *decreasing* (such as from employee plus family to employee only):

- Any company contribution you have received that is in excess of the company contribution amount for your new coverage level remains in your account.

In determining the annual IRS limit, note that any contributions made to an HSA with a previous employer are combined with contributions made to your Fidelity HSA (both yours and the company's). It is your responsibility to keep track of the combined total, as the company has no knowledge of your prior HSA participation.

If you make excess contributions to your HSA (including any contributions you may make when not eligible), you will be subject to taxes and penalties. For more information, see *Taxes and Penalties Associated with HSA Contributions Made in Error* later in this section.

You can change your HSA contribution amount at any time through *Desktop Benefits* or by calling the RBC. Your change will become effective within one or two pay periods after the date you request the change. Keep in mind that if you exceed the annual IRS maximum contribution amount, you will be subject to standard income tax rates plus a penalty.

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Note that you may need to adjust the amount you contribute to your HSA to ensure you do not exceed the maximum total contribution amount for your new coverage level. Any excess contributions are subject to standard income tax rates plus a penalty. For more information, consult with your tax advisor.

- Any expenses your previously covered dependent(s) had incurred *do not* apply toward your medical plan's new deductible or out-of-pocket maximum.

If you have questions about how a change in status affects contributions to your HSA, contact Fidelity.

For details and examples about how a change in status affects your medical plan's deductible or out-of-pocket maximum, see the section that describes your medical plan. Questions about your situation? Contact your medical plan.

Owning the Money in Your Account

There are no vesting rules for your HSA. You always own all of the money in your account.

Carryover Feature

Any money remaining in your HSA at the end of the calendar year carries over from year to year—there aren't any "use it or lose it" rules. You decide how you want to use your account balance and, if you leave or retire from the company, your HSA is portable. That means you can choose to keep your HSA with Fidelity or transfer it to an alternate trustee.

If you carry your account balance forward into the next calendar year, you can invest the money in your HSA. For details, see *Investing Your HSA.*

Transferring Money from Another HSA to Your Fidelity HSA

If you have an HSA balance with another trustee (such as was available through a previous employer) and would like to consolidate it with your HSA at Fidelity, you can transfer balances from another HSA custodian to your Fidelity HSA through a transfer of assets transaction. The tax advantages will stay in effect—and transfers are not included when calculating your maximum annual HSA contribution amount. To initiate a transfer of assets, contact Fidelity.

Note that the following restrictions may apply:

- You may make only one transfer of assets to an HSA during a 12-month period. Transfers must be completed within 60 days of the date you receive the distribution from the other HSA. Direct transfers from retirement accounts, such as 401(k), 403(b), and 457 plans, are not permitted.
- You may also make a one-time contribution to an HSA from amounts distributed from an IRA as a direct trustee-to-trustee transfer. Note that this contribution will count toward your maximum annual contribution amount.

Opening and Activating Your HSA

Whether as a new hire or during the benefits open enrollment period, the process to open your HSA with Fidelity begins when you enroll in an HSA Advantage plan and any other benefits via *Desktop Benefits*.

After you enroll in an HSA Advantage plan, *Desktop Benefits* will prompt you to make an HSA contribution election (for new hires, for the remainder of that calendar year; for all participants during open enrollment, for the following calendar year). You will also be required to review and agree to the terms and conditions of the *Custodial Agreement*. When you click on *Accept and Return to Summary,* you provide electronic consent and agree to the stated terms that will open your HSA. After you have made or revised your other benefit elections, click on *Accept All* and then *Submit* to finish the enrollment process. This brings you to the *Process Complete* page.

Once Fidelity receives notification that you have enrolled (generally within one week), you can log on to NetBenefits and click on *Activate HSA*. From here, simply follow the instructions to activate the features of your account, including making your beneficiary election(s) and requesting your Fidelity HSA® debit card.

By offering access to payroll deduction, using Fidelity to manage your HSA is convenient. Please note that you can open an HSA with an alternate trustee at any point while enrolled in an HSA Advantage plan. You can choose to roll over your entire account balance (including the company's contributions) to an alternate trustee while you are still employed by the company.

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www.netbenefits.com/raytheon
800-544-3716

Keep in mind that the *USA Patriot Act* requires financial institutions, in this case Fidelity, to acquire and maintain a physical address for all account holders. If your address on file with the RBC is a PO box, you must provide Fidelity with a physical address in order to open your HSA. To do so, go to NetBenefits, click *Activate HSA* and enter your legal/residential address and the other required information under *Personal Information.* If you have any questions, call Fidelity.

It's important to note that until Fidelity is provided with your physical address, your HSA cannot be opened. Also, by providing a physical address to Fidelity, you are not changing your address of record with the RBC.

Once everything is in order, Fidelity will mail you a welcome kit verifying that your HSA is opened. This kit will contain your account number, customer service and website information, bank disclosures, a schedule of fees and other important information.

HSA Debit Card

If you request an HSA debit card when you activate the features of your HSA through NetBenefits (click on *Activate HSA)*, Fidelity will send you a debit card. You can use your debit card to pay for eligible expenses—such as specialist visits, emergency room care and prescription drugs—wherever the provider accepts Visa.® You can only use the debit card to access funds deposited to your account.

For security purposes, your HSA debit card is mailed in an unmarked envelope. The letter you receive with your debit card will include instructions on how to activate your card.

If you need additional debit cards, go to NetBenefits. If you encounter any problems ordering cards online, call Fidelity.

HOW TO INCREASE THE SECURITY OF YOUR FIDELITY HSA DEBIT CARD

To enhance the security of your HSA debit card, you can set up a personal identification number (PIN)—a four-digit code that many pharmacies and provider offices now require.

To establish your PIN, simply call 844-201-8403 from the phone you registered when you opened your account. Select option 1, and then option 4. Note that if you call from any other phone, you'll need to provide additional information to complete the authentication process.

When you call, you'll need:

- *Your debit card (number, expiration date and security code);*
- *The cardholder's Social Security number and date of birth; and*
- *The account number for your Fidelity HSA.*

Are any supplemental cards associated with your account? Either you or the cardholder must establish a PIN for each card.

Note that your HSA debit card can be processed as a debit or credit payment transaction. Remember that the card can only be used for qualified health care expenses and cannot be used at an ATM or to get cash back on purchases.

Naming Your Beneficiary

Because you always own the money in your HSA, you should elect a beneficiary(ies) when you activate the features of your HSA through NetBenefits (click on *Activate HSA)*. To designate a beneficiary, follow the prompts when you activate your account via NetBenefits.

If there is no beneficiary(ies) designation on record at the time of your death, your account balance will be transferred to your legal spouse, or if you are not married, to your estate.

For more information about what happens to your HSA in the event of your death, see the *Custodial and Deposit Agreement* in the welcome kit you will receive when your account is first opened.

Managing Your HSA

Account Statements

To check your account, go to NetBenefits. Your account statement shows:

- Your current balance;

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800-544-3716

- All transactions you made during the plan year;
- Investment earnings; and
- Any fees charged.

If you'd like a paper copy of your HSA statement, go to NetBenefits and print it or call Fidelity to request one.

Using Your HSA

You can use your HSA to pay for a variety of medical, pharmacy, dental and vision expenses, including surgery, inpatient hospital care, maternity care, lab tests, doctor visits, mental health and treatment for substance-related and addictive disorders, dental cleanings, fillings, vision exams, contact lenses and laser-vision surgery.

You can also use your HSA to pay for deductibles, coinsurance, COBRA premiums, long-term care insurance and Medicare expenses. In addition, in 2020, the IRS expanded the list of eligible expenses to include menstrual products and over-the-counter medications, including antacids, pain relievers and treatments for cold, flu and allergy symptoms, *without a prescription from a physician.*

For a complete list of eligible expenses, see IRS Publication 502. IRS Publication 969 also lists a few additional expenses that are eligible to be paid from an HSA. Both publications can be found on the IRS website (www.irs.gov).

Accessing the Funds in Your HSA

Generally, your network provider will send the bill directly to the administrator of your medical plan (UHC or Kaiser Permanente). UHC or Kaiser Permanente will then send you and your provider an *Explanation of Benefits,* showing the amount that is owed. If you have not yet met your deductible, your provider will send you a bill, based on the information from the *Explanation of Benefits.*

Remember: One of the biggest benefits of an HSA is that it allows you to save for future health care expenses. If you pay for eligible expenses with personal funds, your HSA balance can continue to grow.

You can choose how to pay your bill: using money in your HSA and/or with personal funds. If you choose to use your HSA, you can pay with your HSA debit card, write a check from your HSA or use the online bill payment feature available via NetBenefits.

If you choose to use your HSA to pay for your expenses, you may only use funds that are in your HSA at the time you pay your bill. In other words, if you have an eligible expense that exceeds your current HSA balance, you cannot pay for it using your HSA until your HSA contributions exceed the amount owed.

You may use your available HSA funds to pay for eligible expenses incurred by those dependents you claim on your federal tax return, even if they are not covered by your HSA Advantage plan.

Note that if you use HSA funds for non-qualified expenses, the money used is included in your annual income and becomes taxable. In addition, the money is subject to a 20% penalty. This penalty is waived if you are older than age 65, if you become disabled or if you die.

Investing Your HSA

When you open a Fidelity HSA, which is a brokerage account, your contributions are initially invested in a "core account," Fidelity Cash Reserves, which unlike other investment options is insured by the Federal Deposit Insurance Corporation (FDIC). This conservative money market fund holds both the company's and your contributions until you invest or withdraw them.

As described in the welcome kit you will receive from Fidelity, you can choose to invest the money in your HSA in a variety of investment options—including more than 5,000 mutual funds, individual stocks and bonds, treasuries and certificates of deposit (CDs). The choices you make depend on your investment objective, time horizon and risk tolerance.

After your account is open and funded, you can invest the money in your account using various "Trade" options available on NetBenefits (from the homepage, click on the *Quick Links* dropdown list from the *Health Savings Account* tile).

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800-544-3716

Other Important Information

Taxes

Federal taxes are not applied to:

- Your contributions (both pre-tax contributions made through payroll deduction and any lump-sum contributions), any catch-up contributions, the company's contributions and any investment earnings on any contributions to your account while the money remains in an HSA; or
- Payments made from an HSA for qualified health-care-related expenses.

Although most states comply with federal regulations regarding HSA taxation, state income tax laws in Alabama, California, New Hampshire, New Jersey and Tennessee differ from the federal income tax treatment of HSA contributions and earnings. You are encouraged to consult a tax advisor for the applicable state tax information where you live.

Taxes and penalties will apply if you use HSA funds for non-qualified expenses. You are also subject to tax penalties if you and/or the company contributes to your HSA once your participation in Medicare Part A, B and/or D begins.

Each year, Fidelity is required to provide you with a:

- Form 1099-SA, which shows all distributions; and
- Form 5498-SA, which shows all contributions and your year-end account value.

HSA participants are required to file a Form 8889 with their annual tax returns, showing their total distributions for qualified health care expenses.

TAXES AND PENALTIES ASSOCIATED WITH HSA CONTRIBUTIONS MADE IN ERROR

If you made HSA contributions in excess of the amount that you're permitted to make or you receive or make contributions when you are not eligible (such as if you enroll in Medicare Part A and/or Part B), you will be subject to taxes and penalties on the excess or ineligible amount. In some specific situations, you may be able to avoid the penalties if you arrange to have the excess amount distributed to you before your tax-filing deadline. A refund of excess contributions can be processed through NetBenefits. For assistance, call Fidelity.

Fees

Similar to many bank accounts, your HSA is charged a quarterly maintenance fee. Additional fees—such as a check re-order fee and an overdraft fee (for writing a check for more than the balance in your HSA)—may also apply. Fidelity determines all fees. The welcome kit you will receive shortly after your account is open will include a complete list of fees, including those charged by the investment fund manager, as detailed in each available fund's prospectus.

Plan Security

Your HSA is a proprietary savings account that you—as the account holder—own to save or spend at your discretion. Your HSA can only be used for current or future qualified health care expenses.

Your Rights

This section describes HSAs in general terms. If any conflict arises between this description and the plan document or the *Health Savings Account (HSA) Custodial and Deposit Agreement* or if any point is not covered, the terms of the plan document or the *Health Savings Account (HSA) Custodial and Deposit Agreement* will govern in all cases.

If you have any questions about the HSA Advantage plans or your participation in one of the plans or this section of your handbook, call your medical plan and see the *Administrative* section of this handbook. If you have questions about the HSAs, call Fidelity.

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www.netbenefits.com/raytheon
800-544-3716

CVS Caremark Prescription Drug Program at a glance

in this section

- Prescription drug coverage for company-sponsored UnitedHealthcare (UHC) medical plans is administered as a separate program by CVS Caremark. CVS Caremark also administers prescription drug coverage for eligible expatriate employees and their Global Choice–enrolled dependents who fill a prescription *inside* the United States.

- Prescription drug benefits with CVS Caremark do not apply to participants covered by Kaiser Permanente or to expatriate employees and their Global Choice–enrolled dependents who fill a prescription *outside* the United States. For information about prescription drug benefits for these plans, refer to the applicable medical plan section.

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

- Your out-of-pocket cost for prescription drugs varies based on your medical plan; if you need a short-term or long-term prescription; and, in most cases, whether your prescription is for a generic, preferred brand or non-preferred brand drug. In all cases, your out-of-pocket costs are lower when you use a CVS Caremark network pharmacy.

- If you have specific questions about your CVS Caremark prescription drug coverage, or for more information about covered services and supplies, go to www.caremark.com or call Customer Care toll-free at 866-329-4023.

CVS Caremark-Administered Prescription Drug Program

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

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

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

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

Note that your out-of-pocket costs are lower when your doctor prescribes up to a 90-day supply. For example, with the UHC HSA Advantage plans, your out-of-pocket costs with Maintenance Choice are lower because the percentage you pay is based on lower contracted rates for mail-service prescriptions. With the UHC Out-of-Area plan, the UHC Hawaii plan and Global Choice (inside the United States), a 90-day supply of a generic maintenance drug is available for the same out-of-pocket cost as two 30-day supply copayments or coinsurance amounts.

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

Important Information for Members Residing in Arkansas, Colorado, Idaho, Oregon or Washington. Because you do not have access to a CVS Pharmacy or Maintenance Choice, you can fill your 90-day supply of maintenance prescriptions at any participating Walmart or Kroger pharmacy for the same out-of-pocket cost as with the CVS Caremark Mail Service Pharmacy.

Important Information for Members Residing in New Mexico. Because you do not have access to a CVS Pharmacy or Maintenance Choice, you can fill your 90-day supply of maintenance prescriptions at any participating Walmart pharmacy for the same out-of-pocket cost as with the CVS Caremark Mail Service Pharmacy.

Important Information for Members Residing in Hawaii. Note that you can visit a Longs Drugs store to purchase short-term prescriptions as well as maintenance prescriptions through the Maintenance Choice program.

CVS Caremark Prescription Drug ID Card

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

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

Prescription drug benefits for company-sponsored UHC medical plans are administered as a separate program by CVS Caremark. CVS Caremark also administers prescription drug coverage for eligible expatriate employees and their Global Choice-enrolled dependents who fill a prescription *inside* the United States.

While your coverage is accepted at any retail pharmacy nationwide, your out-of-pocket costs are lower when you use one of the more than 65,000 pharmacies nationwide that participate in CVS Caremark's national network (including Walgreen's, Rite-Aid, Walmart, Kroger and CVS Pharmacy (including those located in Target stores)). ***Note that you are not required to use a CVS Pharmacy when you purchase a 30-day supply of a prescription.***

Prescription drug coverage with CVS Caremark does not apply to participants covered by Kaiser Permanente or to expatriate employees and their Global Choice–enrolled dependents who fill a prescription *outside* the United States. For information about prescription drug benefits for these plans, refer to the applicable medical plan section.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

SAVING MONEY ON PRESCRIPTION DRUGS

Before you head to the pharmacy to fill your next prescription for a generic drug, it pays to check for less costly alternatives—especially since CVS Caremark frequently reviews and updates its list of generic alternatives.

To see if generic alternatives are available and determine how much certain medications will cost you, go to www.caremark.com (click on Check Drug Costs*). Note that you will need to register with www.caremark.com in order to access this site; see* Using the CVS Caremark Website *later in this section for details.*

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

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

If you do end up purchasing an over-the-counter version or using a manufacturer's coupon, the amount you pay will not count toward your medical plan's calendar-year deductible or out-of-pocket maximum.

Remember: The UHC HSA Advantage plans cover generic preventive prescription drugs that treat chronic conditions as well as diabetes insulin at 100% (no deductible, no coinsurance, no out-of-pocket cost). Note that the list of drugs that are covered at 100% is subject to change.

***Want to save money on prescription drugs?** Do a little research and talk with your doctor to see if the drug you take is available in a less costly generic alternative. Many times, alternative generics are just as effective and can be purchased for a fraction of the cost.*

*For example, Esomeprazole, the generic version of Nexium,® is used to treat heartburn and acid reflux. This common drug can cost as much as $184 for a 30-day supply. Consider talking to your doctor about switching to the generic Omeprazole, another alternative to Nexium, which costs just $1.22 for a 30-day supply!**

* Note that prescription drug prices are subject to change.

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In-Network Prescription Drug Benefits

UHC HSA Advantage Plans

With the UHC HSA Advantage plans, eligible prescriptions are covered at a certain percentage after you meet the plan's deductible (see the chart below). The only exceptions are for certain prescriptions that qualify as preventive care as mandated by the *Affordable Care Act* (ACA), see the sidebar to the right for a description, and those on the Treasury Guidance list, specifically:

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

To review the Treasury Guidance list, go to www.caremark.com or call Customer Care. Note that any coinsurance you pay for brand-name preventive prescription drugs on the Treasury Guidance list ***does not apply*** to the plan's in-network deductible; see the chart below for details.

Your coinsurance depends on your UHC HSA Advantage plan, as shown in this chart:

Plan	Your Cost* For	
	Up to a 30-Day Supply At a CVS Caremark Network Pharmacy	Up to a 90-Day Supply Through Maintenance Choice (CVS Caremark Mail Service or CVS Pharmacy)**
UHC HSA Advantage 1	Covered at 80% after deductible***	Covered at 80% after deductible***
UHC HSA Advantage 2	Covered at 90% after deductible***	Covered at 90% after deductible***

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

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

As described above, the UHC HSA Advantage plans cover preventive prescription drugs on the federal Treasury Guidance list ***before you meet the plan's deductible (generics covered at 100%, no out-of-pocket cost, coinsurance applies for brand-name drugs). Note that any coinsurance you pay ***does not apply*** to the UHC HSA Advantage plan's in-network deductible. To review the Treasury Guidance list, go to www.caremark.com or call Customer Care.

IMPORTANT NOTE REGARDING THE UHC HSA ADVANTAGE PLANS

In most cases, any amount you pay toward the cost of a prescription drug applies to your UHC HSA Advantage plan's in-network deductible and in-network out-of-pocket maximum. This helps you receive a higher level of benefits sooner.

If your provider prescribes—or you request—a preferred brand-name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available, you pay the difference between the retail costs of the brand-name drug and its generic equivalent plus *the applicable coinsurance.* ***The cost difference you pay does not apply to your plan's deductible or out-of-pocket maximum.***

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

If you are a new employee and want to know more about prescription drug coverage, go to www.caremark.com. From here you can locate network providers and see how much certain medications will cost you (click on *Check Drug Costs).* Note that you will need to register with www.caremark.com in order to access this site.

You can reduce your out-of-pocket prescription drug costs by using generic drugs whenever possible. Tell your doctor you prefer generic medications, which meet the same standards for safety, strength, purity and quality as the brand-name alternatives. Then, confirm with your pharmacist that you are receiving a generic-equivalent medication. For more information, see *Generic Drugs* later in this section.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

UnitedHealthcare Out-of-Area Plan, UnitedHealthcare Hawaii Plan and Global Choice (Inside the United States)

Your out-of-pocket cost depends on the type of medication (generic, preferred brand or non-preferred brand), its cost and where you purchase it, as described in this chart:

Type of Prescription	Your Cost* For	
	Up to a 30-Day Supply At a CVS Caremark Network Pharmacy	Up to a 90-Day Supply Through Maintenance Choice (CVS Caremark Mail Service Pharmacy or CVS Pharmacy)**
Generic	$7 copayment	$14 copayment
Preferred brand* **	You pay 20% of the drug's cost	You pay 20% of the drug's cost
Non-preferred brand	You pay 30% of the drug's cost	You pay 30% of the drug's cost

*_**For the UHC Out-of-Area and Hawaii plans only:**_ While amounts you pay toward the cost of prescription drugs do not apply to the plan's deductible, prescription drug copayments and coinsurance apply to the plan's out-of-pocket maximum. This helps you receive a higher level of benefits sooner.

If your provider prescribes—or you request—a preferred brand-name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available, you pay the difference between the retail costs of the brand-name drug and its generic equivalent *plus* the applicable generic copayment. ***The cost difference you pay does not apply to your medical plan's deductible or out-of-pocket maximum.***

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

***The CVS Caremark-administered prescription drug benefit uses a formulary for paying claims. Any brand-name drug that is not on the formulary is considered a non-preferred brand and is subject to the non-preferred brand coinsurance.

IMPORTANT NOTE REGARDING THE UHC OUT-OF-AREA AND HAWAII PLANS

While amounts you pay toward the cost of prescription drugs do not apply to the Out-of-Area or Hawaii plan's deductible, prescription drug copayments and coinsurance apply to the plan's out-of-pocket maximum. This helps you reach the plan's out-of-pocket maximum and receive a higher level of benefits sooner.

If your provider prescribes—or you request—a preferred brand-name drug specifying "dispense as written" (which means substitutions are not permitted) and a generic equivalent is available, you pay the difference between the retail costs of the brand-name drug and its generic equivalent plus *the applicable generic copayment.* ***The cost difference you pay does not apply to your medical plan's deductible or out-of-pocket maximum.***

Save Money with Maintenance Choice!

As illustrated here, a 90-day supply of a generic maintenance drug is available for the same out-of-pocket cost as you would pay for a 60-day supply (two fills of a 30-day supply) at a CVS Caremark network pharmacy.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

Out-of-Network Prescription Drug Benefits

If you choose to fill a prescription at a retail pharmacy that does not participate in CVS Caremark's national network, your claim will be reimbursed at a lower rate. In this case, the amount you pay depends on the medical plan you're enrolled in, as shown below:

Medical Plan	Your Cost*
UHC HSA Advantage 1	After you meet the deductible, you pay 40% of the cost *plus* the difference between the amount charged by a CVS Caremark-network pharmacy and the out-of-network pharmacy
UHC HSA Advantage 2	After you meet the deductible, you pay 10% of the cost *plus* the difference between the amount charged by a CVS Caremark-network pharmacy and the out-of-network pharmacy
UHC Out-of-Area plan, UHC Hawaii plan and Global Choice (inside the United States)	You pay 20% of the cost *plus* the difference between the cost of a CVS Caremark–network pharmacy and the out-of-network pharmacy

*Note that benefits described apply to prescriptions that are not required to be filled through Maintenance Choice or the CVS Caremark Specialty Pharmacy Program.

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

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

Using the CVS Caremark Website

To learn how to get the most from the CVS Caremark-administered prescription drug benefit, go to www.caremark.com, where you'll find convenient, time-saving features.

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

Once you have registered, you can:

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

Manage Your CVS Caremark Coverage on the Go

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

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

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

Learning More by Telephone

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

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

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

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

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

EXTRACARE HEALTH CARD

With CVS Caremark, you will receive an ExtraCare Health card. When you use this card at a CVS Pharmacy or through www.cvs.com, you receive a 20% discount on CVS Pharmacy-brand health items, some of which are also eligible for reimbursement from a health care flexible spending account (FSA), if applicable. FSA-eligible expenses include bandages, contact lens solutions, first-aid supplies and thermometers. (For more information about FSA-eligible expenses, see the Flexible Spending Accounts *section, if applicable.) Other items that are eligible for the ExtraCare Health card discount but not for FSA reimbursement include digital thermometers, hand sanitizer, vitamins and supplements. (For a complete list, call the toll-free number on the back of your ExtraCare Health card.)*

This discount is available to all employees with prescription drug benefits through CVS Caremark; **you do not have to be enrolled in a health care FSA to use the ExtraCare Health card.** *Note that the discount does not apply to brand-name over-the-counter items, prescription drugs or sale items.*

Using the ExtraCare Health Card

In order to receive the discount, simply show your ExtraCare Health card when you make your purchase at a CVS Pharmacy. You can also use your ExtraCare Health card when you shop at www.cvs.com. To do so, create an account (or log on to your existing account) and add your ExtraCare Health card number under ExtraCare Information. *When you shop online, eligible items are identified with an* ExtraCare Health Savings *logo.*

Additional Benefits with the ExtraCare Health Card

In addition to the 20% discount, your ExtraCare Health card maintains the same benefits as the standard CVS ExtraCare card, which is available to any CVS Pharmacy customer. In other words, you'll also be eligible to receive:

- *One Extra Buck® for every two prescriptions filled at a CVS Pharmacy;*
- *2% back in Extra Bucks on all your in-store and online CVS purchases; and*
- *Instant savings on items featured in the CVS weekly circular.*

If you currently have an ExtraCare card, you should replace it with your ExtraCare Health card to receive the 20% discount on CVS Pharmacy-brand health items. You can call the toll-free number on the back of your ExtraCare Health card to transfer any accumulated savings from your existing ExtraCare card.

Note that participants in an HSA Advantage plan are eligible for a limited purpose dental and vision FSA, not a health care FSA, if applicable.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

Using the CVS Caremark Prescription Drug Benefit

Short-Term Prescriptions

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

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

- Ask your retail pharmacist;
- Use the online pharmacy locator at www.caremark.com; or
- Call Customer Care.

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

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

Note that for maintenance medications (described below), you have the option of purchasing *up to three 30-day supplies* of each maintenance drug at a CVS Caremark network pharmacy before you select a Maintenance Choice option (also described below). If you do not, beginning with the fourth fill, your claim will be rejected and you will be required to pay 100% of the drug's non-negotiated cost at a retail pharmacy—including a CVS Pharmacy.

Maintenance Choice (Long-Term Prescriptions)

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

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

For each prescription, you choose the approach that works best.

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

No matter which option you choose, you have access to a number of support services, as outlined in the following section.

If you have a 90-day supply of a maintenance prescription, you can fill it by mail or at any CVS Pharmacy (or applicable alternate pharmacy as described earlier). Remember, for any prescriptions you take on an ongoing basis, you must get a 90-day prescription and choose a Maintenance Choice option.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

Service	Contact Information		
	Any Retail Pharmacy Participating in the CVS Caremark Network	CVS Pharmacy*	CVS Caremark Mail Service Pharmacy
Online access to manage or refill your prescription(s)	Check with your pharmacy of choice	www.cvs.com	www.caremark.com (see *Using the CVS Caremark Website* earlier in this section for more information)
Refills available by phone	Call your pharmacy of choice	Call your local CVS Pharmacy	Call the toll-free phone number on your prescription drug ID card 24 hours a day, seven days a week
Access to pharmacists	Available in-person whenever your pharmacy of choice is open	Available in-person whenever your local CVS Pharmacy is open	Call the toll-free phone number on your prescription drug ID card 24 hours a day, seven days a week

*If you are eligible for in-network coverage with a pharmacy other than a CVS Pharmacy as described earlier, contact that pharmacy for customer service details.

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

Using the CVS Caremark Mail Service Pharmacy

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

The CVS Caremark Mail Service Pharmacy can be used with either a new prescription or to refill an existing prescription. For a new prescription, ask your doctor to write it for up to a 90-day supply, plus refills (if appropriate) for up to one year. Then follow these steps:

Ordering a New Prescription	
Method	**Steps**
Through your health care provider	• Ask your health care provider to electronically submit your prescription and any refills directly to CVS Caremark.
Online	• If you are ordering a prescription online for the first time, you will need to register at www.caremark.com. (See *Using the CVS Caremark Website* earlier in this section for instructions.) • After you have registered with CVS Caremark, simply log on and: - Enter your email address and password. - Click on *Start a New Prescription* on the homepage and follow the instructions. You will need to have your prescription drug ID card number.
With your smartphone	• Download the CVS and/or Caremark apps (available in your app store for either iPhone or Android platforms) and follow the prompts.
By mail	• Fill out a *CVS Caremark Mail Service Pharmacy Order Form.* • Mail the form with your prescription and your share of the prescription's cost to CVS Caremark. To determine your share of the cost, or request additional order forms and envelopes, go to www.caremark.com or call Customer Care.

To take full advantage of CVS Caremark's long-term prescription benefits, ask your doctor to prescribe your maintenance medication for up to 90-day supplies with refills for up to a year.

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

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

To refill an existing prescription, follow these steps:

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

Using a CVS Pharmacy to Fill Your Long-Term Prescription

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

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

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

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

ABOUT SCRIPTSYNC

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

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

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

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

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

If you are eligible for and enroll in a health care FSA, you can use your BenefitWallet debit card to pay for eligible prescription drug expenses from your FSA at the time of purchase. If applicable, see the *Flexible Spending Accounts* section for more information.

If you are enrolled in a UHC HSA Advantage plan, you can use your HSA debit card to pay for eligible prescription drug expenses using the funds in your HSA. See the *Health Savings Account* section for more information.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

Paying for Your Prescriptions

You may pay for your medication at an in-network pharmacy with a credit or debit card (i.e., Visa®, MasterCard®, Discover®/NOVUS® or American Express®); a check; or a money order.

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

Please note: The pharmacist's judgment and dispensing restrictions—such as quantities allowable—govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of dispensed controlled substances.

CVS CAREMARK'S PHARMACY ADVISOR

A More Personal Approach to Diabetes Care

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

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

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

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

CVS CAREMARK'S FASTSTART® PROGRAM

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

To find out if FastStart can help you:

- *Call 800-875-0867. FastStart representatives are available Monday through Friday from 7 a.m. to 7 p.m. Central Time (CT), or*
- *Go to www.caremark.com/portal/asset/NewRX_Fax_Form_v91.pdf. You will need to register before your participation begins.*

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

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

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

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

SPECIALTY PHARMACY PROGRAM

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

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

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

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

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

Generic Drugs

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

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

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

Primary/Preferred Drug List

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

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

A Note about Infertility Coverage

Infertility coverage is limited to $10,000 per lifetime for prescription drugs that are related to infertility and covered by CVS Caremark.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

Protecting Your Privacy and Safety

CVS Caremark promotes the safe and effective use of medications. When your prescription is filled through a CVS Caremark network pharmacy or the CVS Caremark Mail Service Pharmacy, CVS Caremark pharmacists use the health and prescription information they have on file for you to consider many important clinical factors, including drug selection, dosing, interactions, duration of therapy and allergies.

If there is a potential problem, an experienced, registered pharmacist may contact your doctor. If you have any questions about your prescriptions, call Customer Care and talk to a CVS Caremark pharmacist.

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

Prior Authorization

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

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

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

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

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN PRESCRIPTION DRUGS

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

- *Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the* American Hospital Formulary Service*, or the* United States Pharmacopoeia Dispensing Information*, as appropriate for the proposed use; or*
- *The subject of an ongoing clinical investigation to determine FDA approval, regardless of whether the trial is actually subject to FDA oversight; or*
- *Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.*

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

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

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

Other Important Information

When Coverage Normally Ends

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

Claims Appeal

If a claim is denied, you have the right to request a review of the claim by contacting the carrier. See *Applying for Benefits* in the *Administrative* section for details.

CVS Caremark
www.caremark.com

Customer Care
866-329-4023 (available 24/7)

Vision
at a glance

in this section

- The company offers two vision coverage options—the Basic Vision Plan and the Vision Plus Plan.

  Note that while Global Choice provides some level of vision coverage, expatriate employees who elect Global Choice are eligible to elect vision coverage with one of the plans described in this section.

- You may choose from four coverage levels: employee only, employee and spouse, employee and child(ren) or employee and family.

- New employee? If you want vision coverage, you must enroll in a vision plan within 31 days of the date shown on your *Personalized Enrollment Worksheet* or your date of hire, whichever is later. Your coverage becomes effective on your first day of work.

- You may make changes to your vision coverage (i.e., add or drop dependents, add or drop coverage, or change plans) each year during the benefits open enrollment period.

- Outside of the annual benefits open enrollment period, you may make changes only under certain circumstances as outlined in *Changing Your Coverage, At Other Times of the Year* later in this section.

- Both vision plans provide coverage for a wide range of vision care services, including routine examinations, lenses, frames and contact lenses. The plans differ in how often benefits are payable and the retail allowance for benefits.

continued on next page

For the names of VSP doctors in your area, go to www.vsp.com or call VSP Customer Care at 888-426-3937.

- If you are required to wear eye protection at work, you are eligible to receive prescription safety eyeglasses, with supervisory approval, free of charge from a VSP doctor (not from a participating retail chain) every two calendar years—even if you do not elect vision coverage.

- The amount you pay for vision coverage depends on the vision plan you choose and your level of coverage. You pay for vision coverage with pre-tax dollars through payroll deduction.

- The claims administrator makes the final decision as to whether a particular service is covered, based on the benefits available under the plan in which you are enrolled. For more information about covered services for the plan you are enrolled in, contact your vision claims administrator. For information about how to appeal a denied claim, see the *Administrative* section.

Vision
at a glance

Enrolling in a Vision Plan

Coverage Levels

If you choose to enroll in a company-sponsored vision plan, you may choose from four coverage levels. This allows you to choose the coverage level that best meets your specific family situation while ensuring that you only pay for the coverage you actually need.

The four coverage levels are:

- Employee only;
- Employee and spouse;
- Employee and child(ren); or
- Employee and family (spouse and children).

You may select different coverage levels for medical, dental and vision coverage. For example, you may choose medical and dental coverage for your entire family and vision coverage for just yourself.

If you are married to a Raytheon Technologies employee and you are both eligible for legacy Raytheon benefits, you may each select the plan of your preference or only one of you may elect coverage, depending upon your needs and the cost of your plan options.

Note that when you cover eligible dependents, you and your dependents must be enrolled in the same vision plan. In other words, you cannot choose the Basic Vision Plan for yourself and the Vision Plus Plan for your children.

Eligible Dependents

You may enroll your eligible dependents for vision coverage. Eligible dependents include your:

- *Spouse.* A spouse includes a *common-law spouse* if your common-law marriage was established in a state that legally recognizes common-law marriage; all requirements of that state have been met; and the common-law marriage has not ended.

  Note that a spouse from whom you are divorced or legally separated is *not* eligible for coverage. Note also that a party to a civil union is not a spouse;
- *Children before their 26th birthday,* including natural children, legally adopted children (including children lawfully placed for adoption), stepchildren and foster children, regardless of residency, financial dependence, student status, employment status or marital status;
- *Children and other dependents up to their age of majority (usually 18) for whom you are a legal guardian.* If you or your spouse is not the child's parent (or step-parent) and the child is not a foster or adopted child, you must have a court order designating you or your spouse as the child's legal guardian or as the person who has legal responsibility for the care, control and custody of the child that is equivalent to the responsibility of a legal guardian. (Please note that if the court order extends the guardianship beyond the age of majority, the child's coverage will still end no later than the child's 26th birthday.) In all cases, the child must also meet the IRS definition of a dependent of you or your spouse; and
- *Unmarried children age 26 and older who are disabled as well as other dependents age 26 and older for whom you have legal guardianship who are disabled,* if approved by a company-sponsored health plan to be disabled. In general, to qualify, the disabled child must have become disabled before age 26 and be incapable of self-sustaining employment because of intellectual disability, serious mental illness, physical sickness or injury. Coverage may continue for as long as your coverage continues and as long as your child remains incapacitated and is otherwise eligible for coverage.

Note that if you are eligible to add a dependent to your company-sponsored vision plan, you will need to provide dependent eligibility verification (such as a marriage certificate, birth certificate or joint tax return). Your dependent's coverage will not be effective until the verification documents are received. Complete details are on *Desktop Benefits.*

If your covered dependent becomes ineligible for coverage during the year (for example, due to divorce or legal separation), you must remove your dependent from your coverage as of the date that person is no longer eligible for coverage. Coverage for your dependent child who reaches age 26 automatically ends at 11:59:59 p.m. local time on the day before his/her 26th birthday. For more information, see *Changing Your Coverage* later in this section.

Can't locate one or more of the documents that are required to add a dependent to your company-sponsored vision plan? For a fee, Vitalchek can provide official government certificates (e.g., birth, marriage, divorce). For more information, go to www.vitalchek.com.

VSP
www.vsp.com
Customer Care: 888-426-3937

Cost of Coverage

The amount you pay for vision coverage depends on:

- The vision plan you choose; and
- Your level of coverage.

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

The cost of coverage is provided in your new hire materials as well as during annual benefits open enrollment. For current costs and additional information, contact the Raytheon Benefit Center (RBC) at 800-358-1231.

Initial Enrollment for New Employees

As a newly hired employee, you may enroll in a company-sponsored vision plan within the 31-day period following the date shown on your *Personalized Enrollment Worksheet* or your date of hire, whichever is later. This coverage remains in effect for the rest of the calendar year. Note that there is no default vision coverage; if you do not enroll within the 31-day period, you will not have vision coverage for the remainder of that calendar year.

The coverage you elect is effective retroactively to your first day of work, provided you enroll within the 31-day period. Coverage for your dependents generally begins at the same time as your coverage, or as soon as the dependent becomes eligible and his/her verification documents are confirmed (see *Eligible Dependents* earlier in this section for more information). This coverage remains in effect for the remainder of the calendar year. You may change your vision plan and/or coverage level during the next benefits open enrollment period or sooner if you meet the guidelines outlined in *Changing Your Coverage* later in this section.

It's very important that you understand the enrollment procedures and enroll for the coverage you want when you are first eligible. Once your coverage begins, it will be in effect for the remainder of the calendar year. You may not change your elected coverage during the year (unless you meet certain criteria described in *Changing Your Coverage* later in this section).

VSP
www.vsp.com
Customer Care: 888-426-3937

Changing Your Coverage

After you make your initial enrollment elections as a new employee, you are permitted to make changes to your vision coverage as outlined here. In all cases, if you are adding eligible dependents, all necessary verification documents must be confirmed before a dependent's coverage becomes effective. See *Eligible Dependents* earlier in this section for more information.

Annual Benefits Open Enrollment

Each year, the company conducts a benefits open enrollment during which you may make changes to your vision coverage (i.e., add or drop dependents, add or drop coverage, or change plans). Any changes you make become effective the following January 1.

IMPORTANT INFORMATION ABOUT CHANGING YOUR VISION PLAN

If you are enrolled in the Vision Plus Plan and receive glasses and frames or contact lenses during the year, and then elect to change from the Vision Plus Plan to the Basic Vision Plan during open enrollment, you will not be eligible for glasses and frames or contact lenses until the second year you're enrolled in the Basic Vision Plan. For more information about switching between the Vision Plus Plan and the Basic Vision Plan, contact the RBC at 800-358-1231.

At Other Times of the Year

Outside of the annual benefits open enrollment period, you are permitted to make changes to your vision coverage (add or remove a dependent, or add or drop coverage) only in the event of the following:

- If you have a qualified change in status, as follows:
  - Marriage.
  - Divorce or legal separation.
  - Gain or loss of an eligible dependent, such as a child reaching age 26.
  - Change in your, your spouse's or your dependent's employment status, for example:
    - Gain or involuntary loss of vision coverage,
    - Change from full time to part time or vice versa,
    - Transfer between different contracts or positions, providing there is a change in the plans that are available to you or a significant change in the cost of coverage (for example, to or from a Service Contract Act or RayTech position), or
    - Begin or end an unpaid leave of absence.

  In the situations above, the change(s) you make must be due to and consistent with your change in status. For details, see the following inset **Making Changes to Your Coverage Outside the Annual Open Enrollment Period.**
- If your spouse's employer holds benefits open enrollment at a time other than the company's—and, as a result of its benefit offerings, you would like to make a change.
- If you, your spouse or your dependent enrolls in Medicare or Medicaid, or if you, your spouse or your dependent loses eligibility for Medicare or Medicaid.

If any of these situations apply to you, you can make your change on *Desktop Benefits* at https://raytheon.benefitcenter.com or by calling the RBC at 800-358-1231.

The only time you can change your vision plan is during the annual benefits open enrollment period.

If you enroll in a vision plan and add to your family through birth or adoption during that year, ***you must enroll your child within 31 days of the birth date or, for adoptions, the custody date.*** You can enroll your child either online through *Desktop Benefits* at https://raytheon.benefitcenter.com or by calling the RBC at 800-358-1231. ***Note that if you do not add your newborn or newly adopted child, he/she will not be covered—even if you currently have family coverage.***

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MAKING CHANGES TO YOUR COVERAGE OUTSIDE THE ANNUAL OPEN ENROLLMENT PERIOD

Remember: If you are eligible to make a change to your vision coverage due to a qualified change in status (as listed earlier in this section), ***the change(s) you make must be due to and consistent with your change in status. This means you cannot add or remove other still-eligible dependents from your coverage or choose a different plan.***

Event	What Happens/Action Required
You gain an eligible dependent by marriage	• You have six months from the date of your marriage to add your spouse to your coverage. • You must provide dependent eligibility verification (such as a marriage certificate or joint tax return). Your dependent's coverage will not be effective until the verification documents are received and confirmed.
You divorce, legally separate or your common law marriage to your spouse terminates	• You must remove your dependent from your coverage on or before the date that person is no longer eligible for coverage. Coverage for that dependent ends as of 11:59:59 p.m. local time on the day before the event that makes him/her ineligible for coverage. • ***If you don't remove your previously eligible dependent from your coverage as of the date of the event, you must reimburse the company for any claims incurred after that date.***
You gain an eligible dependent by birth or adoption	• You must enroll your child within 31 days of his/her birth/adoption, even if you already have family coverage. • You will need to provide dependent eligibility verification (birth certificate or proof of custody). Your dependent's coverage will not be effective until the verification documents are received and confirmed. • Once the verification documents are confirmed, coverage is effective as of the birth or custody date. If you make your change before the date of the qualified change, coverage becomes effective as of the date of the qualified change.
Your child ages out of the plan	• If your child reaches age 26, his/her coverage automatically ends at 11:59:59 p.m. local time on the day before his/her 26th birthday.
You take or return from a personal leave	• Your active coverage ends and you will be offered COBRA continuation coverage. • If you elect COBRA coverage, any amounts you have accrued toward the current calendar-year's plan allowances while you were an active employee will transfer and be applied to your COBRA coverage. If you return to work within the same calendar year, the cumulative totals will then transfer back to your active plan. To ensure an accurate accounting, contact your plan carrier. • Note that when you return to work, you will have two options: Enroll in the same coverage you had before going out on leave (both the same plan and covering the same dependent(s)) or drop coverage completely. For more information, see *Continued Coverage under COBRA* in the *Administrative* section. Note that if you return to work during the same calendar year and enroll in the same coverage you had before going out on leave, any previously incurred claims will continue to apply toward the current calendar-year's plan allowances.

COVID-19 Update

During the national emergency related to COVID-19, the *Coronavirus Aid, Relief and Economic Security (CARES) Act* passed by Congress in 2020 allows for the extension of certain deadlines.

If you need to enroll yourself or an eligible dependent in your benefits because you or he/she has lost other coverage or he/she is newly eligible to be added to your coverage, you now have until 90 days after the national emergency (or "outbreak period") ends to enroll in coverage, retroactive to the event effective date. You will still be required to pay premiums, retroactively, for the entire time you and any family members are covered.

This section provides an overview of events that are considered qualified changes in status. For questions related to your specific situation, call the RBC.

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ABOUT HIPAA

The Health Insurance Portability and Accountability Act of 1996 *(HIPAA) is designed to help keep personal health information private as well as to make it easier for you and your family members to have continued group health plan coverage when you or a family member loses coverage through an employer. Here is a summary of the act's provisions.*

Protected Health Information. *The company's health benefit plans'* HIPAA Notice of Privacy Practices for Protected Health Information *explains what "protected health information" is; how the plans may use and disclose this information; and how you can exercise your rights concerning this information. HIPAA requires that the plans remind you that this notice is available on* Desktop Benefits *at https://raytheon.benefitcenter.com (click on the link to* Notice of Privacy Practices *in the* Resource Library *under* My Resources*) or by calling the RBC at 800-358-1231.*

If Your Coverage Ends. *If your coverage under a company-sponsored health plan ends, you may request a written certificate of coverage from the RBC.*

VSP® Vision Care

Routine eye care is an important part of your overall health. That's why the company offers two vision plans to choose from:

- Basic Vision Plan, and
- Vision Plus Plan.

Both plans provide coverage for routine examinations and services. The vision plans are provided through VSP Vision Care—the nation's largest vision benefits provider.

No matter which plan you choose, each time you need routine vision care, you may choose either a VSP doctor or a non-VSP provider. You may receive care from any licensed optometrist, ophthalmologist or optician. Generally, your cost is lower when you use a VSP doctor.

For the names of VSP doctors in your area, go to www.vsp.com or call VSP Customer Care at 888-426-3937. VSP Vision Care administers all routine vision-related claims regardless of whether your care is provided by a VSP doctor or a non-VSP provider.

Using a VSP Doctor

Using a VSP doctor can help you save money on routine vision expenses. To make the most of your benefits, simply follow these steps:

1. Choose a VSP doctor;
2. Make an appointment, identifying yourself as a VSP Vision Care-covered individual through Raytheon Technologies. Your doctor will confirm your eligibility and coverage with VSP Vision Care; and
3. Pay only your copayment for care when you receive it. You will also be responsible for any charges that your plan does not cover, such as cosmetic items, tinted lenses and, in the case of the Basic Vision Plan, polycarbonate lenses for adults after the discount has been applied.

When you follow these steps, VSP Vision Care will pay the balance directly to your doctor. You do not need to complete any claim forms.

Note: If you do not follow these steps, your provider will be considered a non-VSP provider and benefits will be limited to the reimbursement amounts listed on the appropriate summary of benefits chart under "From a Non-VSP Provider."

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ABOUT VSP PARTICIPATING PROVIDERS

VSP offers a nationwide network of VSP doctors and participating retail chains—including Costco, Visionworks, Cohen's Fashion Optical, Wisconsin Vision, Walmart, Sam's Club and Rx Optical—providing many options in finding the eye-care provider that is right for you. You can choose from more than 38,000 providers in 98,000 locations. This means chances are good that your current eye care doctor is a VSP doctor.

If you go to a participating retail chain partner, tell your provider your coverage is with VSP—you don't need an ID card and there are no claim forms. Note that while ID cards are not required, you can obtain an ID card when you go to www.vsp.com and enter your user ID and password.

To find participating doctors and retail chain partners in your area, confirm eligibility or verify benefits, contact VSP. Note that coverage and discounts at participating retail chains may differ from coverage and discounts available through VSP doctors.

Using a Non-VSP Provider

If you choose to receive routine vision care from a non-VSP provider, you may ask the provider to contact VSP directly to confirm your eligibility before your appointment. Once confirmed, your provider may submit your claim to VSP. In this case, VSP will directly reimburse your provider the allowed amount, which can then be deducted from your bill. Note that VSP will ask for your permission before discussing allowed reimbursement amounts with your non-VSP provider.

If your provider does not contact VSP to confirm your eligibility, you must pay the full cost of your care when you receive it. To receive reimbursement, you can upload receipts and submit your request online at www.vsp.com (link to the *Benefits & Claims* section), or submit a *VSP Member Reimbursement Form* along with a copy of your itemized receipt (keep your original receipt for your records) to:

VSP Vision Care
Attn: Out-of-Network Claims
P.O. Box 385018
Birmingham, AL 35238-5018

VSP will reimburse either a provider or you for up to the amounts shown in the summary of benefits chart for your plan (see the column "From a Non-VSP Provider" in the charts for both plans, which appear later in this section). If your provider charges more than this amount, you are responsible for paying the difference. Your claim must be submitted *within one year* of the date you receive the vision services or supplies.

If a claim is denied, you will receive a written explanation. You have the right to request a review of the claim by contacting the carrier. See *Applying for Benefits* in the *Administrative* section for more details.

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Basic Vision Plan

The Basic Vision Plan covers a range of vision services, including routine eye exams and a wide array of eyewear.

Basic Vision Plan Summary of Benefits Chart

This chart provides an overview of coverage under the Basic Vision Plan. For a more detailed description of your coverage, refer to *What the Basic Vision Plan Covers* later in this section.

Benefit	Frequency	Copayment	From a VSP Doctor	From a Non-VSP Provider[1]
Routine examination	One every calendar year	$10	Fully covered	Up to $43
Lenses[2]	One pair every 2 calendar years	$10 (total for lenses and/or frames)	Fully covered	Up to $35 single Up to $51 bifocal Up to $68 progressives Up to $68 trifocal Up to $80 lenticular
Frame	One every 2 calendar years	$10 (total for lenses and/or frames)	Covered up to the retail plan allowance of $130 ($180 for featured brands[3]) plus 20% discount on amount over the plan allowance	Up to $45
Contact lenses[4]				
Necessary	Every 2 calendar years	$10	Fully covered	Up to $210
Elective	Every 2 calendar years	None	Up to $105 for contact lens exam (fitting and evaluation) and contacts	Up to $105
Anti-reflective and polycarbonate lens enhancements for adults	Every 2 calendar years	N/A	Average 20% to 25% discount at VSP participating locations	Not covered

[1] Non-VSP provider benefits will be paid minus any applicable copayments.

[2] Polycarbonate lenses for covered dependent children up to age 19 are covered at 100% when purchased from a VSP doctor only.

[3] For a list of featured frame brands or to find a doctor who carries them, contact VSP. Note that featured frame brands are available only from VSP doctors, not participating retail chains.

[4] Contact lenses are in lieu of lenses and frames.

What the Basic Vision Plan Covers

The Basic Vision Plan covers a wide variety of vision services when you use a VSP doctor, including the following:

- ***Routine eye exams*** are covered in full every calendar year after a $10 copayment.
- ***Frames*** are covered in full up to the plan allowance, after a $10 copayment (total for frames and/or lenses). Benefits are provided for one pair every two calendar years in lieu of contact lenses. If the frame costs more than the plan allowance, you will receive a 20% discount on the amount over the plan allowance (the additional amount you pay), as long as you see a VSP doctor. For 2021, the plan allowance is $130 ($180 for featured brands). Note that featured frame brands are available only from VSP doctors, not participating retail chains. For details, contact VSP.
- ***Spectacle lenses*** are covered in full after a $10 copayment (total for frames and/or lenses). Benefits are provided for one pair every two calendar years in lieu of contact lenses. Covered lenses include single vision, lined bifocal, lined trifocal or lenticular lenses. Polycarbonate lenses for covered dependent children up to age 19 are covered at 100% when purchased from a VSP doctor only. (While the plan does not cover polycarbonate

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lenses or anti-reflective coatings for adults, you are eligible for certain discounts when you visit a VSP doctor.) The cost of lenses or lens options that are not necessary for visual welfare is *not* covered.

- ***Medically necessary contact lenses*** are covered in full after a $10 copayment with a VSP doctor when prescribed for certain medical conditions, including:
  - Following cataract surgery;
  - To correct extreme vision problems that cannot be corrected with spectacle lenses; and
  - Certain conditions of anisometropia or keratoconus.

  Benefits are provided once every other calendar year.
- ***Elective contact lenses*** are covered for up to $105 toward the cost of the contact lens materials and the provider's professional fees, including contact lens evaluation examination, fitting costs and any follow-up evaluations (in lieu of lenses and frames). Benefits are provided once every other calendar year. If you obtain contact lenses from a participating provider, you are also eligible for a 15% discount off the provider's professional services (discount does not apply to materials).

Vision Plus Plan

If you or your eligible dependent needs more vision care coverage than is provided by the Basic Vision Plan, you may enroll in the Vision Plus Plan.

Vision Plus Plan Summary of Benefits Chart

The Vision Plus Plan covers the same range of vision services as the Basic Vision Plan but provides benefits more often and has higher retail allowances. This chart provides an overview of coverage under the Vision Plus Plan.

For a more detailed description of your coverage, refer to *What the Vision Plus Plan Covers* later in this section.

Benefit	Frequency	Copayment	From a VSP Doctor	From a Non-VSP Provider[1]
Routine examination	One every calendar year	$10	Fully covered	Up to $43
Lenses	One pair every calendar year	$10 (total for lenses and/or frames)	Fully covered	Up to $35 single Up to $51 bifocal Up to $68 progressives Up to $68 trifocal Up to $80 lenticular
Frame	One every calendar year	$10 (total for lenses and/or frames)	Covered up to the retail plan allowance of $140 ($190 for featured brands[2]) plus 20% discount on amount over the plan allowance	Up to $45
Contact lenses[3]				
Necessary	Every calendar year	$10	Fully covered	Up to $210
Elective	Every calendar year	None	Up to $120 for contact lens exam (fitting and evaluation) and contacts	Up to $105
Anti-reflective and polycarbonate lens enhancements for children and adults	Every calendar year	N/A	Fully covered. Other lens enhancements: Average 20% to 25% discount at VSP participating locations	Not covered

[1] Non-VSP provider benefits will be paid minus any applicable copayments.

[2] For a list of featured frame brands or to find a doctor who carries them, contact VSP. Note that featured frame brands are available only from VSP doctors, not participating retail chains.

[3] Contact lenses are in lieu of lenses and frames.

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What the Vision Plus Plan Covers

The Vision Plus Plan covers a wide variety of vision services when you use a VSP doctor, including the following:

- ***Routine eye exams*** are covered in full every calendar year after a $10 copayment.
- ***Frames*** are covered in full up to the plan allowance, after a $10 copayment (total for frames and/or lenses). Benefits are provided for one pair every calendar year in lieu of contact lenses. If the frame costs more than the plan allowance, you will receive a 20% discount on the amount over the plan allowance (the additional amount you pay), as long as you see a VSP doctor. For 2021, the plan allowance is $140 ($190 for featured brands). Note that featured frame brands are available only from VSP doctors, not participating retail chains. For details, contact VSP.
- ***Spectacle lenses*** are covered in full after a $10 copayment (total for frames and/or lenses). Benefits are provided for one pair every calendar year in lieu of contact lenses. Covered lenses include single vision, lined bifocal, lined trifocal or lenticular lenses. Polycarbonate lenses and anti-reflective coatings for children and adults are covered at 100% when purchased from a VSP doctor only. The cost of lenses or lens options that are not necessary for visual welfare is *not* covered.
- ***Medically necessary contact lenses*** are covered in full after a $10 copayment with a VSP doctor when prescribed for certain medical conditions, including:
  - Following cataract surgery;
  - To correct extreme vision problems that cannot be corrected with spectacle lenses; and
  - Certain conditions of anisometropia or keratoconus.

  Benefits are provided once every calendar year.
- ***Elective contact lenses*** are covered for up to $120 toward the cost of the contact lens materials and the provider's professional fees, including contact lens evaluation examination, fitting costs and any follow-up evaluations (in lieu of lenses and frames). Benefits are provided once every calendar year. If you obtain contact lenses from a participating provider, you are also eligible for a 15% discount off the provider's professional services (discount does not apply to materials).

Additional Available Benefits

Value-Added Discounts and Special Programs

With either the Basic Vision Plan or the Vision Plus Plan, you can take advantage of value-added discounts and special programs (subject to change) through VSP doctors (not through participating retail chains):

- If you order ***additional prescription or non-prescription glasses or sunglasses*** (lenses and frames) from a VSP doctor within 12 months of your routine exam, you are eligible for a 20% discount.
- VSP partners with leading contact lens manufacturers to provide VSP members with ***exclusive discount offers.***
- A 15% discount on ***fees for contact lens exams*** (fitting and evaluation) as long as you see a VSP doctor within 12 months of a covered routine eye exam.
- Discounts on ***laser-vision-correction surgery*** through VSP-contracted surgery centers. Discounts vary by location, but average between 15% and 20% off the usual and customary price. If the participating laser center is offering a temporary price reduction, VSP members receive 5% off the advertised price. After surgery, you may use your frame allowance (if eligible) for non-prescription sunglasses from any VSP doctor. Go to www.vsp.com for the name of a VSP-participating laser vision doctor near you.

For more information on any of these discounts and programs, go to www.vsp.com or ask your VSP doctor for details.

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Low-Vision Coverage

The vision plans provide low-vision coverage from either a VSP doctor or a non-VSP provider (not through participating retail chains). This benefit is available for those patients whose vision loss is sufficient enough to prevent reading, moving around in unfamiliar surroundings and completing desired tasks. If the patient is eligible for low-vision benefits, the VSP doctor will obtain prior authorization from VSP Vision Care. Benefits under this plan include, but are not limited to:

- Supplemental testing for low-vision evaluation;
- Low-vision prescription services; and
- Optical and non-optical aids.

If low-vision supplemental testing is approved, VSP Vision Care will pay up to a maximum of $125 per covered individual every two calendar years. If low-vision aids are approved, VSP Vision Care will pay 75% of the approved amount, up to a maximum of $1,000 per covered individual (less any amount paid for supplemental testing) every two calendar years. The patient is responsible for the remaining 25% of the approved amount in addition to any amount over the maximum.

Extra Cost Items

Vision coverage is designed to cover your vision needs rather than cosmetic materials. Therefore, if you select certain optional items, you will have to pay an additional amount. However, the cost of such items is generally less if you purchase them from a VSP doctor. For some items, such as frames that cost more than the plan allowance, discounts are available when you use a VSP doctor.

Examples of optional items include:

- ***Blended or progressive*** multifocal lenses;
- ***Coated or laminated lenses,*** such as scratch-resistant and anti-glare coatings for the Basic Vision Plan;
- ***Contact lenses,*** in excess of the plan allowance;
- ***Cosmetic lenses;***
- ***Frames*** that are valued at more than the plan allowance;
- ***Optional cosmetic processes;***
- ***Oversized lenses;*** and
- ***UV-protected lenses.***

For more information about extra cost items, contact VSP.

SAFETY EYEGLASSES AS REQUIRED BY OSHA

If you work in an area or on a job that requires eye protection, you are eligible to receive prescription safety eyeglasses with permanently affixed or attachable side shields from a VSP doctor every two calendar years (not through participating retail chains). This benefit includes one repair every two years, based on the date of the first repair. You are eligible for the safety eyeglasses benefit even if you do not enroll in a vision plan. There are no copayments for safety glasses. However, you will be responsible for the cost of any lens options not covered under the plan and/or frame costs that exceed the plan allowance.

You must obtain authorization for safety eyeglasses from your manager or supervisor. The authorization must be presented to the VSP doctor at the time of your appointment. You can receive your safety eyeglasses from your network provider at the same time you receive your examination and regular eyewear. However, if you receive an eye exam for regular eyewear and safety eyewear at the same time, you will be responsible for paying the eye exam copayment.

For more information on how the safety eyeglasses program works, call VSP Customer Care; check with your manager or supervisor; or refer to the Environmental, Health and Safety *section of the oneRTN homepage at http://onertn.ray.com/resources/ehs/ih/SafetyGlasses/index.com.*

Note that the prescription safety eyeglasses benefit described here is available only in the U.S. In the case of an overseas assignment where safety eyeglasses are required, be sure to follow the procedures outlined here *before* you are deployed.

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What the Plans Do Not Cover

While both vision plans provide coverage for a wide range of vision services, there are some services that are not covered, including, but not limited to:

- Any eye examination or corrective eyewear that is required as a ***condition of employment;***
- Corrective vision services, treatments and materials of an ***experimental nature;***
- Services or materials otherwise covered, at no cost, under any type of ***governmental contract or another insurance contract;***
- Lenses and frames furnished under this plan that are ***lost, broken or scratched,*** except at the normal intervals when services are otherwise available;
- ***Medical or surgical eye treatment;***
- Benefits payable under a company-sponsored ***medical plan or other medical program;***
- ***Non-prescription lenses,*** when the refractive error is less than a +/–.50 diopter power;
- ***Non-prescription sunglasses,*** when the refractive error is less than a +/–.50 diopter power;
- ***Orthoptics or vision training*** and any supplemental testing;
- Expenses ***paid by an employer,*** whether under workers' compensation law or otherwise; and
- ***Two pairs of glasses*** in lieu of bifocals.

As Your Needs Change

If You Take a Leave of Absence

Medical Leave

If you're on an authorized medical leave of absence, vision coverage for you and your dependents will continue for up to 24 months. You pay the premium cost in effect during your leave directly to the company. If your leave is for fewer than 90 days, your deductions for vision coverage will be taken from your paycheck on a retroactive basis when you return to work. These deductions will be taken over the same number of pay periods that you were out. If your leave is for 90 days or more, you will receive a bill for the premium cost of your vision coverage and instructions for payment.

After you have been on a medical leave of absence for 24 months, your employment will be administratively terminated and your vision coverage will end. You can extend your coverage under COBRA regulations (see *Extending Your Coverage* later in this section). You'll receive an administrative termination notice that explains your options and the steps you need to take to ensure your coverage continues uninterrupted.

Industrial Leave

If you're on an authorized industrial leave of absence due to an industrial injury, vision coverage for you and your dependents will continue for the duration of the leave on the same basis as a medical leave of absence, as described earlier in this section.

Family and Medical Leave

If you take an authorized family and medical leave, and make arrangements to continue to pay the cost of your coverage, vision coverage for you and your dependents will be continued for up to 12 weeks (or as required under state law).

Remember, if you participate in an HSA Advantage plan, you can use your HSA to pay for eligible expenses that your vision plan does not cover or covers only in part. For more information about HSAs, see the *Health Savings Account* section.

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Other Types of Leaves

If you take an authorized leave of absence other than a medical, industrial or family and medical leave, you can continue vision coverage for you and your dependents through COBRA. For more information, see *Extending Your Coverage* later in this section.

If you take an authorized military leave of absence, see your local HR representative for information on continuing your benefits.

If You Are Laid Off

If you are laid off, contact your Human Resources representative for information regarding your last day of coverage.

Other Important Information

When Your Coverage Ends

Your vision coverage will end when you:

- Terminate employment. In this case, your coverage ends at 11:59:59 p.m. local time on your last day worked;
- No longer meet the plan's eligibility requirements;
- Cancel your coverage; or
- Fail to make the required payment.

Your coverage will also end if a plan is terminated for all employees.

When Coverage for Your Dependents Ends

Coverage for a dependent will end when:

- Your coverage ends;
- He/she no longer meets the definition of an eligible dependent, such as if you and he/she divorce or if he/she reaches age 26. In this case, coverage ends at 11:59:59 p.m. local time on the day before the event that makes him/her ineligible for coverage (i.e., the date of your divorce or the dependent's 26th birthday);
- You cancel your dependent coverage; or
- You fail to make the required payment.

Coverage will also end if dependent coverage under the plan is terminated for all employees.

Extending Your Coverage

You and your covered dependents may be eligible to extend vision coverage for up to 18 or 36 months if you lose coverage as the result of a "qualifying event" under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA). Qualifying events include loss of a job, death, divorce or a dependent reaching age 26. Under COBRA, you and/or each affected dependent may purchase coverage at 100% of the full group cost plus an additional 2% for administrative costs.

If the qualifying event is your divorce or legal separation, or if your dependent no longer qualifies for coverage under the plan, you must notify the RBC at 800-358-1231 within 31 days from the last day covered to qualify for COBRA coverage. Refer to the *Administrative* section for details about COBRA coverage.

Tax Considerations

You pay for vision coverage through payroll deduction with pre-tax dollars. Since the cost is deducted from your pay before taxes are withheld, you will not pay federal, Social Security and, in many cases, state and local income tax on this money. The actual amount of your tax savings will depend on your income tax bracket and local tax laws.

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This reduction in your taxable pay may slightly impact your future Social Security benefits because you may be paying lower Social Security taxes. Generally, the tax savings you receive now far outweigh any nominal decrease in your future Social Security benefit. However, if you have any questions, you should consult a personal tax advisor.

Effect on Your Other Benefits

While pre-tax deductions reduce your pay for tax purposes, they do not have any effect on your other pay-related benefits, such as life insurance coverage or Raytheon Savings and Investment Plan (RAYSIP) participation. These benefits are based on your annual base pay before any deductions are withheld.

Claims Appeal

If a claim is denied, you will receive a written explanation. You have the right to request a review of the claim by contacting the vision carrier. Please see *Applying for Benefits* in the *Administrative* section for details.

Your Rights

This section describes the vision plans in general terms. If any conflict arises between this description and the plan documents, or if any point is not covered, the terms of the plan documents will govern in all cases. See the *Administrative* section for information related to the administration of the vision plans.

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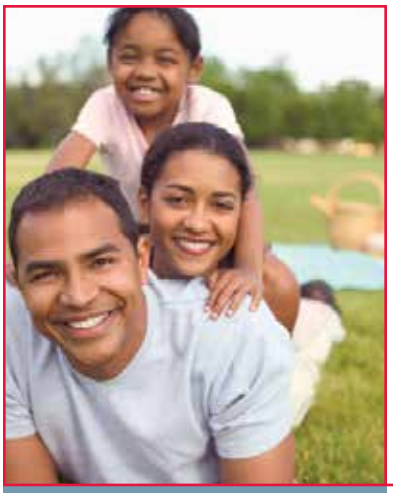

Dental
at a glance

in this section

- You may choose from up to three options for dental coverage. All employees may choose either the Delta Dental PPO *Plus Premier* High Option or the Delta Dental PPO *Plus Premier* Low Option.

  If you live in Massachusetts, you have the option of choosing coverage with the DeltaCare Dental Maintenance Organization (DMO). If you live in Arizona, California, Colorado, Florida, Indiana, Virginia or Texas, you have the option of choosing coverage with the DeltaCare USA DMO.

  Note that since Global Choice includes medical *and* dental coverage, expatriate employees who elect Global Choice are not eligible for the plans described in this section.

- You may choose from four coverage levels: employee only, employee and spouse, employee and child(ren) or employee and family.

- New employee? You must enroll within 31 days of the date shown on your *Personalized Enrollment Worksheet* or your date of hire, whichever is later. Your coverage will become effective on your first day of work.

- You may make changes to your dental coverage (i.e., add or drop dependents, add or drop coverage, or change plans) each year during the benefits open enrollment period.

- Outside of the annual benefits open enrollment period, you may make changes only under certain circumstances as outlined in *Changing Your Coverage, At Other Times of the Year* later in this section.

continued on next page

For the names of network dentists in your area, go to or call:

PPO *Plus Premier* (Nationwide)

www.deltadentalma.com/raytheon

877-335-8227

(Delta Dental PPO and Delta Dental Premier networks)

DeltaCare (Massachusetts Only)

www.deltadentalma.com/raytheon

877-335-8227

(DeltaCare network)

DeltaCare USA (All States Except Massachusetts)

www.deltadentalins.com

800-422-4234

(DeltaCare USA network)

- All dental plans provide coverage for a wide range of dental services, including periodic evaluations and cleanings, x-rays and fillings.

- The plans differ in how you access care (which dentists are available to you); how much you pay out-of-pocket for deductibles, copayments or coinsurance; and whether coverage for major services and orthodontia is provided. (The Delta Dental PPO *Plus Premier* Low Option does not provide coverage for major services or orthodontia.)

- The amount you pay for coverage depends on the dental plan you choose and your level of coverage. You pay the cost of your coverage with pre-tax dollars through payroll deduction.

- The claims administrator makes the final decision as to whether a particular service is covered, based on the benefits available under the plan in which you are enrolled. For more information about covered services for the plan you are enrolled in, contact your dental claims administrator. For information about how to appeal a denied claim, see the *Administrative* section.

Dental
at a glance

Enrolling in a Dental Plan

Coverage Levels

When you enroll in a company-sponsored dental plan, you may choose from four coverage levels. This allows you to choose the coverage level that best meets your specific family situation while ensuring that you only pay for the coverage you actually need.

The four coverage levels are:

- Employee only;
- Employee and spouse;
- Employee and child(ren); or
- Employee and family (spouse and children).

You may select different coverage levels for medical, dental and vision coverage. For example, you may choose medical coverage for your entire family and dental and vision coverage for just yourself.

If you are married to a Raytheon Technologies employee and you are both eligible for legacy Raytheon benefits, you may each select the plan of your preference or only one of you may elect coverage, depending upon your needs and the cost of your plan options.

Eligible Dependents

You may enroll your eligible dependents for dental coverage. Eligible dependents include your:

- *Spouse.* A spouse includes a *common-law spouse* if your common-law marriage was established in a state that legally recognizes common-law marriage; all requirements of that state have been met; and the common-law marriage has not ended.

  Note that a spouse from whom you are divorced or legally separated is *not* eligible for coverage. Note also that a party to a civil union is not a spouse;
- *Children before their 26th birthday,* including natural children, legally adopted children (including children lawfully placed for adoption), stepchildren and foster children, regardless of residency, financial dependence, student status, employment status or marital status;
- *Children and other dependents up to their age of majority (usually 18) for whom you are a legal guardian.* If you or your spouse is not the child's parent (or step-parent) and the child is not a foster or adopted child, you must have a court order designating you or your spouse as the child's legal guardian or as the person who has legal responsibility for the care, control and custody of the child that is equivalent to the responsibility of a legal guardian. (Please note that if the court order extends the guardianship beyond the age of majority, the child's coverage will still end no later than the child's 26th birthday.) In all cases, the child must also meet the IRS definition of a dependent of you or your spouse; and
- *Unmarried children age 26 and older who are disabled as well as other dependents age 26 and older for whom you have legal guardianship who are disabled,* if approved by a company-sponsored health plan to be disabled. In general, to qualify, the disabled child must have become disabled before age 26 and be incapable of self-sustaining employment because of intellectual disability, serious mental illness, physical sickness or injury. Coverage may continue for as long as your coverage continues and as long as your child remains incapacitated and is otherwise eligible for coverage.

Note that if you are eligible to add a dependent to your company-sponsored dental plan, you will need to provide dependent eligibility verification (such as a marriage certificate, birth certificate or joint tax return). Your dependent's coverage will not be effective until the verification documents are received. Complete details are on *Desktop Benefits* at https://raytheon.benefitcenter.com.

If your covered dependent becomes ineligible for coverage during the year (for example, due to divorce or legal separation), you must remove your dependent from your coverage as of the date that person is no longer eligible for coverage. Coverage for your dependent child who reaches age 26 automatically ends at 11:59:59 p.m. local time on the day before his/her 26th birthday. For more information, see *Changing Your Coverage* later in this section.

Can't locate one or more of the documents that are required to add a dependent to your company-sponsored dental plan? For a fee, Vitalchek can provide official government certificates (e.g., birth, marriage, divorce). For more information, go to www.vitalchek.com.

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www.deltadentalins.com
800-422-4234

Cost of Coverage

The amount you pay for dental coverage depends on:

- The dental plan you choose; and
- Your level of coverage (employee only, employee and spouse, employee and child(ren) or employee and family).

Rates are provided in your new hire materials as well as during annual benefits open enrollment.

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

For current rates and additional information, contact the Raytheon Benefit Center (RBC) at 800-358-1231.

Initial Enrollment for New Employees

As a newly hired employee, you may enroll in a company-sponsored dental plan within the 31-day period following the date shown on your *Personalized Enrollment Worksheet* or your date of hire, whichever is later. If you do not enroll within this 31-day period, you will not be eligible to enroll in a dental plan for the rest of the calendar year. Your next opportunity to enroll in a dental plan will be during the next benefits open enrollment period (held each fall).

The coverage you elect is effective retroactively to your first day of work, provided you enroll within the 31-day period. Coverage for your dependents generally begins at the same time as your coverage, or as soon as the dependent becomes eligible and his/her verification documents are confirmed (see *Eligible Dependents* earlier in this section for more information). This coverage remains in effect for the remainder of the calendar year. You may change your plan and/or coverage level during the next benefits open enrollment period, held each fall. You are permitted to make certain changes sooner if you meet the guidelines outlined in *Changing Your Coverage* later in this section.

Note that if you enroll in the DeltaCare or DeltaCare USA DMO, you will need to name a dentist for yourself and each family member that you cover. You should contact the DMO directly to request an information kit, including a provider election form.

Be sure you understand the enrollment procedures and enroll for the coverage you want when you're first eligible. Once your coverage begins, it will be in effect for the remainder of the calendar year. You are not permitted to change your elected coverage during the year unless you meet certain criteria described in *Changing Your Coverage*.

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Changing Your Coverage

After you make your initial enrollment elections as a new employee, you are permitted to make changes to your dental coverage as outlined here. In all cases, if you are adding eligible dependents, all necessary verification documents must be confirmed before a dependent's coverage becomes effective. See *Eligible Dependents* earlier in this section for more information.

Annual Benefits Open Enrollment

Each year, the company conducts a benefits open enrollment during which you are permitted to make changes to your dental coverage (i.e., add eligible dependents, remove dependents, add or drop coverage, or change plans). Any changes you make become effective the following January 1.

At Other Times of the Year

Outside of the annual benefits open enrollment period, you are permitted to make changes to your dental coverage (add or remove a dependent, or add or drop coverage) only in the event of the following:

- If you have a qualified change in status, as follows:
  - Marriage.
  - Divorce or legal separation.
  - Gain or loss of an eligible dependent, such as a child reaching age 26.
  - Change in your, your spouse's or your dependent's employment status, for example:
    - Gain or involuntary loss of dental coverage,
    - Change from full time to part time or vice versa,
    - Transfer between different contracts or positions, providing there is a change in the plans that are available to you or a significant change in the cost of coverage (for example, to or from a Service Contract Act or RayTech position), or
    - Begin or end an unpaid leave of absence.
- If your home address changes to outside your current dental plan's service area.

  ***Note that in the situations above, the change(s) you make must be due to and consistent with your change in status. For details, see the following inset* Making Changes to Your Coverage Outside the Annual Open Enrollment Period.**
- If your spouse's employer holds benefits open enrollment at a time other than the company's and, as a result of its benefit offerings, you would like to make a change.
- If you, your spouse or your dependent enrolls in Medicare or Medicaid, or if you, your spouse or your dependent loses eligibility for Medicare or Medicaid.

If any of these situations apply to you, you can make your change through *Desktop Benefits* at https://raytheon.benefitcenter.com or by calling the RBC at 800-358-1231.

In general, you may not change your dental plan until the next annual benefits open enrollment period, unless you move out of the service area covered by your plan. If you move out of the service area for your plan, you may elect coverage with another company-sponsored dental plan. To enroll in a new plan, you must call the RBC at 800-358-1231.

In the event of the birth or adoption of a child, you must enroll your child within 31 days of the birth date or, for adoptions, the custody date. You can enroll your child either online through *Desktop Benefits* at https://raytheon.benefitcenter.com or by calling the RBC at 800-358-1231. ***Note that if you do not add your newborn or newly adopted child, he/she will not be covered—even if you currently have family coverage.***

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MAKING CHANGES TO YOUR COVERAGE OUTSIDE THE ANNUAL OPEN ENROLLMENT PERIOD

Remember: If you are eligible to make a change to your dental coverage due to a qualified change in status (as listed earlier in this section) or because your home address changes to outside your dental plan's service area, ***the change(s) you make must be due to and consistent with your change in status. This means you cannot add or remove other still-eligible dependents from your coverage or, with the exception of a change in your home address that is outside your dental plan's service area, choose a different plan.***

Event	What Happens/Action Required
You gain an eligible dependent by marriage	• You have six months from the date of your marriage to add your spouse to your coverage. • You must provide dependent eligibility verification (such as a marriage certificate or joint tax return). Your dependent's coverage will not be effective until the verification documents are received and confirmed.
You divorce, legally separate or your common law marriage to your spouse terminates	• You must remove your dependent from your coverage on or before the date that person is no longer eligible for coverage. Coverage for that dependent ends as of 11:59:59 p.m. local time on the day before the event that makes him/her ineligible for coverage. • ***If you don't remove your previously eligible dependent from your coverage as of the date of the event, you must reimburse the company for any claims incurred after that date.***
You gain an eligible dependent by birth or adoption	• You must enroll your child within 31 days of his/her birth/adoption, even if you already have family coverage. • You will need to provide dependent eligibility verification (birth certificate or proof of custody). Your dependent's coverage will not be effective until the verification documents are received and confirmed. • Once the verification documents are confirmed, coverage is effective as of the birth or custody date. If you make your change before the date of the qualified change, coverage becomes effective as of the date of the qualified change.
Your child ages out of the plan	• If your child reaches age 26, his/her coverage automatically ends at 11:59:59 p.m. local time on the day before his/her 26th birthday.
You take or return from a personal leave	• Your active coverage ends and you will be offered COBRA continuation coverage. • If you elect COBRA coverage, any amounts you have accrued toward the current calendar-year's deductible and benefit maximum (if applicable) while you were an active employee will transfer and be applied to your COBRA coverage. If you return to work within the same calendar year, the cumulative totals will then transfer back to your active plan. To ensure an accurate accounting, contact your plan carrier. • When you return to work, you will have two options: Enroll in the same coverage you had before going out on leave (both the same plan and covering the same dependent(s)) or drop coverage completely. For more information, see *Continued Coverage under COBRA* in the *Administrative* section. Note that if you return to work during the same calendar year and enroll in the same coverage you had before going out on leave, any previously incurred claims will continue to apply toward the current calendar-year's deductible and benefit maximum (if applicable).
Your home address changes and is outside your plan's service area	• You can change to a plan that is available in your new zip code.

COVID-19 Update

During the national emergency related to COVID-19, the *Coronavirus Aid, Relief and Economic Security (CARES) Act* passed by Congress in 2020 allows for the extension of certain deadlines.

If you need to enroll yourself or an eligible dependent in your benefits because you or he/she has lost other coverage or he/she is newly eligible to be added to your coverage, you now have until 90 days after the national emergency (or "outbreak period") ends to enroll in coverage, retroactive to the event effective date. You will still be required to pay premiums, retroactively, for the entire time you and any family members are covered.

This section provides an overview of events that are considered qualified changes in status. For questions related to your specific situation, call the RBC.

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ABOUT HIPAA

The Health Insurance Portability and Accountability Act of 1996 *(HIPAA) is designed to help keep personal health information private as well as to make it easier for you and your family members to have continued group health plan coverage when you or a family member loses coverage through an employer. Here is a summary of the act's provisions as they relate to dental coverage.*

Protected Health Information. *The health benefit plans'* HIPAA Notice of Privacy Practices for Protected Health Information *explains what "protected health information" is; how the plans may use and disclose this information; and how you can exercise your rights concerning this information. HIPAA requires that the plans remind you that this notice is available on* Desktop Benefits *at https://raytheon.benefitcenter.com (click on the link to* Notice of Privacy Practices *under* My Resources *in the* Other Benefits *section) or by calling the RBC at 800-358-1231.*

If Your Coverage Ends. *If your coverage under a company-sponsored health plan ends, you may request a written certificate of coverage from the RBC.*

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Delta Dental PPO *Plus Premier*

You may elect dental coverage from one of two Delta Dental PPO *Plus Premier* options: High and Low. Both options provide coverage for a wide range of dental services, including periodic evaluations, cleanings, x-rays and fillings. The plans differ in covered services, how much you pay for your coverage and how much you pay when you receive care. While you may go to any dentist you choose, your costs are always lower when you visit a network dentist. For details, see the section *Network Providers.*

No matter which option you choose, there is no deductible for preventive services and routine care. The High and Low options cover these services at 100% if you see a network dentist, up to the maximum allowable charge if you see an out-of-network dentist. In all cases, out-of-network services are subject to *balance billing,* which means you may be required to pay any difference between the out-of-network dentist's charge and the maximum allowable charge. For more information about out-of-network services, see the section *Non-Network Providers.*

If your needs go beyond preventive services and routine care, you must first meet the calendar-year deductible for the option you choose. Then, benefits are paid as a percentage of eligible costs, up to a per-person annual benefit maximum (see the *Delta Dental PPO* Plus Premier *Summary of Benefits Chart*). If you elect the High Option, you may add to your annual benefit maximum with *Rollover Max,* described later in this section. Note that if you receive treatment after you have reached the annual benefit maximum (including any *Rollover Max* amount, if applicable), while you will be responsible for the cost of such treatment, you will be billed at the dentist's Delta Dental negotiated rate. For more information, see the inset box *Delta Dental Offers Expanded Access to Network Discounts*.

For a complete list of services covered by Delta Dental PPO *Plus Premier,* see *What the Delta Dental PPO* Plus Premier *Covers* later in this section.

Questions? Delta Dental representatives are available by calling 877-335-8227, Monday through Thursday from 8:30 a.m. to 8 p.m., and Friday from 8:30 a.m. to 4:30 p.m. Eastern Time (ET).

With Delta Dental PPO *Plus Premier,* you may always see the dentist of your choice. Your claims are paid based on the option you have elected, the services performed, and whether you use a participating or a nonparticipating dentist.

Network Providers

With the Delta Dental PPO *Plus Premier,* you have access to both the Delta Dental PPO and Delta Dental Premier networks. When you use a network provider:

- *You generally pay less* each time you receive eligible services, since your share of the cost is based on specially negotiated rates. (Note that you realize the most significant savings when you see a Delta Dental PPO dentist.)
- *There is no balance billing.* You are not billed for charges in excess of the maximum allowable charge for an eligible service.
- *There are no claim forms to file.* Your provider takes care of all the paperwork.

To take advantage of all that Delta Dental has to offer, check that your dentist participates in either the Delta Dental PPO or Delta Dental Premier network before receiving care.

To check if your dentist participates in either the Delta Dental PPO or Delta Dental Premier network, go to www.delta dentalma.com/raytheon, click on *Find a Dentist* and choose the appropriate network. If your dentist is not a member of either network, call Delta Dental to recommend your dentist. A Delta Dental provider relations representative will then contact your dentist.

DELTA DENTAL OFFERS EXPANDED ACCESS TO NETWORK DISCOUNTS

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

- *Exceed your visit limit for a certain service, including cleanings or X-rays;*
- *Exceed your annual benefit maximum;*
- *Are over the age limit for a certain service, such as for fluoride varnish; or*
- *Receive a service that is covered by an alternative benefit, such as posterior tooth white fillings.*

(continued)

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DELTA DENTAL OFFERS EXPANDED ACCESS TO NETWORK DISCOUNTS (CONTINUED)

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

- *The Delta Dental* Plus Premier *plans cover two cleanings per calendar year and Susan likes to have three cleanings per year. While the plan will not cover the third cleaning, Susan will be charged the full, negotiated rate instead of the retail rate for the third cleaning.*
- *Mike is in the Delta Dental* Plus Premier *Low Option and just learned he needs a root canal. While root canals are generally covered, he'll be responsible for 100% of the cost of the procedure since he has already hit the plan's $500 benefit maximum. Mike will be charged the full, negotiated rate for the procedure, not the retail rate.*

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

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

This change went into effect on November 1, 2016. It applies to all claims with dates of service on or after this date, and does not apply to any claims with dates of service prior to the effective date.

Non-Network Providers

With Delta Dental PPO *Plus Premier*, you always have the option of seeing a provider who does not participate in the plan's networks. In this case, you generally pay a larger share of the cost for your care. Here's an overview:

- Eligible services are covered up to the maximum allowable charge for dentists in your area. For purposes of the plan, the *maximum allowable charge* means the lowest of:
  - The usual charge by the dentist or other provider for the same or similar service or supplies;
  - The prevailing charge of most other dentists or other providers in the same or a similar geographic area for the same or similar service or supplies; or
  - The actual charge.
- If your dentist charges more than the maximum allowable charge for your geographic area, your care is subject to balance billing.
- You may be asked by your dentist to pay for your care up front and then submit a claim for reimbursement to Delta Dental.

Delta Dental will reimburse you directly for eligible charges from non-network providers. You are responsible for payment to the dental provider.

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Delta Dental PPO *Plus Premier* Summary of Benefits Chart

The following chart shows the deductibles and maximums for the Delta Dental PPO *Plus Premier* High and Low options and depending on the option you elect, your share of the cost for some common covered services.

	High Option*	Low Option*
Deductibles and Maximums (do not apply to preventive and routine care)		
Individual deductible	$ 50	$ 50
Family deductible	$ 100	$100
Annual benefit maximum (per person)	$2,000**	$500
Orthodontia maximum (per person, lifetime)	$2,000	N/A
Preventive and Routine Care (Type 1) • Periodic evaluation*** and cleaning twice each calendar year • Bitewing x-ray, twice per calendar year for covered persons under age 19 and once per calendar year for covered persons age 19 and over • Full mouth x-ray once every five years (per provider) • Periodontal cleaning, once every three months following active periodontal treatment (not to be combined with preventive cleanings) • Space maintainers, dependents covered to age 14 • Sealants for unrestored permanent molars, every 4 years per tooth for covered persons through age 15. Sealants are also covered for covered persons aged 16 up to age 19 for those who had a recent cavity and are at risk for decay	Plan pays 100%	Plan pays 100%
Basic Services (Type 2) • Fillings • Root canal therapy • Oral surgery and extractions • Repair of bridgework and dentures • Periodontics	After you meet the deductible, plan pays 80%	After you meet the deductible, plan pays 75%
Major Services (Type 3) • Installation of bridges • Crowns and gold restorations • Implants (in lieu of a three-unit bridge; see *Services Covered under the High Option Only* for details) • Dentures	After you meet the deductible, plan pays 60%	Not covered; you pay 100%
Orthodontics (including treatment for adults)	After you meet the deductible, plan pays 80%	Not covered; you pay 100%

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

**The Delta Dental PPO *Plus Premier* High Option offers *Rollover Max,* a program that allows participants to roll forward a portion of unused dental benefits to accumulate for future use. See *Rollover Max* later in this section for details.

***Coverage for periodic evaluations is available twice per calendar year regardless of whether care is routine.

While the Delta Dental PPO Plus Premier *High and Low options cover many of the same services, certain types of care are covered under the Delta Dental PPO* Plus Premier *High Option only. For more information, see* Services Covered under the High Option Only *later in this section.*

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Rollover Max

The Delta Dental PPO *Plus Premier* High Option offers access to *Rollover Max,* a program that allows participants to roll forward a portion of unused dental benefits to accumulate for future use.

Provided you receive at least one cleaning or periodic evaluation each calendar year, you can roll forward up to $600 of your unused annual benefit maximum to help pay for more expensive procedures down the road (excluding orthodontia). To qualify, your total claims paid in any given year cannot exceed $800—*the annual threshold amount.* The maximum amount you can accumulate is $1,500. Note that if you qualify for *Rollover Max* and then opt out of the High Option, you forfeit access to the rolled over amount, including if you later re-enroll in the High Option.

Here's an example of how *Rollover Max* works (assumes you have at least one cleaning or periodic evaluation each year):

	Years You Participate in the High Option			
Delta Dental PPO *Plus Premier* High Option Feature	**First Year***	**Second Year**	**Third Year**	**Fourth Year**
Annual Benefit Maximum	$2,000	$2,000	$2,000	$2,000
Rollover Amount from Previous Year	N/A (this is the first year you participate in the High Option)	$600 (From the prior year)	$600 (From your first year, since you were not eligible in your second year)	$300 (Remainder from your second year, since you were not eligible for an additional rollover in your third year)
Adjusted Annual Maximum	$2,000	$2,600	$2,600	$2,300
Total Claims Paid**	$600	$1,200	$2,300***	$600
Eligible for *Rollover Max*	Yes	No	No	Yes
Accumulated *Rollover Max* Total	$600*	$600 (the amount you accumulated in your first year still applies)	$300 ($600 from your second year minus $300 applied to this year's claims)	$900

*The first year (the qualifying year for *Rollover Max)* assumes you have enrolled in the High Option prior to October 1.

**To be eligible for *Rollover Max,* total claims paid cannot exceed the annual threshold amount ($800) in any given year.

***In this example, while the total claims paid exceeded the annual benefit maximum of $2,000, thanks to *Rollover Max,* the plan paid an additional $300 in benefits.

If you enroll in the High Option during the fourth quarter of any year (October 1 to December 31), such as if you are a new hire, you are not eligible to participate in *Rollover Max* for that year.

Pre-Treatment Estimates

Before undergoing any dental treatment that will cost more than $300, you should request a pre-treatment estimate to find out what the plan will cover for the proposed treatment. You are encouraged to request a pre-treatment estimate before beginning any costly or extensive dental treatment (for example, a root canal or bridgework).

To request a pre-treatment estimate, ask your dentist to complete the regular dental claim form, indicating the type of work planned and the estimated cost. Delta Dental will provide you and your dentist with a statement showing the estimate of benefits payable under your plan.

When you request a pre-treatment estimate, you find out up front how much your dental plan will pay for that treatment. You also have the opportunity to learn about alternative treatment methods that may meet your needs.

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Alternative Treatments

For many dental conditions, there may be more than one acceptable course of treatment. When you request a pre-treatment estimate, Delta Dental may suggest one or more alternative treatment methods that meet professional dental standards. In this case, you may still choose the original treatment proposed by your dentist. However, the plan will only pay benefits equal to the less expensive treatment. You are responsible for paying any difference *in addition to* any deductible or coinsurance.

HEALTHY MOUTHS FOR LIFE℠

Healthy Mouths for Life, Delta Dental's comprehensive oral health program, offers education on treatment and prevention of oral disease. You also have coverage for enhanced benefits, such as:

- ***Periodontal cleaning,** available once every three months following active periodontal treatment;*
- ***Fluoride toothpaste,** as a covered benefit when administered and dispensed in the dentist's office following periodontal surgery; and*
- ***Sealants,** which are covered for members age 16 through 19 for those who had a recent cavity and are at risk for decay.*

For more information about Healthy Mouths for Life, go to www.deltadentalma.com/raytheon.

How to File a Claim

When you receive care from a network dentist, your dentist will file claims directly with Delta Dental.

If you use a non-network dentist, you may have to pay the dentist up front for your care and file a claim for reimbursement by following these steps:

1. Before your appointment, go to www.deltadentalma.com/raytheon to download a dental claim form. (You may also use a standard American Dental Association (ADA) claim form);
2. Complete and sign the following sections of the form:
   - *Insurance Company/Dental Benefit Plan Information,*
   - *Policyholder/Subscriber Information,*
   - *Other Coverage,*
   - *Patient Information,* and
   - *Authorizations;*
3. Give the form to your dentist to complete and sign the remaining sections; and
4. Submit the completed form, together with your original itemized dental bill(s) and the plan group number (called the *Subscriber Number* on your dental ID card), to:

   Delta Dental of Massachusetts
   P.O. Box 2907
   Milwaukee, WI 53201-2907

If your claim for benefits is denied in whole or in part, you have the right to an appeal, as described in the *Administrative* section. All claims must be submitted within one year from date of service.

If you receive payment from a third party that is held liable for any injury that required dental care, you may be required to reimburse Delta Dental for claim payments. For more information, see *Subrogation and Recoveries (All Plans Except UHC)* in the *Administrative* section.

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What the Delta Dental PPO *Plus Premier* Covers

The Delta Dental PPO *Plus Premier* High and Low options cover a wide variety of services. When you receive care from a non-participating provider, services are covered up to the maximum allowable charge.

Services Covered under the High and Low Options

- ***Apicoectomy,*** once per tooth;
- ***Bitewing x-rays,*** twice per calendar year for covered persons under age 19 and once per calendar year for covered persons age 19 and over;
- ***Cleaning of teeth*** (oral prophylaxis), twice per calendar year;
- ***Comprehensive oral evaluation*** for new and established patients, once every five years per dentist;
- ***Emergency, minor treatment for pain relief,*** three occurrences in six months;
- ***Extractions.*** Note that benefits are paid once per tooth for extractions;
- Amalgam, silicate, acrylic, synthetic porcelain or composite ***fillings.*** Note that silver amalgam and, in the case of front teeth, synthetic tooth color fillings are limited to one filling for each tooth surface every two years. Synthetic (white) fillings are limited to single-surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth are treated as an alternate benefit, covered with an amalgam allowance and the patient is responsible for charges up to the dentist's contracted fee for the multi-surface synthetic white restoration;
- ***Fluoride treatments,*** once per calendar year for covered persons up to age 20;
- ***Full mouth x-rays,*** once every five years per provider;
- ***General anesthesia/IV sedation administration*** for covered surgical extractions only, up to one hour;
- ***Occlusal guard,*** once every five years after active periodontal treatment;
- ***Oral surgery*** when performed to remove impacted wisdom teeth or diseased or damaged natural teeth; treat oral disease and injury involving the teeth and oral tissues; or treat diseased gum tissue or bone;
- ***Periodic evaluations,*** twice each calendar year;
- ***Periodontal cleaning,*** once every three months following active periodontal treatment. Note: This is not to be combined with preventive cleanings;
- ***Periodontal surgery,*** once every three years per quadrant and no more than two quadrants on the same date of service on natural teeth;
- ***Prosthetic maintenance*** of crowns, inlays, onlays, dentures or bridgework, once every 12 months per tooth or denture;
- ***Recementing*** of crowns, inlays, onlays or bridgework, once every 12 months per tooth;
- ***Relinings and rebasings*** of existing removable dentures, once every 36 months;
- ***Root canal treatment,*** once per tooth;
- ***Root canal retreatment,*** once per tooth, after 24 months of original root canal;
- ***Scaling and root planing,*** once every two years per quadrant and no more than two quadrants on the same date of service;
- ***Sealant.*** Coverage is provided once every four years per unrestored permanent molar for covered persons through age 15 as well as for covered persons age 16–19 who have had a recent cavity and are at risk for decay;
- ***Single tooth x-rays*** (intraoral-periapical), as needed;
- ***Space maintainers*** for covered persons to age 14; and
- ***Vital pulpotomy,*** limited to deciduous teeth (once per tooth, primary teeth only).

Questions about the services your plan covers? Contact Delta Dental.

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Services Covered under the High Option Only

- ***Adding teeth to an existing partial removable denture*** or to bridgework when needed to replace one or more natural teeth after the existing denture or bridgework was installed, once per tooth every 12 months. *If the dentist is adding a missing tooth (pontic crown) to an existing bridge, Delta Dental prior authorization is required;*
- For covered persons age 12 or older, ***crowns (onlays, build-ups and post and cores),*** when a tooth is damaged by decay or fracture to the point that it cannot be restored by a regular filling. Once every five years per tooth;
- Replacement of an ***existing immediate temporary full denture*** by a new permanent full denture when:
  - The existing denture cannot be made permanent, and
  - The permanent denture is installed within 12 months after the existing denture was installed;
- Replacement of an ***existing removable denture or fixed bridgework*** if needed because the existing denture or bridgework can no longer be used and was installed at least five years prior to replacement;
- ***Implants,*** once per tooth per five years. An implant is covered only when:
  - A three-unit bridge is the primary course of treatment,
  - One tooth is missing (instead of a three-unit bridge),
  - The two adjacent teeth have a good prognosis from both a restorative and periodontal perspective and do not require crowns (otherwise they would only be eligible for a three-unit bridge), *and*
  - There are fewer than three teeth missing in the arch.

  If multiple three-unit bridges are necessary, each implant space is evaluated separately. To qualify for a surgical implant, the patient must be at least age 16. For specific information about available coverage, contact Delta Dental. You are encouraged to request a pre-treatment estimate before receiving any implants;
- ***Inlays.*** Note that multi-surfaces will be processed as an alternate benefit of an amalgam filling and the patient is responsible up to the dentist's Delta Dental negotiated rate;
- Replacement of one or more ***natural teeth*** through installation of:
  - Fixed bridgework, once every five years, or
  - A full or partial removable denture, once every five years;
- ***Occlusal guards*** once every five years, after active periodontal treatment ***or*** for bruxism;
- ***Orthodontia, including appliance therapy or harmful-habit appliances,*** as well as surgical access of an unerupted tooth and placement of device to facilitate eruption of impacted tooth, for all covered persons. Orthodontic treatment must be administered/supervised by a licensed dentist. Once you satisfy the deductible, eligible treatment is covered at 80% of the maximum plan allowance charges. There is a $2,000 separate lifetime maximum. Payable in monthly installments; and
- Treatment of ***temporomandibular joint (TMJ) syndrome,*** including the appliance, necessary adjustments and diagnostic services. (Surgery is generally covered under the individual's medical plan.)

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What the Delta Dental PPO *Plus Premier* Does Not Cover

While the Delta Dental PPO *Plus Premier* provides coverage for a wide range of dental services, there are some services that are not covered, even if your dentist approves or recommends them. Services that Delta Dental PPO *Plus Premier* does not cover include the following:

- Services or supplies received ***before your coverage becomes effective;***
- ***Bleaching;***
- ***Bone grafts*** and guided tissue regeneration in conjunction with surgical implant placement and endodontic procedures, such as apicoectomy (a surgical procedure to remove the end of a tooth root), root amputations, soft tissue grafts and extractions;
- Charges for ***broken appointments;***
- ***Caries susceptibility tests;***
- Charges by the dentist for ***completing dental forms;***
- ***Cosmetic services,*** meaning those that are meant to change or improve appearances, such as laminate veneers;
- ***Cosmetic surgery,*** treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn covered child;
- ***CT (computerized tomography) scans, cone beam images, surgical stents or surgical guides*** for implants;
- Adjustment of a ***denture or bridgework that is made within six months after installation;***
- Any ***duplicate appliance or prosthetic device;***
- Services or supplies that are covered by any ***employers' liability laws;***
- Services or supplies that are deemed ***experimental*** in terms of generally accepted dental standards;
- Services or supplies furnished by a ***family member;***
- ***Home health aids*** used to prevent decay, such as toothpaste and fluoride gels;
- Surgical or nonsurgical procedures around dental ***implants;***
- ***Injections of antibiotic drugs;***
- ***Instruction for oral care,*** such as hygiene or diet;
- Replacement of a ***lost, missing or stolen crown, bridge or denture;***
- Services or supplies received through a ***medical department or similar facility that is maintained by the covered person's employer;***
- ***Myofunctional therapy;***
- ***Nitrous oxide;***
- Services or supplies received by a covered person for which ***no charge would have been made*** in the absence of dental coverage for the covered person;
- Services or procedures that Delta Dental determines are ***not generally acceptable,*** e.g., laser assisted new attachment protocol (LANAP);
- Services ***not performed by a dentist,*** except for the services of a licensed hygienist whose services are supervised and billed by a dentist and that are for:
  - Cleaning and scaling of teeth, or
  - Fluoride treatments;
- Services or supplies for which a covered person is ***not required to pay;***
- ***Office visits after regular office hours;***
- Repair or replacement of an ***orthodontic appliance;***

Remember, if you participate in an HSA Advantage plan, you can use your HSA to pay for eligible expenses that your dental plan does not cover or covers only in part. For more information about HSAs, see the *Health Savings Account* section.

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- ***Orthodontic treatment*** that is not administered and directly supervised by a licensed dentist, and mail-order orthodontic kits;
- Services or supplies to the extent that benefits are ***otherwise provided under this plan or under any other plan*** sponsored or contributed to by the company;
- ***Periodontal splinting;***
- ***Photographs,*** such as any "before and after" pictures;
- ***Prescription drugs;***
- Services or supplies that any employer is ***required by law*** to furnish in whole or in part;
- ***Restorations for reasons other than decay or fracture,*** such as to increase the height of teeth;
- ***Ridge augmentation or preservation;***
- ***Silver fluoride;***
- ***Sinus lifts;***
- ***Sterilization supplies;***
- ***Surgical access of an unerupted tooth*** and placement of device to facilitate eruption of impacted tooth (unless related to orthdontia, which is covered only by the *Plus Premier* High Option);
- ***Teledentistry;***
- ***Temporary crowns, fixed bridges and dentures*** that are placed as part of the procedure to place a permanent appliance;
- ***Therapeutic drug injections;***
- ***Transitional implants;***
- ***Treatment of failed dental implants,*** including surgical debridement (removal of dead tissue) and bone graft placement;
- Services or supplies received as the result of dental disease, defect or injury due to an act of ***war or warlike act in time of peace,*** which occurs while coverage is in effect; and
- Services or supplies that are covered by any ***workers' compensation law*** or occupational disease law.

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DeltaCare Dental Maintenance Organization (DMO) or DeltaCare USA DMO

If you live in Massachusetts, you have the option of choosing coverage with the DeltaCare Dental Maintenance Organization (DMO). If you live in Arizona, California, Colorado, Florida, Indiana, Virginia or Texas, you have the option of enrolling in the DeltaCare USA DMO. A DMO works similarly to a medical health maintenance organization (HMO), in that you and your covered family members receive care from a network of participating dentists.

With a DMO, there is little to no cost to you for diagnostic and preventive care, such as periodic evaluations, fluoride treatments and cleanings. For other dental care, there is no annual deductible and no annual benefit maximum. You simply pay a fixed amount (called a *copayment)* when you receive care. This means that you always know exactly how much your care will cost. And, there are no claim forms to file. It's important to note that ***care received outside your DMO's network is*** **not** ***covered except in emergencies*** (see *Emergency Care* later in this section for details).

Choosing Your Dentist

When you enroll in a DMO, you must choose a primary care dentist (PCD) for yourself and your eligible dependents from the DeltaCare (in Massachusetts) or the DeltaCare USA (in all other available locations) network of providers. You may each choose a different PCD or you may choose one PCD to provide care for all covered family members. (Note that if you live in a state other than Massachusetts and cover your eligible dependents, you cannot choose more than three different PCDs for your family.)

To find a network dentist in your area, consult the appropriate provider directory, which is available online, or call DeltaCare or DeltaCare USA. All dentists who participate in DMO networks meet or exceed strict quality standards.

Changing Your Dentist. You may change your PCD at any time by calling DeltaCare or DeltaCare USA. Changes become effective the following month.

Visits to Specialists. If you need to see a specialist, your dentist will refer you to another provider in the DeltaCare or DeltaCare USA network.

Emergency Care

You are *always* covered for emergency care under a DMO. If you are in your DMO's network area, you should contact your network dentist immediately. If you cannot reasonably reach your dentist (for example, you are traveling outside your DMO's network area), you should see a local licensed dentist for treatment. The DMO will provide limited coverage for emergency services required to reduce swelling, relieve pain and reduce the potential for infection. Your network dentist must coordinate all follow-up care.

The DeltaCare DMO is available to employees in Massachusetts. The DeltaCare USA DMO is available to employees in Arizona, California, Colorado, Florida, Indiana, Virginia and Texas.

When you choose a dentist, make sure he or she participates in the network in the state where you live.

- In Massachusetts: Go to www.deltadentalma.com/raytheon, click on *Find a Dentist* and select "DeltaCare" as your network,
- For all other available locations: Go to www.deltadentalins.com, click on *Find a Dentist* and select "DeltaCare USA" as your network.

Note that with DMOs, your dentist is responsible for coordinating your care. Care received outside your DMO's network is covered only in emergencies.

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DeltaCare DMO and DeltaCare USA DMO Overview of Benefits Chart

With the DeltaCare or DeltaCare USA DMO, you are covered for all services under the plan when your coverage becomes effective. There is no need to meet an annual deductible first. This chart provides examples of your copayment for some common covered services.

Covered Service	Copayment (Amount You Pay)
Diagnostic and Preventive Care	
Periodic evaluation	$ 0
Panoramic x-ray	$ 0
Fluoride treatment (up to age 19) and cleaning	$ 0
Restorative Services	
One surface white filling (front tooth)	$ 21
Porcelain and noble metal crown	$ 225
Repair broken denture	$ 25
Major Services	
Complete upper denture	$ 250
Add tooth to existing partial denture	$ 10
Periodontal scaling and root planing (per quadrant)	$ 45
Root canal treatment for molar tooth	$ 180
Orthodontics	
24-month comprehensive treatment under age 19	$1,950
24-month comprehensive treatment over age 19	$2,150

For More Information about Covered Services. As highlighted in the above chart, the DMOs cover a wide variety of services. However, there are some services that are not covered, even if your dentist approves or recommends them. For detailed information about what the DMOs do and do not cover, contact DeltaCare or DeltaCare USA directly.

What the DMOs Do Not Cover

- ***Accidental injury,*** defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function are covered at the normal schedule of benefits;
- Dental expenses incurred in connection with any dental procedures started ***after termination of eligibility for coverage;***
- General ***anesthesia***, IV sedation and nitrous oxide, as well as the services of a special anesthesiologist;
- ***Congenital malformation;***
- ***Cosmetic dental care;***
- ***Cysts and malignancies;***
- Dispensing of ***drugs*** not normally supplied in a dental office;
- Dental conditions arising out of and due to the covered person's ***employment*** or for which workers' compensation is payable;
- Treatment of ***fractures and dislocations;***
- Services that are provided to the enrollee by state ***government*** or agency thereof, or are provided without cost to the covered person by any municipality, country or other subdivision;
- Dental services performed in a ***hospital*** and related fees;

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- ***Implant placement or removal,*** appliances placed on or services associated with implants;
- Any service that is ***not specifically listed*** as a covered expense;
- Loss or theft of fixed and removable ***prosthetics*** (crown, bridges, full or partial dentures);
- Dental services ***received from any dental office other than the assigned PCD's office,*** unless expressly authorized in writing from DeltaCare or DeltaCare USA;
- Prophylactic ***removal of impactions*** (asymptomatic nonpathological);
- Cases in which the attending dentist determines, in his or her professional judgment, that a ***satisfactory result cannot be obtained*** or where the prognosis is poor or guarded;
- ***Specialist consultations*** for noncovered benefits; and
- Treatment required by reason of ***war.***

As Your Needs Change

If You Take a Leave of Absence

Medical Leave

If you're on an authorized medical leave of absence, dental coverage for you and your covered dependents will continue for up to 24 months. You pay the premium rate in effect during your leave directly to the company. If your leave is for fewer than 90 days, your deductions for dental coverage will be taken from your paycheck on a retroactive basis when you return to work. These deductions will be taken over the same number of pay periods that you were out. If your leave is for 90 days or more, you will receive a bill for the cost of dental coverage from the first day of your leave and instructions for payment.

After you have been on a medical leave of absence for 24 months, your employment will be administratively terminated and your dental coverage will end. You can extend your coverage under COBRA regulations (see *Extending Your Coverage* later in this section). You'll receive an administrative termination notice that explains your options and the steps you need to take to ensure your coverage continues uninterrupted.

Industrial Leave

If you're on an authorized industrial leave of absence due to an industrial injury, dental coverage for you and your covered dependents will continue for the duration of the leave on the same basis as a medical leave of absence, as described earlier.

Family and Medical Leave

If you take an authorized family and medical leave and make arrangements to continue to pay for your dental coverage, dental coverage for you and your covered dependents will be continued for up to 12 weeks (or as required by state law). The amount of time off for which you are eligible may vary based on state regulations. For more information, see the *Work/Life* section or contact your Human Resources office.

Other Types of Leaves

If you take an authorized leave of absence other than a medical, workers' compensation, industrial or family and medical leave, dental coverage for you and your covered dependents may be continued through COBRA, as defined in each applicable policy. For more information, see *Extending Your Coverage* later in this section.

If you take an authorized military leave of absence, see your local HR representative for information on continuing your benefits.

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If You Are Laid Off

If you are laid off, contact your Human Resources representative for information regarding your last day of coverage.

Other Important Information

When Your Coverage Ends

Your dental coverage will end when you:

- Terminate employment. In this case, your coverage ends at 11:59:59 p.m. local time on your last day worked;
- No longer meet the plan's eligibility requirements;
- Cancel your coverage; or
- Fail to pay the premiums.

Your coverage will also end if a plan is terminated for all employees.

When Coverage for Your Dependents Ends

Coverage for a dependent will end when:

- Your coverage ends;
- He/she no longer meets the definition of an eligible dependent, such as if you and he/she divorce or if he/she reaches age 26. In this case, coverage ends at 11:59:59 p.m. local time on the day before the event that makes him/her ineligible for coverage (i.e., the date of your divorce or the dependent's 26th birthday);
- You cancel your dependent coverage; or
- You fail to pay the premiums.

Coverage will also end if dependent coverage under the plan is terminated for all employees.

Extending Your Coverage

You and your covered dependents may be eligible to extend dental coverage for up to 18 or 36 months if you lose coverage as the result of a "qualifying event" under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA). Qualifying events include loss of a job, death, divorce or a dependent reaching age 26. Under COBRA, you and/or each affected dependent may purchase coverage at 100% of the full group cost plus an additional 2% for administrative costs.

If the qualifying event is your divorce or legal separation, or if your dependent no longer qualifies for coverage under the plan, you must notify the RBC at 800-358-1231 within 31 days from the last day covered to qualify for COBRA coverage. Refer to the *Administrative* section for details about COBRA coverage.

Tax Considerations

You pay for dental coverage through payroll deduction with pre-tax dollars. Since the amount you pay is deducted from your pay before taxes are withheld, you will not pay federal, Social Security and, in many cases, state and local income tax on this money. The actual amount of your tax savings will depend on your income tax bracket and local tax laws.

This reduction in your taxable pay may slightly impact your future Social Security benefits because you may be paying lower Social Security taxes. Generally, the tax savings you receive now far outweigh any nominal decrease in your future Social Security benefit. However, if you have any questions, you should consult a personal tax advisor.

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Effect on Your Other Benefits

While using pre-tax dollars reduces your pay for tax purposes, they do not have any effect on your other pay-related benefits, such as life insurance coverage or the Raytheon Savings and Investment Plan (RAYSIP). These benefits are based on your base annual salary, before any deductions are withheld.

Claims Appeal

If a claim is denied, you will receive a written explanation. You have the right to request a review of the claim by contacting the dental carrier. Please see *Applying for Benefits* in the *Administrative* section for details.

Your Rights

This section describes the dental plans in general terms. If any conflict arises between this description and the plan documents, or if any point is not covered, the terms of the plan documents will govern in all cases. See the *Administrative* section for information related to the administration of the dental plans.

FINAL COVERAGE DETERMINED BY DENTAL PLAN CARRIER

The dental plan carrier makes the final decision as to whether or not a particular service is covered. In order to determine what is and is not covered under your plan, see your plan's summary of benefits chart as well as the list of limitations and exclusions, or contact your dental carrier at the toll-free Customer Service number listed on your dental ID card.

For information about how to appeal a denied claim, see Applying for Benefits *in the* Administrative *section.*

COORDINATION OF BENEFITS

The company's dental plans include non-duplication coordination of benefits (COB). The non-duplication COB provision provides payment up to the normal reimbursement level under the plan. This means your combined benefits from all plans will equal, but never exceed, the amount that would normally be payable from your company-sponsored plan when there is no COB with another plan.

See the Administrative *section for more information about COB.*

SUBROGATION PROVISIONS

The company's dental plans include subrogation provisions. Subrogation applies if you receive payment from a third party that is held liable for any injury that required dental care. In this case, you may be required to reimburse your plan for claim payments.

See the Administrative *section for more information about subrogation.*

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Business Travel Accident Insurance at a glance

in this section

- The company provides you with business travel accident (BTA) insurance, which provides accidental death and dismemberment coverage if you are injured or die as a result of a covered accident while you are traveling on company business, including travel between company facilities.

- All employees are automatically enrolled in the BTA plan on their first day of work. The company pays the full cost of this coverage.

- Coverage begins when you leave your home, place of regular employment or permanent assignment and continues until you return to your home, place of regular employment or permanent assignment, whichever occurs first. The BTA plan does not, however, cover commuting between home and work, or time spent on an authorized leave of absence or on vacation. Benefits under this plan are in addition to any benefits payable under the employee optional life insurance plan.

- In most cases, your benefit—called a *principal sum*—is equal to four times your annual base pay rounded to the next highest $1,000, with a minimum of $50,000 up to a maximum of $5 million.

- As a participant in the BTA plan, you automatically have access to travel assistance services from AIG Travel, which provide emergency travel assistance, VIP concierge services, worldwide travel assistance, travel medical assistance and security assistance, including if you are a victim of identity theft.

continued on next page

- AIG Accident and Health administers the BTA plan. The plan is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. (NUFIC), an AIG Company.

Business Travel Accident Insurance at a glance

Enrolling in Business Travel Accident (BTA) Insurance Coverage

With BTA insurance, you are covered in the event of a covered accidental death, dismemberment or loss while traveling on company business.

The business travel accident (BTA) plan provides accidental death and dismemberment (AD&D) coverage if you are injured or die as a result of a covered accident while you are traveling on company business, including travel between company facilities. The plan also provides coverage for your eligible spouse and/or dependent children when they are accompanying you or on their way to join you, and when the trip is authorized and/or paid for by the company.

You are automatically enrolled in the BTA plan on your first day of work. The company pays the full cost of this coverage. There are no enrollment forms to complete.

Naming Your Beneficiary

Your *beneficiary(ies)* is the person(s) who would receive benefits under the plan upon your death. When you are hired, you will be asked to name a beneficiary(ies) for any employee optional life insurance coverage you purchase. The person you name as beneficiary for your employee optional life insurance is automatically the beneficiary for your BTA coverage. If you have not elected employee optional life insurance coverage, you can choose a beneficiary for your BTA coverage by completing the accidental death and dismemberment (AD&D) section of the *Beneficiary Designation* form, available through *Desktop Benefits* at https://raytheon.benefitcenter.com or by calling the Raytheon Benefit Center (RBC) at 800-358-1231.

What the BTA Plan Covers

Amount of Coverage

The BTA plan's AD&D benefit, called a *principal sum,* is equal to four times your annual base pay rounded to the next highest $1,000, with a minimum of $50,000 up to a maximum of $5 million. (Note that benefits may vary depending upon your position or location.) Your *annual base pay* means your regular base pay, not including overtime or any other compensation.

The benefit for which you are eligible is based on the loss you experience, as shown in this chart:

If, due to a covered accident, you lose	The BTA plan pays this percentage of the principal sum
Your life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
Speech and hearing in both ears	100%
Use of all four limbs	100%
Use of any two limbs	75%
Speech or hearing in both ears	50%
One hand or one foot	50%
Sight of one eye	50%
Use of one limb	50%
Thumb and index finger of the same hand	25%
Hearing in one ear	25%

For purposes of the plan, an *injury* means bodily injury that:

- Is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while your coverage is in force, and
- Directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

Loss means:

- *For a hand or a foot:* Complete severance through or above the wrist or ankle joint.
- *For a thumb and index finger:* Complete severance through or above the metacarpophalangeal joints of both digits.
- *For sight of an eye:* Total and irrecoverable loss of the entire sight of that eye.
- *For speech:* Total and irrecoverable loss of the ability to speak.
- *For hearing in an ear:* Total and irrecoverable loss of the entire ability to hear in that ear.
- *For loss of use of an arm:* Loss of use of the entire arm from the shoulder joint, including the attached hand.
- *For loss of use of a leg:* Loss of use of the entire leg form the hip joint, including the attached foot.
- *For permanent total loss of use:* In this case, loss means complete and irreversible loss of functional, normal or characteristic use of the entire arm or leg due to complete and irrreversible paralysis; atrophy; or an arthritic condition.

To be eligible for BTA benefits, you must suffer a loss within 365 days of an accident that occurs while you are traveling on company business. If more than one loss arises out of the same accident, the plan will pay only one benefit equal to the largest eligible percentage for any one injury. The most the plan will pay is the principal sum.

Additional Principal Sum Applies to Injuries Sustained from a Test Aircraft

An additional principal sum amount of $500,000 applies if a covered injury is sustained while boarding, operating, riding or alighting from any aircraft being used for test-flight purposes or any aircraft considered experimental. In order for benefits to be paid, the aircraft and the pilot must meet Federal Aviation Administration requirements or the requirements of a similar governing authority, where applicable.

Accident Medical Expense Benefit

If you incur eligible medical expenses as the result of a covered accident within 180 days of the date of the accident that caused the injury, the BTA plan will pay benefits that are in excess of benefits payable for medical expenses under a:

- Valid and collectible workers' compensation claim, including Canadian Workers' Compensation and California Unemployment Compensation Disability Benefits, etc.; or
- Group hospital, surgical or major medical plan sponsored by the company.

A list of eligible medical expenses follows:

- Hospital semi-private room and board (or, when medically necessary, room and board in an intensive care or cardiac care unit); hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an ambulatory medical center;
- Services of a physician or a registered nurse (R.N.);
- Ambulance service to or from a hospital;
- Laboratory tests;
- Radiological procedures;
- Anesthetics and the administration of anesthetics;
- Blood, blood products and artificial blood products, and the transfusion thereof;
- Physical therapy and occupational therapy;
- Rental of durable medical equipment;
- Artificial limbs, artificial eyes or other prosthetic appliances; and
- Medicines or drugs administered by a physician or that can be obtained only with a physician's written prescription.

Benefits payable under this plan provision are *in addition to* any other benefits you may be eligible to receive from the plan for any loss you experience as a result of the same accident. In other words, your benefit due to a loss from the same covered accident will not be reduced by benefits payable under this provision of the plan. The maximum benefit payable is $5,000 for any one covered accident. Expenses must be incurred within 26 weeks of the date of the covered accident.

Carjacking Benefit

If you or a covered family member suffers a specified covered loss as the result of a carjacking, the BTA plan pays an additional benefit of 10% of the largest principal sum payable under the accidental death, accidental dismemberment or loss of use benefit, up to a maximum of $50,000. Only one benefit is payable for all losses as a result of the carjacking.

Family Member Benefit

Benefits are payable if your spouse and/or dependent children experience accidental death or dismemberment in a covered accident while traveling with you on company business, while on his or her way to join you or while relocating. Benefits for your spouse and/or dependent children are based on the amount of your BTA coverage:

- *For your spouse,* the maximum benefit payable is 50% of your principal sum, to a maximum of $250,000; and
- *For your dependent children,* the maximum benefit payable is 10% of your principal sum, to a maximum of $50,000.

Benefits are paid on the loss experienced, as outlined in *Amount of Coverage* earlier in this section.

Permanent Total Disability Benefit

Under the BTA plan, you are also eligible for a benefit if you become permanently and totally disabled within 365 days of a covered injury, provided you are under age 75 at the time you become disabled. *Permanently and totally disabled* means that you are permanently unable to perform the material and substantial duties of any occupation for which you are qualified by reason of education, experience or training.

If you are disabled for 12 consecutive months, during the 13th consecutive month, you will be paid the principal sum of your BTA coverage less any other benefit that has been paid or is payable under other coverage for which you are eligible as the result of the same accident.

Return of Pet

If your pet is traveling with you and is left unattended following your death in an area that is outside a 100-mile radius from your current place of primary residence, the BTA plan pays the reasonable cost, to a maximum of $1,000, to transfer your pet to your home (as defined by the plan). Reasonably incurred costs are for transportation expenses only. Expenses to kennel the pet are not reimbursable.

Return of Vehicle

In the event of your death in an area that is outside a 100-mile radius from your current place of primary residence or place of vehicle rental, the BTA plan pays the reasonable cost, to a maximum of $2,000, to transfer your motor vehicle to your home (as defined by the plan).

Seat Belt and Air Bag Benefit

The BTA plan pays an additional seat belt and/or air bag benefit if you or an covered family member suffers a covered accidental death while operating or riding in a private passenger automobile.

The seat belt benefit is payable if the death occurs while wearing a properly fastened, original, factory installed seat belt. (Children must be in a properly installed and fastened child-restraint device as defined by state law.) If proper seat belt use is verified, the BTA plan

pays an additional benefit equal to 25%, to a maximum of $100,000, of your or your covered family member's principal sum.

The air bag benefit is payable if the death occurs while in a seat protected by a properly functioning, original, factory-installed air bag that inflated upon impact in the same accident. In this case, the BTA plan pays an additional benefit equal to 10%, to a maximum of $50,000, of your or your covered family member's principal sum.

Severe Burn Benefit

The BTA plan pays benefits if you or a covered family member suffers a covered severe burn, as shown below.

Specified Body Area	Maximum Payable Percentage of Principal Sum
Face, neck and head	99%
Hand and forearm, below elbow joint (right or left)	22.5%
Upper arm, below shoulder joint to elbow joint (right or left)	13.5%
Torso, below neck to shoulder joints and hip joints (front or back)	36%
Thigh, below hip joint to knee joint (right or left)	9%
Foot and lower leg, below knee joint (right or left)	27%

Travel Benefits

The BTA plan provides you or a covered family member with access to travel benefits while more than 100 miles from either your home or place of employment. Benefits are provided through AIG Accident and Health.

Bedside Visitor Benefit

If you or your covered family member is confined to a hospital or other medical facility for three or more days due to an illness (that begins while coverage under the plan is in force) or injury and the place of confinement is outside a 100-mile radius from your or your covered family member's place of primary residence, the plan will pay for expenses reasonably incurred (but not to exceed the cost of one round-trip economy airfare ticket) to bring one person chosen by you or your covered family member to and from the hospital or other medical facility where you or your covered family member is confined. The plan will also pay for lodging and meals for up to five days (not to exceed $200 per day for lodging and $50 per day for meals) for such person in the area of such place of confinement, but only while you or your covered family member remains so confined. For this benefit to be payable, AIG Travel must make all arrangements and must authorize all expenses in advance.

Emergency Evacuation Benefit

The BTA plan will pay benefits for covered evacuation expenses for a medically necessary evacuation if you or a covered family member suffers an injury or emergency sickness while more than 100 miles from home or permanent place of assignment or residence (as defined by the plan). A medically necessary evacuation is one ordered by a physician due to the severity of the accident or emergency sickness.

The plan will also pay benefits equal to the cost of an economy-class airfare ticket to:

- Return your dependent child(ren), who were traveling with you, to your home or permanent place of assignment or residence (in this case, a one-way economy airfare(s) may apply);

- Bring one person to and from the hospital or other medical facility where the covered person is confined, if more than 100 miles from home or permanent place of assignment or residence (in this case, a single round-trip economy airfare may apply); and
- Bring one non-medical person from the place of the medical emergency to the place where the insured person is evacuated if more than 100 miles from home or permanent place of assignment or residence (not to exceed the cost of an economy-class round-trip airfare ticket).

For covered expenses to be paid under the BTA plan, all arrangements must be made by AIG Travel, as described in the section *AIG Travel Assistance Services.*

Repatriation of Remains Benefit

If you or a covered family member dies in a covered accident or due to an emergency sickness while more than 100 miles from home or permanent place of assignment or residence for all expatriate insured persons (as defined by the plan), the BTA plan pays benefits for covered expenses to return the body home. Covered expenses include:

- Embalming or cremation;
- The most economical coffin or receptacle adequate for transportation of the remains; and
- Transportation of the remains by the most direct and economical method of transportation and route possible.

ATTENDOR BENEFIT

If a repatriation of remains benefit becomes payable under the plan, the plan will also pay for expenses reasonably incurred (but not to exceed the cost of one round-trip economy airfare ticket) for one person (referred to as the attendor) to accompany your or your covered family member's remains from the place where death occurred to your place of primary residence. The plan will also pay for the attendor's lodging and meals for up to seven days (not to exceed $300 per day), but only while the attendor is away from his or her place of primary residence in connection with accompanying your or your covered family member's remains as described above. For this benefit to be payable, AIG Travel must make all arrangements and must authorize all expenses in advance.

AIG TRAVEL ASSISTANCE SERVICES

The BTA plan provides emergency travel assistance, VIP concierge services, worldwide travel assistance, travel medical assistance and security assistance (including if you are a victim of identity theft) through AIG Travel.

Registering with AIG Travel

Before you leave for an international trip, be sure to register with AIG Travel for a user account to access the member-only assistance website (where the full array of services is available). To register for a new user account:

1. *From your desktop computer, go to www.aig.com/us/travelguardassistance.*
2. *Click the* Register Here *button.*
3. *Enter your name, email address (which serves as your username) and policy number (9051307A).*
4. *Click the* Submit *button.*

Once your registration is complete, you will receive an automated email with instructions on how to create a permanent password.

If you have questions during the registration process, call 877-249-5187.

Once you have registered, you can log in to the site on your desktop or smartphone/tablet at any time.

When you register with AIG Travel, you have access to the following covered services.

(continued)

For more information about AIG Travel, call 877-249-5187 (when outside of the United States and Canada, contact an international operator to call 715-295-9624 collect), email assistance@aig.com or read the *AIG Travel Employee Guide* brochure available on *Desktop Benefits* at https://raytheon.benefitcenter.com under *My Resources* in the *Other Benefits* section.

AIG TRAVEL ASSISTANCE SERVICES (continued)

Emergency Travel Assistance

AIG Travel's assistance services are like having a dedicated travel counselor just a phone call away 24 hours a day, seven days a week to solve last-minute travel problems or emergencies, including:

- *Flight, hotel and rental car booking or rebooking;*
- *Emergency return travel arrangements;*
- *Roadside assistance;*
- *Rental vehicle return service; and*
- *Coordinating a late-arrival hotel check-in following a travel delay.*

To make the most of this service, be sure to set up your traveler profile to store emergency contact information and employer information. (Simply follow the log in instructions in the section Registering with AIG Travel.)

VIP Concierge Services

AIG Travel's personal assistance coordinators are available 24 hours a day, seven days a week to help with obtaining:

- *Restaurant referrals and reservations;*
- *Event tickets, including movie and theater information as well as local activity recommendations;*
- *Golf tee time reservations and referrals;*
- *Ground transportation;*
- *Private air and cruise charter assistance;*
- *Wireless device assistance;*
- *Up-to-date weather and ski reports worldwide;*
- *Floral services and gifts;*
- *Special occasion reminders and gift ideas; and*
- *Latest sports scores, stock quotes, lottery results.*

Worldwide Travel Assistance

From arranging travel plans to providing the latest travel information for more than 180 countries, this complete suite of travel tools includes assistance with:

- *Finding or replacing lost or stolen baggage and passport/travel documents;*
- *Return travel arrangements;*
- *Travel information, including travel health and safety information; visa/passport requirements; inoculation information; country guides and pre-trip travel tips; travel delays; and travel supplier strike information;*
- *Email travel alerts providing the latest updates on emerging situations for selected destinations plus daily news reports covering political instability, civil unrest and news from around the world;*
- *Financial assistance, including help locating ATMs; arranging emergency cash transfers; converting or purchasing currencies;*
- *Communications, including providing emergency telephone interpretation assistance; relaying urgent messages to family, friends or business associates; obtaining long-distance calling cards worldwide;*
- *Medical and health issues, including local medical advisories, epidemics, required immunizations and available preventive measures; inoculation information;*
- *Legal needs, such as embassy or consulate referrals, local legal referrals or bail bond assistance; and*
- *Worldwide public holiday information.*

Travel Medical Assistance

AIG Travel can help with any medical needs that may arise during your travel, such as:

- *Emergency prescription, eyeglass, contact lens or medical equipment replacement;*

(continued)

AIG Travel offers a mobile app, which you can use on your smartphone (not available for tablets). To download the app, search for "AIG Travel Assistance" in the app store or go to www.aig.com/travelapp/apple or www.aig.com/travelapp/android and log in with the credentials you established when you first registered for a user account.

AIG TRAVEL ASSISTANCE SERVICES (continued)

Travel Medical Assistance (continued)

- *Local physician, hospital, dental or vision referrals, or dispatching a doctor or specialist;*
- *Accessing and providing medical records;*
- *Providing inpatient and outpatient medical case management;*
- *Acting as a qualified liaison to relay medical information to family members and coordinating travel arrangements for family in the event of a medical emergency;*
- *Medical bills, including audits, cost containment or expense recovery, and overseas investigation;*
- *Emergency medical evacuation transportation assistance; and*
- *Repatriation of mortal remains.*

Security Assistance

Available while you are at home or traveling, AIG Travel's security assistance services are available 24 hours a day, seven days a week and include:

- *Assistance in evacuating a dangerous situation or event (note that you will be responsible for expenses incurred);*
- *Providing security and safety advisories based on in-depth risk analysis by country and city;*
- *Relaying urgent messages; and*
- *Confidential storage of personal and medical information for use in emergency situations.*

AIG Travel also provides assistance in the event of identity theft by:

- *Ordering and reviewing credit bureau records;*
- *Investigating financial accounts if identity theft is suspected;*
- *Interacting with law enforcement to pursue prosecution of criminals;*
- *Reviewing account activity to identify any suspicious activities; and*
- *Reviewing and resolving a victim's issues.*

Note that identity-theft assistance services are not available for residents of New York.

Weekly Accident Disability Benefit

Under the BTA plan, you are eligible for a weekly disability benefit of 70% of your annual base pay for up to one year if you become disabled within 180 days of a covered accident. *Totally disabled* means that you are unable to perform each and every duty of your occupation.

The maximum benefit payable is $500 per week *less* any disability benefits you receive or are eligible to receive, such as a state-mandated disability plan or Social Security disability benefits. Benefits are payable for a maximum of 52 weeks for any disability caused by the same accident.

Weekly benefits will continue until the earliest of the date that:

- The benefit is paid for the maximum number of weeks allowed under the plan;
- You no longer qualify as disabled, as defined by the plan;
- You fail to provide proof of your disability when requested by the insurance company;
- You return to work; or
- You die.

You may be required to periodically provide the insurance company with proof of your continued disability. Failure to provide proof may result in suspension or termination of your benefits.

What the BTA Plan Does Not Cover

Business travel accident benefits are not payable for losses caused by:

- Any loss related to an ***accident that occurs while you are on vacation, commuting between home and work, on a leave of absence or not actively employed;***
- Full-time active duty in the ***armed forces, National Guard or organized reserve corps*** of any country or international authority. Note that unearned premium for any period for which you are not covered due to your active duty status will be refunded;
- ***Infections*** of any kind, regardless of how contracted. The exceptions are for bacterial infections directly caused by botulism; ptomaine poisoning; and an accidental cut or wound that is independent from and in the absence of any underlying sickness, disease or condition, including but not limited to diabetes;
- ***Sickness, disease, mental incapacity or bodily infirmity,*** whether the loss results directly or indirectly from any of these;
- ***Suicide*** or any attempt at suicide, as well as intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury; or
- ***Travel or flight*** in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a passenger, pilot, operator or crew member, unless specifically provided by the policy.

How to File a Claim

If you or your beneficiary need to file a claim, contact your local Human Resources representative, who can provide information about filing a claim. To claim death benefits, you or your beneficiary must provide a completed claim form together with a certified copy of the death certificate and any other documentation required by the insurance company.

If a Claim Is Denied

There are specific procedures to be followed if you or your beneficiary decides to appeal a denied claim. See the *Administrative* section for more information on claims processing and appeal procedures. If you decide to request a review of a claim, send your written request to:

AIG, Accident and Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987

How Benefits Are Paid

Upon approval of the claim, benefits are paid in a lump sum. In the event of a covered accidental dismemberment or loss of use, benefits are payable to you. In the event of your death, benefits are paid to your beneficiary. If the person to whom benefits are to be paid is a minor child or not competent to give a valid release for payment, the payment is made to the individual's legal guardian.

As Your Needs Change

Changes to Your Pay

The amount of your BTA coverage will be adjusted to reflect any changes in your annual base pay. Your new coverage will become effective as of the date your annual base pay changes.

If You Take a Leave of Absence

Because the BTA plan covers only accidents that happen while you are traveling on company business, you are not covered for accidents that occur while you are on a leave of absence, except as described in this section.

If you are traveling at the request of the company while on leave, you are covered at four times your annual base pay rounded to the next highest $1,000, up to a maximum of $500,000, until you return to your home or permanent job location, whichever occurs first. While you are traveling at the request of the company, you are covered 24 hours a day for travel for business and pleasure.

If you are on a "home leave" (leave to travel while you are stationed in a country other than your home country), you are covered 24 hours a day for the duration of your home leave. This coverage includes the travel from and return trip to the country in which you are stationed. Home leave does not have to include travel to your home country.

If You Are Laid Off

If you are laid off, your coverage ends on your last day worked.

Coverage at Age 65

Your coverage under the BTA plan continues unchanged for as long as you work at the company, regardless of your age.

Other Important Information

When Coverage Normally Ends

Your coverage under the BTA plan ends on your last day worked or on the date you are no longer eligible.

Converting to a Non-Group Policy

BTA coverage cannot be converted.

Assigning Your Benefits

Assigning your benefits means that you transfer all rights, title and interest in your BTA insurance to someone else. You may assign ownership of your BTA insurance with the written consent of the insurance company. Contact the RBC at 800-358-1231 for the appropriate forms to assign your insurance. Because there are important legal and tax questions involved, you are strongly encouraged to seek professional advice before making this decision.

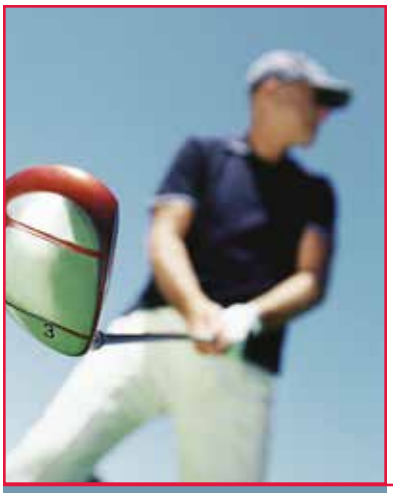
Your Rights

This section describes your BTA insurance in general terms. If any conflict arises between this description and the plan document, or if any point is not covered, the terms of the plan document will govern in all cases. See the *Administrative* section for information related to the administration of the BTA plan.

This document provides only a brief description of the coverage(s) available. The policy contains reductions, limitations, exclusions and termination provisions.

IMPORTANT: This program provides accident insurance only. It does not provide comprehensive/major medical coverage and does not satisfy the minimum essential coverage requirements of the *Patient Protection Affordable Care Act.*

BTA insurance is underwritten by National Union Fire Insurance Company of Pittsburgh, PA., a Pennsylvania insurance company, with its principal place of business at 175 Water Street, 15th Floor, New York, NY 10038. It is currently authorized to transact business in all states and the District of Columbia; NAIC No. 19445.



RAYSIP
at a glance

in this section

- If you are eligible to participate in the Raytheon Savings and Investment Plan (RAYSIP), you may enroll in the plan as of your first day of work, regardless of how many hours per week you are regularly scheduled to work. Your participation will begin as soon as administratively possible after you enroll.

- You may elect to save as little as 1% of your eligible compensation through convenient payroll deduction. When you save:
  - On a *pre-tax basis,* your contributions are deducted from your pay before taxes are withheld, reducing your taxable income.
  - On an *after-tax basis,* your contributions are deducted from your pay after federal, state and local income taxes are withheld. Earnings are tax-deferred as long as they remain in your account.
  - *Using the plan's Roth 401(k) feature,* your contributions are made on an after-tax basis. Your assets grow tax free as long as you meet certain distribution requirements.

  Your total RAYSIP contributions—pre-tax, after-tax and Roth 401(k)—are limited to a maximum of 50% of your eligible compensation, up to certain limits set by the Internal Revenue Service (IRS) each year.

- You always own, or are vested in, the value of your contributions, including any investment earnings on those contributions.

- The plan offers 16 core investment options, including three asset allocation funds. Asset allocation funds are designed to meet specific investment objectives and offer a "one-stop shopping" approach to investing.

  In addition, for experienced investors who are comfortable managing risk and having the responsibility of more closely monitoring their investments, the plan offers Fidelity BrokerageLink®, a self-directed account that allows you to invest in a broad range of mutual

continued on next page

To access information about your RAYSIP account:

- Go to NetBenefits at www.netbenefits.com/raytheon; or
- Call the Savings and Investment Service Line at 800-354-3966 (TDD# 800-847-0348). Outside the United States, call Fidelity collect by dialing the International Access Code (IAC) and then 877-833-9900. IACs can be found at www.att.com/traveler. Customer Service Representatives are available during business days between 8:30 a.m. and midnight, Eastern Time (ET).

For information about Edelman Financial Engines, go to www.EdelmanFinancialEngines.com/forRaytheon or call 800-601-5957.

funds and exchange traded funds (ETFs). ETFs are securities that are listed on an exchange and traded intraday at a price set by the market, similar to stocks.

You make your investment choices in increments of 1%, and change your investment choices as your needs change.

- To help you build a diversified portfolio, the company partners with Edelman Financial Engines, Inc., a leading, independent provider of investment advisory services for 401(k) plan participants. The company offers two Edelman Financial Engines® programs:
  - *Professional Management.* If you don't have the time, interest or expertise to actively manage your RAYSIP account, you can let professionals do it for you (a fee-based service). These professionals will analyze your fund options based on your retirement goals and create an optimum portfolio for you, making ongoing changes as necessary.
  - *Online Advice.* By modeling different contribution rates, risk preferences and retirement ages, Online Advice (available at no additional cost) can help you develop an investment strategy. You can then implement the recommendations and manage your account on your own.

- While you are an active employee, you have access to your account through loans, subject to certain conditions. In addition, you may withdraw money from your account under certain circumstances. Finally, your account is portable, which means you may take the vested money in your account with you if you leave the company.

- Recordkeeping services for RAYSIP are performed on a day-to-day basis by Fidelity Investment Institutional Operational Company, Inc.

- For additional information about RAYSIP, be sure to review the *Administrative* section.

RAYSIP at a glance

Enrolling in the Raytheon Savings and Investment Plan (RAYSIP)

If you are eligible to participate in the Raytheon Savings and Investment Plan (RAYSIP), you may enroll as of your first day of work, regardless of how many hours per week you are regularly scheduled to work. You may elect to make pre-tax, after-tax and/or Roth 401(k) contributions to the plan. Your contributions begin as soon as administratively feasible after you enroll. Contributions to your account are not made retroactively to your date of employment or re-employment.

You may enroll at any time through Fidelity NetBenefits® or by calling the Savings and Investment Service Line. Both systems will walk you through the steps to:

- Set up your password;
- Select the percentage of eligible compensation you want to save, in increments of 1%;
- Decide whether to make pre-tax, after-tax and/or Roth 401(k) contributions;
- Decide whether to have your pre-tax contributions automatically spill over to after-tax contributions once you reach the pre-tax contribution maximum (see *Contributions You Make to Your Account* later in this section);
- Choose how you want to invest your savings; and
- Choose the voluntary Edelman Financial Engines account management program that best fits your needs (for a description, see *Investing the Money in Your Account* later in this section).

You must also name your beneficiary(ies), as described in the following section. Shortly after you enroll, you will receive a confirmation statement from Fidelity Investment Institutional Operational Company, Inc. (Fidelity) verifying your elections.

If you are hearing impaired, you will not be required to establish a password. Instead, each time you call 800-847-0348, the Savings and Investment Service Line's toll-free TDD number, you will be asked to identify yourself by providing certain personal information (for example, your Social Security number and date of birth).

If you are a new employee, a RAYSIP enrollment kit will be mailed to your home. Your kit includes the information you need to make your enrollment and investment decisions as well as a *Beneficiary Designation* form.

Naming Your Beneficiary

When you first join the plan, you will be asked to name your *beneficiary(ies)*—the person(s) or legal entity(ies) (e.g., trust(s) or charity(ies)) that will receive your account balance in the event of your death. To name or change your beneficiary(ies), go to NetBenefits. This makes it easy to review and update your beneficiary(ies) as needed. If you prefer, you may submit a paper *Beneficiary Designation* form (available by calling the Savings and Investment Service Line). If you submit a paper form, you will need to call the Savings and Investment Service Line each time you wish to review and/or update your beneficiary(ies).

If you are married and wish to name—or later wish to change—your beneficiary to someone other than your spouse, federal law requires that your spouse provide written, notarized consent in the "Spousal Consent" section of the *Beneficiary Designation* form. Note that the plan recognizes a common law marriage if the marriage was established at a time when the state in which it was established permitted common law marriages.

If you are not married, you may name anyone you wish as your beneficiary.

Note that if you are married on the date of your death, your spouse is automatically your beneficiary, unless you have provided written, notarized consent from your spouse for your designation of someone other than him/her as your beneficiary.

More information is available through NetBenefits or by calling the Savings and Investment Service Line.

It is your responsibility to keep your beneficiary designation up to date. You can update or change your beneficiary designation at any time through NetBenefits or by calling the Savings and Investment Service Line.

NetBenefits
www.netbenefits.com/raytheon

Savings and Investment Service Line
800-354-3966

Edelman Financial Engines
www.EdelmanFinancialEngines.com/forRaytheon
800-601-5957

MANAGING YOUR RAYSIP ACCOUNT

You may access information about your RAYSIP account in two ways:

- ***Online,** through NetBenefits at www.netbenefits.com/raytheon; or*
- ***By phone,** through the Savings and Investment Service Line at 800-354-3966 (TDD# 800-847-0348), (outside the United States, call Fidelity collect by dialing the International Access Code (IAC) and then 877-833-9900. IACs can be found at www.att.com/traveler).*

The services of the Savings and Investment Service Line and NetBenefits are provided by Fidelity, the plan recordkeeper.

Services Available Online or by Phone

- *Enroll in RAYSIP and make your initial investment elections.*
- *Set up or change your password.*
- *Name or change your beneficiary(ies).*
- *Check or change your current payroll deduction amount (in increments of 1%).*
- *Review/request fund prospectuses/investment facts and obtain other information on the plan's core investment options, including current prices, expense ratios and historical performance information (real-time market updates available online only).*
- *Review or change how your current contributions are being invested.*
- *Enroll in or change your investments through Fidelity BrokerageLink.*
- *Enroll in or change your preferences in an Edelman Financial Engines program.*
- *Check your current account balance.*
- *Obtain information about your transaction history.*
- *Initiate and track the progress of a rollover contribution from another qualified plan.*
- *Obtain information about loans, including the outstanding balance.*
- *Initiate a new loan.*
- *Initiate an in-service withdrawal (hardship, after-tax or upon reaching age 59½).*

Services Available Only through a Customer Service Representative

You must speak with a Customer Service Representative to conduct certain transactions, including:

- *Initiation of a final distribution.*
- *Initiation of a rollover to another employer's qualified retirement plan or to an individual retirement account.*
- *Change of address, if you are a retired or terminated plan participant.*

Customer Service Representatives are available by calling the Savings and Investment Service Line from 8:30 a.m. to midnight Eastern Time (ET) any business day.

KEEPING TABS ON YOUR NEST EGG WITH THE FIDELITY NETBENEFITS APP

With the Fidelity NetBenefits app, you can monitor your RAYSIP account nearly all the time from wherever you are. For example, you can:

- *Follow your RAYSIP account balance and total portfolio of Fidelity-managed accounts;*
- *Check current account balances by investment option and source;*
- *View and change your contribution percentages;*
- *Make exchanges between investment options; and*
- *Learn more about investment basics.*

To download the free NetBenefits app, go to www.fidelity.com/go/netbenefitsapp or visit the App Store®, Google Play™ or Windows Store.

For a complete, up-to-date display of all your financial information on one, easy-to-view webpage, check out Full View,℠ available through NetBenefits. Here you can access a consolidated view of your investment, bank, credit card, loan and mortgage accounts from more than 7,000 financial institutions—providing an easy way to manage your finances.

RAYSIP Info to Go!

With Fidelity, you can get expert insight on an array of personal finance topics and discover new investing strategies via Facebook and Twitter. Simply "like" or "follow" Fidelity Investments at facebook.com/fidelityinvestments and twitter.com/fidelity.

NetBenefits
www.netbenefits.com/raytheon

Savings and Investment Service Line
800-354-3966

Edelman Financial Engines
www.EdelmanFinancialEngines.com/forRaytheon
800-601-5957

Contributions You Make to Your Account

There are three types of contributions you may make to RAYSIP:

- ***Pre-tax,*** which are deducted from your pay before taxes are withheld, reducing your taxable income;
- ***After-tax,*** which are deducted from your pay after federal, state and local income taxes are withheld. Earnings are tax-deferred as long as they remain in your account; and
- ***Roth 401(k),*** an after-tax option that allows your assets to grow tax-free if you meet certain distribution requirements.

Your contributions can be as little as 1% of your eligible compensation and are made in increments of 1%. Contributions cannot exceed 50% of your eligible compensation, up to certain limits set by the Internal Revenue Service (IRS). For 2021, there is a $290,000 compensation limit (subject to annual cost of living adjustments). For more information about IRS limits, see *IRC Limits on Contributions* later in this section.

For the purpose of plan contributions, your eligible compensation includes your base pay as well as any Achievement Awards or spot awards. Eligible compensation does not include reimbursed expenses, such as moving expenses or tuition reimbursement, if eligible; certain amounts paid after termination of employment; or payments made under certain special compensation programs.

To help you determine your maximum RAYSIP contribution, use the *401(k) Estimator* tool. This tool can be found under *MyInfo Home* in the *My Tools & Resources* section of RTXConnect.

INCREASE THE AMOUNT YOU SAVE—AUTOMATICALLY

Increasing your savings can go a long way toward helping you build a comfortable nest egg for retirement. To make sure you don't miss an opportunity to increase the amount you save, such as when your pay increases, Fidelity offers the Annual Increase Program.

When you sign up, you elect to automatically increase the percentage of pay you save in RAYSIP, on a date that you choose, by 1%, 2% or 3% of your pay. You may also consider using this feature to automatically direct a portion of an anticipated annual merit increase toward RAYSIP. For more information or to elect this feature, go to NetBenefits or call the Savings and Investment Service Line.

Pre-Tax Contributions

You may contribute from 1% to 50% of your eligible compensation to RAYSIP on a pre-tax basis in increments of 1%. For 2021, the maximum amount you can contribute to the plan on a pre-tax and/or Roth 401(k) basis combined is $19,500.

When you save on a pre-tax basis, your contributions are deducted from your pay before federal and, in most cases, state and local income taxes are withheld. This reduces your taxable income. Withdrawals of pre-tax contributions are taxable.

It's important to note that you have only limited access to any money you set aside on a pre-tax basis. You may only access your money before age 59½ through loans or through withdrawals due to certain limited hardships. For more information, see *Accessing the Money in Your Account* later in this section.

You may elect to save as little as 1% of your eligible compensation to the plan through convenient payroll deduction. Your total RAYSIP contributions—pre-tax, after-tax and Roth 401(k)—are limited to a maximum of 50% of your eligible compensation, up to certain limits set by the IRS each year.

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After-Tax Contributions

You may contribute from 1% to 50% of your eligible compensation to RAYSIP on an after-tax basis in increments of 1%. While there are no specific after-tax contribution limits, after-tax contributions are considered when calculating other contribution maximums as outlined in *IRC Limits on Contributions* later in this section.

When you save on an after-tax basis, your contributions are deducted from your pay after federal, state and local income taxes are withheld. Earnings on your after-tax contributions are tax-deferred as long as they remain in your account. Unlike with Roth 401(k) contributions, taxes are payable on the earnings on any after-tax contributions.

When you make after-tax contributions to your account, you have greater access to your savings while you are working. That's because you may access after-tax savings at any time through loans or withdrawals. For more information, see *Accessing the Money in Your Account* later in this section.

Roth 401(k) Contributions

You may contribute from 1% to 50% of your eligible compensation to RAYSIP through the plan's Roth 401(k) feature in increments of 1%. For 2021, the maximum amount you can contribute to the plan on a pre-tax and/or Roth 401(k) basis combined is $19,500.

A Roth 401(k) is an after-tax contribution option that allows your assets to grow tax-free. While Roth 401(k) contributions are deducted from your pay *after* taxes have been withheld, your earnings are tax-free as long as you meet the IRS requirements for a qualified distribution—one that is taken:

- At least five tax years from the year of your first Roth 401(k) contribution, and
- After you have either reached age 59½ or become disabled, or in the event of your death.

For more information about the Roth 401(k) feature, go to NetBenefits or call the Savings and Investment Service Line. You are encouraged to consult with a tax advisor to determine if Roth 401(k) contributions are right for you.

CONVERTING EXISTING RAYSIP ACCOUNT BALANCES TO A ROTH 401(K)

If you choose, you may convert eligible funds from your RAYSIP accounts to a Roth 401(k) account (called an Roth In-Plan Conversion).

To be eligible for conversion, funds must be considered immediately distributable. *Examples of immediately distributable funds are shown in this chart:*

Your Age	RAYSIP Accounts Eligible for Conversion
Up to 59½	After-tax
59½ and Above	Pre-tax and after-tax, up to your entire account balance

You may elect to convert any amount of funds from eligible accounts to a Roth 401(k); there are no limits. Conversion is a taxable event; see your tax advisor for more information. Outstanding loans are not eligible for conversion.

For more information about in-plan conversions, call the Savings and Investment Service Line.

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CATCH-UP CONTRIBUTIONS

If you will have reached at least age 50 during any given calendar year, you may make an additional "catch-up" contribution of up to $6,500 (in 2021) to RAYSIP beyond the IRS contribution and compensation limits. Your catch-up contribution can be made with pre-tax and/or Roth 401(k) contributions. (Note that you do not have to wait until you reach the $19,500 limit before making your catch-up contribution.)

You may make a catch-up contribution election through NetBenefits or by calling the Savings and Investment Service Line.

Any earnings on your pre-tax catch-up contributions are not taxable as long as they remain in your account. This means that taxes are deferred until you withdraw the money from your account. Taxes are payable on the money you withdraw.

Any earnings on Roth 401(k) catch-up contributions are not taxable if you meet certain distribution requirements. See Roth 401(k) Contributions *later in this section for details.*

THE BENEFIT OF PRE-TAX SAVINGS

When you make pre-tax contributions to RAYSIP, it actually costs you less to save the same amount of money when compared with saving on an after-tax basis. For example, suppose you are single, your eligible compensation is $35,000 per year and you decide to save 10% of your compensation, or $3,500, in the plan. By saving with pre-tax dollars, you lower your taxable income and save money. Here's how:*

	You save 10% on a pre-tax basis	You save 10% on a Roth 401(k)* or after-tax basis
Your eligible compensation	$35,000	$35,000
You save 10% in the plan on a pre-tax basis	$ 3,500	-0-
Your taxable income	$31,500	$35,000
Your federal income and FICA tax	$ 4,753	$5,173
You save 10% in the plan on an after-tax basis	-0-	$ 3,500
Your take-home pay	$26,747	$26,327
Your tax savings for this calendar year	**$ 420**	

**While your immediate tax consequences mimic after-tax savings, with Roth 401(k) contributions, tax benefits are realized later. Specifically, if your withdrawal of Roth 401(k) contributions and any related earnings meets IRS regulations, no part of your distribution is taxable. However, if you withdraw pre-tax contributions and any associated earnings, or any earnings associated with after-tax contributions, the plan is required to withhold 20% of any withdrawal for federal taxes, plus any applicable state taxes. An additional 10% penalty usually applies to the withdrawal of previously untaxed money (such as pre-tax contributions and earnings on both pre-tax and after-tax contributions to your account) made before age 59½.*

Taxes for this example are based on filing single with one exemption using 2021 federal tax withholding tables. In most states you would also save on state income taxes, which are not shown in this example. This example is for illustrative purposes only. Your situation would likely differ depending on a number of factors, including actual earnings, amount saved, where you live and tax law changes. Remember, with pre-tax and after-tax contributions, taxes will generally be due on at least a portion of any distribution you take from your plan account.

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Rollover Contributions

In certain circumstances, you may also make a tax-deferred rollover contribution to your account as of or after your date of employment or re-employment, even if you choose not to contribute to the plan. If you are an active employee of the company and receive an eligible rollover distribution from another qualified savings and/or retirement plan (other than a retirement plan sponsored by the company), from a Simplified Employee Pension–Individual Retirement Account (SEP–IRA), and/or from an individual retirement account (IRA) you have as a result of a previous rollover from an employer's plan, you may be able to defer taxes and penalties by rolling your distribution over into RAYSIP. You may also be eligible to roll over other forms of retirement savings, including:

- 403(b) and 457 plan accounts;
- After-tax retirement savings from a previous employer's retirement plan;
- Qualified domestic relations order (QDRO) distributions received from another qualified employer's retirement plan; or
- Distributions received as the beneficiary of a participant in another qualified employer's retirement plan.

In addition to simplifying the management of your retirement funds, rolling other retirement accounts into your RAYSIP account may save you money—particularly with IRAs, as most IRA administrators charge annual fees that are likely higher than similar fees associated with RAYSIP.

Rollovers must be received within 60 days of your receipt from the other qualified savings and/or retirement plan or IRA. Otherwise, your rollover must be treated as a taxable withdrawal.

To initiate and track the progress of a rollover contribution, go to NetBenefits and click on the *Rollover* tab. Here you'll find easy-to-follow steps to complete a rollover, a list of the distribution options available for your account with a former employer and instructions on how to submit a copy of the rollover check from your smartphone. If you have any questions about making a rollover contribution to the plan, call the Savings and Investment Service Line.

Changing or Stopping Your Contributions

You may change or stop the amount you contribute to your account at any time through NetBenefits or by calling the Savings and Investment Service Line. If you stop your contributions, you may restart them at any time through NetBenefits or by calling the Savings and Investment Service Line.

Any change you request, including stopping or starting contributions, will become effective as soon as administratively feasible. You will receive written confirmation of your requested change from Fidelity.

If your employment ends, your current contribution percentage election will remain on record for 35 days from your last day worked, unless you go online or call to change it. After 35 days, to comply with IRS regulations, Fidelity will automatically set your contribution percentage to zero. If you are re-employed or receive any payments after your termination date, the contribution percentage on record for you at that time—whether your most recent election or zero—will apply until you change it or stop contributions.

If you are on a leave of absence for military service, your participation in RAYSIP continues. For information about how contributions are affected during a military leave of absence, see *If You Take a Leave of Absence* later in this section.

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Owning the Money in Your Account

You always own, or are vested in, the value of your contributions, including investment earnings on those contributions.

Investing the Money in Your Account

When you first enroll in RAYSIP, you are asked to choose how to invest the money in your account. The investment elections you choose apply to *all* your contributions—pre-tax, after-tax and Roth 401(k). If you do not make an investment election, your contributions will be invested automatically in the Janus Henderson Balanced Fund Class N until you change the investment direction. For information about the Janus Henderson Balanced Fund Class N, see the chart *Choose the Investment Approach That's Right for You* later in this section.

The plan offers 16 core investment options, including three asset allocation funds. Asset allocation funds are designed to meet specific investment objectives and offer a "one-stop shopping" approach to investing.

In addition, for experienced investors who are comfortable managing risk and having the responsibility of more closely monitoring their investments, the plan offers Fidelity BrokerageLink, a self-directed account that allows you to invest in a broad range of mutual funds and exchange traded funds (ETF). (Note that at least 10% of your RAYSIP contributions must be invested among the core investment options.) You make your investment choices in increments of 1%, and change your investment choices as your needs change.

To encourage you to diversify the money in your RAYSIP account (see the inset box Importance of *Diversifying Your Retirement Savings* to learn more), no more than 20% of your RAYSIP contributions may be directed to the Raytheon Technologies Stock Fund. Funds may not be transferred from another investment option into the Raytheon Technologies Stock Fund—either by action you take or action taken by Edelman Financial Engines Professional Management—if more than 20% of your total account balance is invested in the Raytheon Technologies Stock Fund.

The Raytheon Technologies Stock Fund invests primarily in Raytheon Technologies common stock. It also invests in a small amount of short-term cash investments, so that the fund can buy or sell every business day without the usual trade settlement period associated with stock transactions.

Your RAYSIP account statement (see the section *Your Account Statement)* shows any balance you have in the Raytheon Technologies Stock Fund in "units." The value of a unit includes the market value of the Raytheon Technologies common stock, plus any short-term cash or liquid investments held by the fund (usually from ¾% to 1¼%). Using unitization for this fund does not change the market value of your investment.

PROFESSIONAL INVESTMENT HELP AVAILABLE

Since there are as many approaches to investing as there are people, unless you're well-versed in the field, developing the strategy that's right for you may require expert advice. To help, the company offers Edelman Financial Engines—a leading, independent provider of investment advisory services for 401(k) plan participants. Whether your investment style is hands-off or hands-on, Edelman Financial Engines offers an independent advisory service for you. See Professional Help Available through Edelman Financial Engines *later in this section for details.*

To meet the needs of a variety of investors, RAYSIP offers a range of investing approaches. Whether you think developing a plan is best left up to the experts, feel confident in your ability to choose investments, or fall somewhere in between, RAYSIP offers an investment approach that's right for you. Before making any investment decisions, think about how involved you want to be in developing and managing an investment strategy. For guidance, see the next page.

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Choose the Investment Approach That's Right for You

Level of Your Involvement	Investing Approach
Not Very Involved	**Have a Professional Do It for You** **Edelman Financial Engines Professional Management*** *For those who do not have the time, interest or expertise to actively manage their investment accounts (a fee-based service)* • Develops and implements a customized investment strategy using RAYSIP's core investment options (listed later in this section) • Takes into account your personal situation—preferred risk tolerance, desired retirement age and other retirement income sources, if applicable • Automatically monitors and manages your investments (buying and selling, as necessary) to keep pace with changes in your retirement horizon, the economy and investment markets
Slightly More Involved	**Do It Yourself: One-Stop Shopping** **Asset Allocation Funds** *For those who want a diversified portfolio, and have a strong sense of which mix of stocks and bonds best fits their investing style* You select the asset allocation option(s) that best matches your investing style: • Income Oriented Allocation Index Fund, designed for more conservative investors (35% stocks/65% bonds) • Janus Henderson Balanced Fund Class N, designed for more moderate investors (normally 60% stocks/40% bonds) • Growth Oriented Allocation Index Fund, designed for more aggressive investors (75% stocks/25% bonds)
More Involved	**Have a Professional Make Recommendations for You** **Edelman Financial Engines Online Advice*** *This online tool is for those who are confident in making investment decisions or executing investment recommendations from Edelman Financial Engines on their own and monitoring their accounts over time (no additional cost)* • Models different contribution rates, risk preferences and retirement ages • Makes personalized recommendations for your portfolio using RAYSIP's core investment options (listed later in this section) • Takes into consideration savings, investment mix, risk preferences, retirement age, additional retirement income (such as Social Security or a pension) and retirement income goals • You choose whether or not to implement the recommendations • You manage your investments over time
Much More Involved	**Do It Yourself** **RAYSIP's Core Investment Options** *For those who prefer having the flexibility to take a more active role in choosing their investments from a select number of options and are somewhat confident with investing and asset allocation* • Choose from RAYSIP's core investment options (listed later in this section)
Completely Involved	**Do It Yourself** **Fidelity BrokerageLink** *For experienced investors who are comfortable managing risk and having the responsibility of more closely monitoring this portion of their investment portfolio (no annual fee, however a Securities and Exchange Commission (SEC) sales fee and brokerage commissions apply)* • Provides access to thousands of Fidelity mutual funds and non-Fidelity mutual funds, available through Fidelity FundsNetwork® and exchange traded funds (ETFs) • Does not provide access to the core investment options

**For more information about this program, see* Professional Help Available through Edelman Financial Engines *later in this section.*

To help you build a diversified portfolio for your RAYSIP account, the company partners with Edelman Financial Engines. To try an Edelman Financial Engines program, go to www.EdelmanFinancialEngines.com/forRaytheon or call 800-601-5957 (advisors are available Monday through Friday from 9 a.m. to 9 p.m. ET). For more information, see *Professional Help Available through Edelman Financial Engines* later in this section.

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Core Investment Options

To help you build an investment portfolio with varying amounts of risk and return that are appropriate for you, the company and Fidelity offer a streamlined lineup of 16 core investment options, including three asset allocation funds. Asset allocation funds are designed to meet specific investment objectives and offer a "one-stop shopping" approach to investing. The lineup is structured to focus on an analysis of the characteristics of each investment option's general investment categories, ***not*** on the actual options and their holdings, which can change frequently and often overlap between investment options, creating a false sense of diversification.

You can invest in any combination of these options, giving you a wide range of investment choices to help meet your personal goals.

Changing Your Core Investment Options

You may make changes to your investment strategy by transferring your current investments and/or your future contributions as often as you wish, subject to certain restrictions on frequent trading imposed by the funds. For example, you may not exchange money directly from the Raytheon Fixed Income Fund to the BlackRock Government Short-Term Investment Fund Class 3. In this case, money must be invested in other funds for 90 days before it can be invested in the BlackRock Government Short-Term Investment Fund Class 3. For information on short-term trading restrictions, frequent trading policies and/or fees for any specific fund, see the fund's prospectus/investment facts available on NetBenefits.

You may change your investment elections in the core investment options through NetBenefits or by calling the Savings and Investment Service Line. The change you request will become effective as of the date of your request, provided your request is confirmed by the close of the New York Stock Exchange (normally 4:00 p.m. ET). Changes confirmed after the close of the market or on weekends or holidays will receive the next available closing price.

You will receive written confirmation of the change from Fidelity once it has been processed. (Note that the minimum exchange amount is the lesser of $250 or 100% of your balance in the fund from which the exchange is being made.)

BEFORE YOU INVEST, BE SURE TO KNOW …

All investment funds offer a different potential rate of return and associated level of risk. Risk *means the possibility that your investment may go up or down. High-risk investments may fluctuate more over the short term but may offer the potential for higher returns over longer periods of time.* Rate of return *means the percentage of gain or loss on the money invested over a specific period of time.*

For detailed information about RAYSIP's core investment options, see the fund's prospectus/investment facts available on NetBenefits or call the Savings and Investment Service Line. These materials provide valuable information about each fund's investment goals, risk level, performance and any applicable fees.

Most people's financial goals vary over time. When you're young, you may be saving for shorter-term goals, such as buying a home or paying for your child's college education. Later, you may be more concerned about saving for retirement.

With RAYSIP, you can change your investment choices and contributions from time to time, as your needs change. Prior to making any investment decision, you should consider your current situation and your future needs carefully.

You are encouraged to consult with a qualified investment professional if you have any questions. It's important to note that past performance of an investment is no guarantee of future performance.

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RAYSIP Core Investment Options

This chart shows the risk spectrum of the core investment options. Categories at the top are typically less risky but have a potentially lower rate of return. Categories at the bottom are typically more risky but have a potentially higher rate of return. These general categories do not represent the investment options' objectives, do not predict the investment options' future styles, and do not represent actual or implied performance.

Money Market (Short Term)

- BlackRock Government Short-Term Investment Fund Class 3

Managed Income (Stable Value)

- Raytheon Fixed Income Fund

Bond

- Northern Trust Collective[1] Aggregate Bond Index Fund–Non-Lending (Tier R)
- PIMCO Total Return Fund Institutional Class

Balanced/Hybrid

- Income Oriented Allocation Index Fund[2,3,5]
- Janus Henderson Balanced Collective Fund Fee Class I[4]
- Growth Oriented Allocation Index Fund[2,3,5]

Domestic Equity–Large-Cap Blend

- Northern Trust Collective[1] S&P 500® Index Fund–DC–Non-Lending (Tier R)
- Vanguard Institutional Total Stock Market Index Fund Institutional Plus Shares

Domestic Equity–Small-Cap Blend

- Northern Trust Collective[1] Russell 2000 Index Fund–DC–Non-Lending (Tier R)

Domestic Equity–Small-Cap Growth

- T. Rowe Price Institutional Small-Cap Stock Fund

International/Global Equity–Diversified

- American Funds New Perspective Fund® Class R-6
- Northern Trust Collective[1] All Country World (ACWI) ex-US Fund–DC–Non-Lending (Tier R)

International/Global Equity–Emerging Markets

- Oppenheimer Developing Markets Fund Class R6

Specialty

- Vanguard Real Estate Index Fund Institutional Shares

Company Stock

- Raytheon Technologies Stock Fund

The RAYSIP core investment options are subject to change. To review the current fund offerings, go to NetBenefits or call the Savings and Investment Service Line.

RAYSIP offers 16 core investment options across a broad risk spectrum. You can invest in any combination of these professionally managed core investment options. Note that 10% of your total RAYSIP account must be invested in the core investment options (you can allocate up to 90% of your account balance to a Fidelity BrokerageLink account, described later). If you do not make an investment election, your contributions will be invested automatically in the Janus Henderson Balanced Fund Class N, until you change the investment direction.

For detailed information about each option, see the fund's prospectus/investment facts available on NetBenefits or call the Savings and Investment Service Line. These materials provide valuable information about each fund's investment goals, risk level, performance and any applicable fees.

[1]For a description of collective investment trusts, see the inset box *About Collective Investment Trusts* on the next page.

[2]The Growth Oriented Allocation Index Fund and the Income Oriented Allocation Index Fund are relatively new CITs/funds; therefore, performance history is limited.

[3]This is an asset allocation option. The portfolio of underlying funds for each fund will be rebalanced at every month-end, if needed, to pre-set equity and fixed income targets.

[4]This is an asset allocation option. It normally invests 35% to 65% of its assets in equity securities and the remaining assets in fixed-income securities and cash equivalents. It typically invests at least 25% of its assets in fixed-income securities.

[5]Regarding our asset allocation funds, approach to diversification and asset allocation does not ensure a profit or guarantee against loss. In addition, keep in mind that you will need to periodically re-evaluate your risk tolerance and adjust your investments accordingly.

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ABOUT COLLECTIVE INVESTMENT TRUSTS

Some RAYSIP investment options are collective investment trusts (CITs). CITs are tax-exempt, pooled investment vehicles maintained by a bank or trust company for investment by tax-qualified employee benefit plans and governmental retirement plans.

While CITs are exempt from registration with the U.S. Securities and Exchange Commission (SEC), they are considered "plan assets" and therefore subject to the Employee Retirement Income Security Act of 1974 *(ERISA), as well as oversight by the Office of the Comptroller of the Currency (in the case of national bank trustees), local banking and trust law and SEC (in the case of registered adviser trustees).*

BECOMING A SHAREHOLDER

One of the investment options available through RAYSIP is the Raytheon Technologies Stock Fund. When you hold stock in the Raytheon Technologies Stock Fund, you become a part owner of the company. This means that you are eligible to vote confidentially on important issues at the stockholders' annual meeting, including electing members to the Board of Directors.

Here's how voting works:

- *You will receive a packet of information in the mail or via email before the annual meeting. This packet will include an explanation of each issue requiring shareholder voting action, a ballot (also called a "proxy") and instructions on how to complete the ballot, including the deadline by which the ballot must be returned.*
- *Read the information in the packet carefully, then decide how you wish to vote on each issue.*
- *Mark the ballot with your votes, sign and date it, then mail it to the transfer agent before the voting deadline.*
- *The Plan Trustee will vote your shares as you have requested at the annual meeting.*

It's important to note that you must return your ballot by the voting deadline or your votes cannot be counted.

DIVIDEND PAYOUT FEATURE FOR THE RAYTHEON TECHNOLOGIES STOCK FUND

With the Dividend Payout feature, you have the option of choosing to receive the dividends paid on your Raytheon Technologies Stock Fund balance as a cash payment without a penalty or to reinvest them.

By going to NetBenefits or calling the Savings and Investment Service Line, you can:

- *Find out if a dividend has been declared for the quarter (the company's Board of Directors decides if a dividend will be paid);*
- *See what date the Board of Directors has selected for payout; and*
- *Elect to receive your dividends in cash, if you wish.*

You must make your election at least 10 days before the dividend payment date. Once you've made this election, you will continue to receive dividend payments as cash until you elect otherwise.

When you choose to receive your dividend payment in cash, it will be taxable in the year it is received. After the end of the year, you will receive a Form 1099-DIV indicating the total dividends you received as cash for the year.

Note that while any cash received is taxable as ordinary income, there isn't a 10% penalty associated with this transaction. This means that the Dividend Payout feature allows you to obtain cash from your RAYSIP account to use for any purpose without incurring the 10% early withdrawal penalty normally associated with distributions made before you turn age 59½.

If you have elected to receive dividends in cash, but payments out of your account are not permitted (because of a QDRO) or monies are undeliverable due to an incorrect address, your dividends will continue to be reinvested in your Raytheon Technologies Stock Fund account.

If you wish to continue to reinvest your dividend proceeds in the Raytheon Technologies Stock Fund, no action is necessary. Your dividends will continue to be reinvested on a tax-deferred basis. The choice is up to you.

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FIDELITY BROKERAGELINK®

With Fidelity BrokerageLink,® RAYSIP provides you with the opportunity to invest in a broad range of investment options beyond the plan's core investment options. BrokerageLink provides access to the Fidelity Funds Network®, which offers thousands of Fidelity and non-Fidelity mutual funds, and exchange traded funds (ETFs). This additional flexibility and choice may help you build a retirement portfolio that's more tailored to your individual goals.

While many mutual funds and ETFs are available through BrokerageLink, you cannot use the program to invest in any of the core investment options available through RAYSIP, tax-exempt securities, employer securities (including all types of equities, such as common stock, preferred stock, convertible stock and options), physical certificates, precious metal, limited partnerships (including investments that may generate unrelated business taxable income, such as limited partnerships and ETFs with a limited partnership structure), futures contracts, commodities, currencies, currency options, CAPS or options. In addition, you may not invest in any other issue/security that may result in a RAYSIP-prohibited transaction.

Participating in BrokerageLink

To participate in BrokerageLink, you must establish a Fidelity BrokerageLink account with at least $2,500. Future transfers carry a $1,000 minimum. To open an account, you'll need a BrokerageLink kit, which is available:

- *Through NetBenefits:*
  - *Under* Quick Links, *click on* BrokerageLink.
  - *Review the materials under* Learn More *and* Review BrokerageLink Plan Information.
  - *Click on* Open an Account *and follow the instructions.*
- *By calling the Savings and Investment Service Line.*

Once you receive your kit, complete and return the Fidelity BrokerageLink Participant Acknowledgment Form. *Approximately two weeks after Fidelity receives your form, you will receive your account number and the* Expand Your World of Investment Choices *handbook.*

Once your BrokerageLink account is open, you can direct up to 90% of your future RAYSIP contributions to this service; 10% of your RAYSIP contributions must be invested among the core investment options. You may also choose to transfer up to 90% of your existing contributions and any associated earnings to BrokerageLink. (Note that transfers are not allowed from the Raytheon Fixed Income Fund.)

Although there isn't an annual fee for the service, a SEC sales fee and brokerage commissions apply. For a complete list of fees, refer to the BrokerageLink Fact Sheet *and commission schedule in the* Participant Acknowledgment Form.

For more information about BrokerageLink, go to NetBenefits or call the Savings and Investment Service Line.

Changing Your Investments with BrokerageLink

Any changes you make to BrokerageLink investments—in terms of exchanges you make from a core investment option into your BrokerageLink account—go through a two-step process, as described here:

- *90% of your transfer amount is immediately available to trade through a Fidelity Retirement Brokerage Services Representative. To allow for market fluctuation, the remaining 10% is held in the Fidelity BrokerageLink core account, Fidelity® Government Cash Reserves, during the required settlement period.*
- *The following business day, the remaining portion of your transfer amount (or 100% if you did not take action the prior business day) is available for trading online or through a representative.*

For questions about BrokerageLink trading, refer to your BrokerageLink kit, go to NetBenefits or call the Savings and Investment Service Line.

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IMPORTANCE OF DIVERSIFYING YOUR RETIREMENT SAVINGS

To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform very well often cause another asset category, or another particular security, to perform poorly. If you invest more than 20% of your retirement savings in any one company or industry, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk.

In deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of RAYSIP. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals and different tolerances for risk.

It is also important to periodically review your investment portfolio, your investment objectives and the investment options under RAYSIP to help ensure that your retirement savings will meet your retirement goals.

The Department of Labor website provides sources of information on investing and diversification.

Professional Help Available through Edelman Financial Engines

To help you build a diversified portfolio for your RAYSIP account, the company partners with Edelman Financial Engines, Inc., a leading, independent provider of investment advisory services for 401(k) plan participants. Edelman Financial Engines Advisors LLC is an independent, registered investment advisor and wholly owned subsidiary of Edelman Financial Engines, Inc., which was co-founded in 1996 by Nobel Prize-winning economist Bill Sharpe. Edelman Financial Engines helps participants with their overall retirement picture by offering personalized plans for saving and investing for retirement and retirement income.

Since different individuals have different investment styles—from hands-off to hands-on—the company offers two Edelman Financial Engines programs:

- ***Professional Management,*** which is designed to help participants who do not have the time, interest or expertise to actively manage their investment accounts. With Professional Management, Edelman Financial Engines investment professionals create, implement, monitor and manage a diversified retirement plan just for you. If you choose to participate in Professional Management, your current RAYSIP account is analyzed. Then, based on your personal situation—preferred risk tolerance, desired retirement age and other retirement income sources you may have, if you choose to provide this information—a customized investment strategy is created and implemented for you using the core investment options.

  Your account is regularly monitored and your RAYSIP investment options are actively managed (bought or sold, as necessary) to keep pace with changes in your retirement horizon, the economy and investment markets.

  You will receive quarterly, printed Retirement Updates and always have access to investment advisors by calling 800-601-5957 (the Advisor Center is open Monday through Friday from 9 a.m. to 9 p.m. ET).

  The cost to participate in this program is 0.28% (.0028) for the first $100,000 in your RAYSIP account balance. That's about $2.33 a month for each $10,000 in your account. Discounts apply for higher account balances. Fees are deducted directly from your account on a quarterly basis. There are no commissions or transaction fees for the program, and you can end your participation at any time. For a complete fee schedule, contact Edelman Financial Engines.

- ***Online Advice,*** which is designed for RAYSIP participants who are confident in making investment decisions or executing investment recommendations from Edelman Financial Engines on their own and monitoring their accounts over time.

While Edelman Financial Engines' investment models typically recommend that less than 20% of your RAYSIP account balance be invested in the Raytheon Technologies Stock Fund, you can direct Edelman Financial Engines to invest up to 20% of your account balance in the Raytheon Technologies Stock Fund. If you enroll in Professional Management, your Edelman Financial Engines' analysis will include a recommended target percentage for the Raytheon Technologies Stock Fund.

When it comes to navigating your financial future, Edelman Financial Engines can help you understand where you are, where you want to go and how to get there. In addition, Edelman Financial Engines puts your interests first, and does not sell investments or receive commissions for providing investment advice.

Professional Management is available to all RAYSIP participants, but can be especially helpful to those who are not active, hands-on, educated investors, or to those who have portfolios that aren't appropriately diversified.

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Online Advice is a user-friendly, intuitive tool that prompts you to list any outside retirement investments—such as your spouse's account(s), IRAs and brokerage assets—and provide information about your risk preferences, anticipated retirement age, additional retirement income (such as Social Security or a pension) and retirement income goals.

By modeling different contribution rates, risk preferences and retirement ages, Online Advice can help you develop an investment strategy. From here, you can enroll in Professional Management as described earlier, or implement the recommendations and manage your account yourself—it's your choice!

There is no additional cost to take advantage of Online Advice, the program's cost is included in the cost of providing education and retirement-planning tools to all RAYSIP participants. In addition to being streamlined and easy to use, the tool offers a convenient chat feature. And, if you ever have questions, you can call Edelman Financial Engines.

While Edelman Financial Engines can take a lot of the guesswork out of investing, you still are required to be an active participant in managing your investments.

For more information about these programs and/or to enroll in either program, contact Edelman Financial Engines.

Keep in mind that Edelman Financial Engines' investment recommendations are personalized for you. If you are comfortable implementing these recommendations and monitoring/rebalancing your account over time, you can use the no-additional-cost Online Advice platform. If you don't have the time or don't feel confident managing your account, be sure to check out the Professional Management program (a fee-based service).

EDELMAN FINANCIAL ENGINES ADVISOR CENTERS

Edelman Financial Engines provides independent, fee-based investment advice and asset management services at more than 130 offices and by-appointment locations across the country. When you visit an Advisor Center, an investment advisor can develop a personalized investment plan based on your financial goals. For details and a list of Advisor Center locations, go to www.EdelmanFinancialEngines.com/financial-planners.

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FIDELITY RETIREMENT PLANNING SERVICES

Fidelity offers a comprehensive approach to retirement planning, including investing your savings and preparing to manage your expenses once you stop working. You can take advantage of Fidelity's free one-on-one consultations, online planning tools and online workshops as often as you like.

Fidelity Workplace Planning and Advice

As a RAYSIP participant, you have access to free one-on-one retirement planning sessions with a Fidelity representative. When you call, a Fidelity Workplace Planning and Guidance consultant can help you assess your personal financial circumstances and plan for retirement or any other financial goals you may have. During your free consultation, this investment professional can review your RAYSIP account, learn about your individual situation and help you develop simple steps toward reaching your goals.

For example, your consultant can:

- *Review your current investment choices and asset allocation strategy;*
- *Suggest a model portfolio strategy based on RAYSIP investment options;*
- *Help with planning and investing for non-retirement savings goals, such as paying for college, buying a home or building an emergency fund;*
- *Develop some illustrations on how much you will need to retire and suggest steps you can take to continue to build your RAYSIP account; and*
- *Develop a plan for income in retirement.*

To help you stay on track, you are eligible for free follow-up sessions—recommended to occur annually, but available as often as you'd like. To schedule your first free, one-on-one retirement-planning session with Fidelity, call 800-603-4015, Monday through Friday (excluding New York Stock Exchange holidays) from 8:30 a.m. to 8:30 p.m. ET.

(continued)

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FIDELITY RETIREMENT PLANNING SERVICES (continued)

Planning & Guidance Center

The Planning & Guidance Center on NetBenefits makes it easy to plan for the retirement you envision. By answering just a few questions, you'll be able to:

- *Estimate how much income you may have and how much you might need in retirement, and identify any gaps;*
- *Choose an investment strategy that is targeted to meet your needs and goals;*
- *View the effects of your pre-tax contributions, given their beneficial tax treatment, on your take-home pay; and*
- *Create a retirement plan in just a few minutes.*

You can access this powerful, easy-to-use online resource through NetBenefits by selecting the Planning *tab from the home page.*

IMPORTANT: The projections or other information generated by Fidelity's Planning & Guidance Center Retirement Analysis regarding the likelihood of various investment outcomes are hypothetical in nature, do not reflect actual investment results and are not guarantees of future results. Results may vary with each use and over time. *Guidance provided by Fidelity through the Planning & Guidance Center is educational in nature, is not individualized and is not intended to serve as the primary basis for your investment or tax-planning decisions.*

Fidelity e-Learning® Workshops

With the Fidelity e-Learning® Workshops, you can learn about retirement savings at your own convenience. The workshops provide all the educational tools and information you need to make the most of your RAYSIP account. You'll learn about investment concepts and determine the right investment strategy for you. Plus, you have access to interactive calculators, which can help you learn by doing.

These self-directed, online lessons are easy to navigate and are interactive. You can come and go when you please, and when you return, you can pick up from where you left off.

To get to e-Learning's educational tools and information, go to NetBenefits, select the Learn *tab and choose* Workshops*. From the* Learn *tab, you can also access the Library, where you can view articles, calculators, interactive tools and videos designed to help you plan for and prepare for your retirement.*

404(c) Applicability

RAYSIP is intended to constitute a plan described in Section 404(c) of the *Employee Retirement Income Security Act* and Title 29 of the Code of Federal Regulations, Section 2550.404(c)-1. Each individual participant in a 404(c) plan, such as RAYSIP, is responsible for his or her own investment decisions. Plan fiduciaries are relieved of liability for any losses that are a direct and necessary result of investment instructions given by a participant or beneficiary.

This section of your handbook is intended to provide you with an understanding of how RAYSIP works and the investment alternatives available to you under the plan. Additional information about basic investment principles, investing to meet your needs and detailed fund information—including fund expenses and performance—is available through NetBenefits or by calling the Savings and Investment Service Line.

Each participant should consider whether, under his or her particular circumstances, a consultation with a qualified professional financial advisor is appropriate. Any specific questions with respect to the plan should be directed to Fidelity, the plan's recordkeeper.

Your Account Statement

Quarterly account statements are automatically available through NetBenefits. Through NetBenefits, you can enter your email address to receive an email notification that your updated statement is available. If you'd like to receive a paper statement, you can change your preferences on NetBenefits or by calling the Savings and Investment Service Line.

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Your RAYSIP statement shows:

- Your total account value as of the last business day of the quarter;
- Your total vested account value as of the last business day of the quarter;
- Transactions you or Professional Management made during the quarter and transfers among funds;
- The total value of and interest or income earned on each of your investments; and
- Information about any outstanding loans you may have.

If you have a BrokerageLink account, you will receive a separate quarterly statement from BrokerageLink, which will contain more detailed transaction and account information.

Every effort is made to report the information on your statement accurately. However, you are responsible for verifying that your deferral percentages are correct and that any transactions you or Professional Management made during the quarter (e.g., investment fund changes or fund transfers) are reflected. If you find an error, you must call the Savings and Investment Service Line within 90 days of receiving your statement. It may not be possible to correct errors reported after that time.

You can learn the value of your account or view/request a statement of your account at any time through NetBenefits or by calling the Savings and Investment Service Line. Accounts are valued at the close of the New York Stock Exchange (NYSE) each business day.

EDUCATIONAL TOOLS

In today's investment market, staying informed is essential. That's why RAYSIP offers a number of tools, including:

- Fund profile *updates for information about investment funds specially designed for RAYSIP participants;*
- Prospectuses/investment facts. *Click on a fund name anywhere it appears on NetBenefits and see a snapshot of investment information, including fund performance, Morningstar ratings, Lipper rankings, style maps and volatility measures;*
- Online e-Learning seminars. *Offered several times per week, learn about investing by attending a web workshop. (For more information, see* Fidelity Retirement Planning Services *earlier in this section)*;
- Investment research. *Screen, evaluate and compare plan investment options that may meet your preferences;*
- Retirement health care calculator. *Estimate your potential out-of-pocket health care costs in retirement; and*
- Planning & Guidance Center. *Estimate how much income you may have and how much you might need in retirement and identify any gaps. In addition, choose an investment strategy that is targeted to meet your needs and goals. (For more information, see* Fidelity Retirement Planning Services *earlier in this section.)*

To take advantage of these tools, go to NetBenefits or watch your home mail during the year.

To learn the current value of your account or view/request a statement of your account at any time, go to NetBenefits or call the Savings and Investment Service Line.

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Accessing the Money in Your Account

Borrowing Against Your Account

While RAYSIP is a great way to save for retirement, you have access to certain money in your account to meet shorter-term financial goals while you are still an active employee.

RAYSIP is designed primarily to help you build savings for the future. However, there may be times when you need access to the money in your account before you retire.

While you are still employed with the company, you may borrow against your account balance for any reason. Unlike a withdrawal from your account, you pay no current federal income taxes on the amount you borrow, provided you repay the loan within the specified time period.

The minimum you may borrow is $500. The maximum you may borrow is the lesser of 50% of your account balance (which is the total of your investments in the core investment options and BrokerageLink) or $50,000, minus your highest outstanding loan balance during the previous 12 months. If the amount you wish to borrow is more than is available in your core investment options, you will need to move any needed balance from your BrokerageLink account to the core investment options before your loan will be processed. You may have two loans outstanding at a time. Once you have paid off a loan, there is a 21-day waiting period before you can initiate another loan. If you obtain a loan from your RAYSIP account, there is a $50 loan origination fee. This fee will be deducted from your RAYSIP account on the first business day following the quarter in which your loan was taken.

The funds for any individual loan proportionately reduce the amount in each investment option, and then from your contributions, again proportionately reduce the amount in each investment option.

When you borrow from your account, you repay the loan with automatic after-tax deductions from your pay. Loan payments are reinvested proportionally into the source(s) from which they were redeemed, and into fund(s) based on current investment elections. Your entire payment, including any interest, is reinvested in the same investment options and in the same percentages that you have selected for your current contributions.

The interest charged on your loan is a fixed rate equal to the prime rate published by Reuters on the last business day of the quarter (March, June, September and December) preceding the quarter in which the loan is made. The interest rate is fixed for the duration of the loan. You will not be charged any fees to continue a loan.

To apply for a loan, you may call the Savings and Investment Service Line, or you can request a loan from your RAYSIP account through NetBenefits. With this feature, you have the ability to model and initiate a loan online any time—virtually 24 hours a day, seven days a week. In most cases, you will receive a check within 10 business days of your request. Instead of waiting for a check, you may have the proceeds transferred electronically to your bank account. This feature also gives you the ability to set up or change your bank account information online via NetBenefits or through a Customer Service Representative, available by calling the Savings and Investment Service Line.

Repaying Your Loan. Based on the reason for your loan, you may choose the repayment schedule that works best for you. The maximum repayment period for a loan to purchase your principal home or residence is 15 years. The maximum repayment period for all other loans is five years. You may also repay the full balance or any portion of the balance of your loan at any time in a lump-sum payment. Please note that loan repayments must be made in substantially level payments of principal and interest. For information, call the Savings and Investment Service Line.

If you have an outstanding loan and are approved for a leave of absence or are laid off, you may make arrangements to continue to repay your loan either online at NetBenefits or by calling the Savings and Investment Service Line. You can continue making payments on your loan by arranging for a "one-time" payment every two weeks through Automated Clearing House (ACH)—the nation's conduit for electronic funds transfer (EFT)—or you can choose not to make loan payments for up to 12 months or the length of your layoff period, whichever is less. At the end of this 12-month period, if you haven't been re-employed by the company, Fidelity will convert your status to "terminated" on its system and send you

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information about repaying your loan with automatically recurring ACH payments. If you have missed any payments during the 12-month period, you will be required to become current in your payments in addition to arranging for automatically recurring ACH payments. If you fail to both make up your missed payments *and* arrange for automatically recurring ACH payments, the loan will be defaulted and the outstanding balance will be treated as a taxable distribution from the plan and may be subject to applicable income taxes and penalties. For more information, see *Important Information about Taxes* later in this section.

If you are not actively at work, you will be required to make payments in the same frequency as you had been making payroll payments while you were actively at work; the loan will not be re-amortized to monthly payments.

If you are re-employed by the company before the end of the 12-month layoff period, you must notify the Global People Services (GPS) HR Support Center to resume loan repayments from your pay when you return to work. If you had chosen not to make payments during that period, you will be required to become current in the payments that you missed.

If your employment ends, Fidelity will send you an ACH instruction packet that will describe how to continue repaying your loan on a monthly basis. You can arrange for a "one-time" payment each month or set up automatically recurring monthly ACH payments either online at NetBenefits or by calling the Savings and Investment Service Line. Note that if no payments are made within 90 days of your termination, the loan will be defaulted and the outstanding balance will be treated as a taxable distribution from the plan and may be subject to applicable income taxes and penalties. You will be sent a notice advising you of the specifics about your loan before your loan is defaulted. For more information, see *Important Information about Taxes* later in this section.

Special rules apply to repayment of loans during military service. For more information, call the Savings and Investment Service Line.

ELECTRONIC FUNDS TRANSFER (EFT) SERVICES AVAILABLE

The electronic funds transfer (EFT) service allows participants to transfer funds electronically between their bank account and Fidelity. Offered by Fidelity, this service enables participants to electronically authorize Fidelity to debit or credit their checking or savings account.

For example, in the event you need to take a loan or withdrawal from your RAYSIP account, you may arrange for an EFT to your bank account. Once you set up an EFT through NetBenefits, your proceeds from any loan or withdrawal will be automatically deposited in your bank account within one or two business days—offering you quicker access to your money.

Electronic transactions are processed through ACH. If you have any questions about this service, call the Savings and Investment Service Line.

Withdrawals During Employment

You may make withdrawals from your *after-tax contributions* and any *rollover contributions* at any time for any reason. When you withdraw your *after-tax contributions,* a pro rata share of the earnings on those contributions must be withdrawn at the same time. The earnings withdrawn are taxed as ordinary income for the year in which the withdrawal is made. When you withdraw your *rollover contributions,* both the rollover contributions and earnings become taxable.

If you are age 59½ or older, you may withdraw *pre-tax contributions* and earnings on those contributions for any reason without penalty. Pre-tax contributions and earnings on those contributions are taxed as ordinary income when withdrawn.

Roth 401(k) contributions and earnings on those contributions can be withdrawn tax-free for any reason provided the withdrawal is a qualified distribution, meaning it is taken at least five tax years from the year of the first Roth 401(k) contribution *and* after you reach age 59½ or become disabled, or in the event of your death.

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Hardship Withdrawals

Under the Internal Revenue Code (IRC), you may make withdrawals from your pre-tax contributions (as well as earnings on these contributions) *before* you reach age 59½ for hardship reasons, as described in this section. You must be able to demonstrate that you do not have any other sources to meet that hardship need, including taking any other available distributions from the plan.

Subject to IRS rules and tax implications, contributions and any associated earnings to a Roth 401(k) account *may* be eligible for a hardship withdrawal. Contact the Savings and Investment Service Line or a tax advisor if this situation applies to you.

Hardship withdrawals may only be made for the following reasons:

- The purchase of your principal residence (not including mortgage payments);
- Tuition, fees, and room and board expenses for the next 12 months of post-secondary education for you, your spouse, your children or any other eligible dependents;
- Certain medical expenses not covered by insurance for you, your spouse, your children or any other eligible dependents;
- The prevention of eviction or foreclosure on your principal residence;
- To pay for burial or funeral expenses for your deceased parent, spouse, child or another eligible dependent;
- To repair damage to your principal residence that qualifies as a casualty deduction under Section 165 of the IRC. (Examples of *casualty deductions* include damage as a result of car accidents, fires, earthquakes, hurricanes, tornadoes, floods and vandalism); and
- To pay for expenses and losses (including loss of income) you incur on account of a disaster declared by the Federal Emergency Management Agency (FEMA) under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 100–707. To qualify, at the time of the disaster, your principal residence or principal place of employment must have been located in an area designated by FEMA for individual assistance with respect to the disaster.

If you have questions about an event that may qualify for a hardship withdrawal, call the Savings and Investment Service Line.

Applying for a Withdrawal

To apply for a withdrawal, go to NetBenefits or call the Savings and Investment Service Line. In most cases, you will receive a check within 10 business days of your request. Instead of waiting for a check, you may have the proceeds transferred electronically to your bank account (see *Electronic Funds Transfer (EFT) Services Available* earlier in this section). (Electronic transfers typically are processed within two to three business days after you make your request.) This feature also gives you the ability to set up or change your bank account information online via NetBenefits or through a Customer Service Representative. While proof of your hardship is not required, the IRS may require proof in the event you are audited.

There is no minimum withdrawal amount. The amount you withdraw will be taken proportionately from each fund in which you are investing.

Taxes on Withdrawals. Under current federal law, money you withdraw (other than after-tax contributions or Roth 401(k) contributions and associated earnings that are considered a qualified distribution) is taxable as part of your income for the year in which the withdrawal was made. The plan is required to withhold 20% of any withdrawal for federal taxes, plus any applicable state taxes. An additional 10% penalty usually applies to the withdrawal of previously untaxed money (such as pre-tax contributions and earnings on both pre-tax and after-tax contributions to your account) made before age 59½.

When you make a withdrawal from your account, you are generally required to pay taxes on all or a portion of the withdrawal amount. You are encouraged to consult a qualified tax advisor before applying for a withdrawal.

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Receiving Payment from Your Account

Once you are eligible to receive a distribution from your account, you make a distribution election (see *Distributions* below). The Raytheon Technologies Stock Fund balance, if any, may be paid out in stock if you choose.

Pre-Tax and After-Tax (Excluding Roth 401(k)) Contributions

You are eligible to receive the value of your pre-tax and after-tax (excluding Roth 401(k) contributions, described later) contributions and their associated earnings when you:

- Leave the company for any reason;
- Become totally and permanently disabled; or
- Die.

When one of these events occurs, Fidelity will send you or your beneficiary information about distributions from the plan. Information may also be requested by calling the Savings and Investment Service Line.

Roth 401(k) Contributions

You are eligible to receive the value of your Roth 401(k) contributions and their associated earnings tax-free when you make a *qualified distribution*, meaning one that is taken:

- At least five tax years from the year of the first Roth 401(k) contribution; *and*
- After you reach age 59½, become disabled or die.

If you make a distribution that is not qualified, any earnings are taxable.

To make a distribution of your Roth 401(k) contributions, call the Savings and Investment Service Line.

Distributions

If the Value of Your Account Is $1,000 or Less

If the value of your account is $1,000 or less, within approximately six months of your termination of employment (or earlier upon your request), your account balance will either be paid out to you in one lump sum and taxes will be withheld, or upon your request, rolled over to another employer's retirement plan or to an IRA. In this case, you avoid the tax withholding. Fidelity reviews all account balances each quarter.

If the Value of Your Account Is More Than $1,000

If the value of your account is more than $1,000, you may request a distribution at any time following your termination of employment or leave your money in the plan. You have the option of rolling over your account balance to an IRA or another employer's retirement plan, if applicable, and avoiding the tax withholding.

In all cases, Fidelity will advise you of your options before a distribution is made.

RAYSIP offers the following distribution options:

- Lump sum (with taxes withheld) or to avoid the tax witholding, a lump-sum rollover to another employer's retirement plan or to an IRA;
- Recurring, automatic monthly, quarterly, semi-annual or annual installments where you choose the date of the distribution (such as the 1st or the 15th of the month);
- Fixed-dollar installments;
- Ad hoc, partial distributions withdrawn by selected source (e.g., employee pre-tax), fund (e.g., Janus Henderson Balanced Collective Fund Fee Class I) or on a pro rata basis across all sources and funds.

Note that you may change any of your prior installment elections at any time.

If you were part of the AST Base 401(k) Plan, the Henggeler Computer Consultants, Inc. 401(k) Plan or the Visual Analytics, Inc. Retirement Plan *and* had frozen Money Purchase Pension Plan Assets as part of that transfer, you are eligible to receive an annuity based on those frozen assets. Those assets are also protected by joint and survivor annuity rules and will require your spouse's notarized consent for most withdrawals and distributions.

If you were part of the Sensintel 401(k) plan, you are permitted to take an annuity distribution from the portion of your RAYSIP account that resulted from the transfer of assets from the Sensintel 401(k) plan.

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Minimum Required Distributions*

Minimum required distributions (MRDs) are annual minimum amounts that you must withdraw from your RAYSIP account starting with the year you reach 72 years of age or, if later, the year you terminate employment. While you must take your first MRD for the year in which you turn age 72, you can elect to delay this first payment until April 1 of the following year. For all years following the year you turn 72, including the year *after* you reached 72 if you elected to delay the first payment until the following April 1, you must take the MRD by December 31 of each year. When applicable, Fidelity will calculate your MRD amounts.

*If you reached age 70½ prior to January 1, 2020, you were/are required to take an MRD starting with the year you reached age 70½.

Important Information about Taxes

Pre-Tax Contributions

As long as the money remains in RAYSIP, your pre-tax savings, any catch-up contributions and any investment earnings on any contributions to your account are not taxable. Taxes apply only when you make a withdrawal or receive a distribution from your account.

You may elect to have all or a portion of any payment you are eligible to receive from RAYSIP paid directly to you or paid as a direct rollover into another employer's retirement plan or IRA.

In some cases, you may be required to pay an additional 10% tax on any payment you receive from the plan before you reach age 59½ if you do not roll it into an IRA or another employer's retirement plan. This additional 10% tax does not apply if payment is made because:

- Your employment with the company ends due to retirement during or after the year in which you reached age 55;
- Your account is distributed due to permanent and total disability; or
- Payment is used to pay medical expenses above the IRS threshold.

For more information about the additional 10% tax, go to www.irs.gov or call the Internal Revenue Service at 800-829-3676 and request a copy of *Form 5329.*

After-Tax and Roth 401(k) Contributions

Because you made these contributions to RAYSIP using after-tax dollars, any payment to you of after-tax contributions, Roth 401(k) contributions or earnings on Roth 401(k) contributions from RAYSIP is not subject to taxes. (Note that earnings on after-tax contributions will be subject to taxes.)

Rollover Option. You may choose to roll over any after-tax contributions, Roth 401(k) contributions or earnings on Roth 401(k) contributions to a rollover IRA or certain defined contribution plans.

Payments Made Directly to You

Mandatory Withholding. If you choose to have payment made directly to you, the plan administrator is required by federal law to withhold 20% of any eligible payment. This amount is sent to the IRS as income tax withholding to be credited against your taxes for the year in which payment is made. For example, if your distribution is $10,000, you will receive $8,000 and $2,000 will be withheld. State tax withholding may also apply. If you receive the payment before you reach age 59½, you may also be required to pay an additional 10% tax, as described earlier.

Rollover Option. In some cases, you may be able to continue deferring taxes on your money by rolling it over into a rollover IRA or your new employer's retirement plan. If the check is made out to you, you must make the rollover within 60 days of the date you receive the check or your payment will be subject to applicable taxes. In addition, if you wish to roll over 100% of the taxable distribution, you must add, or make up for, the 20% that had been withheld. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld and not rolled over.

This section provides information on federal tax rules that may apply to taxable distributions you receive under the plan. Other rules may apply under your state or local tax laws.

Because tax laws are complex and subject to change, you are encouraged to consult a qualified tax or financial advisor before receiving payment under the plan. You may also obtain information about payments from qualified retirement plans from the IRS. To request a copy of Publication 575, *Pension and Annuity Income* and/or Publication 590, *Individual Retirement Accounts,* go to www.irs.gov or call 800-829-3676.

For information on rolling over your Roth 401(k) account, contact your tax advisor.

For more information about IRAs, including limits on how often you can roll over between IRAs, go to www.irs.gov or call 800-829-3676 and request a copy of Publication 590, *Individual Retirement Accounts.*

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For example, if you have an eligible distribution of $10,000 that you choose to have paid directly to you, you will receive $8,000 and $2,000 will be withheld for federal income taxes. You have the option of deferring taxes on all or part of your eligible distribution by rolling it over to an IRA or another employer's retirement plan within 60 days of receipt.

You may elect to roll over the full $10,000 by rolling over the $8,000 you received plus an additional $2,000 to make up for the $2,000 that was withheld. In this case, taxes are deferred on the full $10,000 distribution and you may get a refund of the $2,000 withheld when you file your federal income taxes for the year in which the distribution was made.

PAYMENTS ELIGIBLE TO BE ROLLED OVER

Certain payments from the plan are considered "eligible rollover distributions." This means that you can defer paying taxes on these payments by rolling them into an IRA, another employer's retirement plan or another eligible retirement vehicle that accepts rollover contributions. Generally, you can roll over the taxable portion of any payment you receive from the plan. You may also roll over after-tax contributions to an IRA (or through a direct rollover described in the next section).

You may not roll over required minimum payments from the plan. In general, you must receive a distribution of your account after you reach age 72, unless you continue working for the company. This required minimum payment cannot be rolled over.

For more information about eligible rollover distributions, call the Savings and Investment Service Line.

To request a distribution or a rollover, call the Savings and Investment Service Line.

Payments Made as Direct Rollovers

You may choose to directly roll over all or any eligible portion of your payment from the plan. In this case, the distribution is paid from the plan to an IRA or another employer's retirement plan that accepts rollovers. If the direct rollover is to an IRA or certain defined contribution plans, you may also roll over after-tax contributions, Roth 401(k) contributions and any associated earnings. If you choose a direct rollover, any applicable taxes are not withheld or applied to the applicable rollover distribution. Any applicable taxes are only applied once you receive a distribution from the plan into which your money is rolled over.

For information on rolling over your Roth 401(k) account, contact your tax advisor.

If you wish to have your distribution made as a direct rollover, call the Savings and Investment Service Line to initiate the rollover. You will need to give the Customer Service Representative the exact name of the IRA or plan into which the payment is being rolled over. The check will be made payable to the receiving plan or IRA and sent to you for deposit to the new plan or IRA.

Direct Rollover to an IRA. If you wish to have your eligible rollover distribution paid to an IRA, you must open an IRA to receive the rollover. To do so, contact an IRA sponsor, usually a financial institution. If you are uncertain as to how to invest your money, you may temporarily establish an IRA to receive payment while you make your decision. In this case, you should consider whether or not the temporary IRA will allow you to move all or a part of your payment to another IRA or qualified account without penalties or limitations.

Direct Rollover to Another Employer's Plan. If you wish to direct your rollover to your new employer's eligible retirement plan, you must first determine whether or not that plan will accept a rollover contribution and what, if any, restrictions or eligibility requirements apply. It's important to note that employer plans are not legally required to accept rollover contributions. If your new employer's plan does not accept rollover contributions, you may want to consider rolling your money into an IRA, as described earlier.

If a portion of your RAYSIP account is invested in the Raytheon Technologies Stock Fund, you may receive the stock "in kind" (i.e., in shares instead of cash) and roll over the shares to an IRA. You may benefit by consulting your financial advisor for information regarding special tax treatment of your stock fund's net unrealized appreciation (NUA). For information about the tax basis of your stock account, call the Savings and Investment Service Line.

Payments Made to Surviving Spouses, Alternate Payees or Other Beneficiaries

Beneficiaries, surviving spouses or alternate payees (i.e., an individual whose interest in the plan results from a QDRO) can take a distribution from the plan at any time. Payments made to a surviving spouse, alternate payee or other beneficiary are not subject to the 10% penalty, even if the individual is younger than age 59½ when payment is received.

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However, if a beneficiary, surviving spouse or alternate payee does not elect to take a distribution immediately (and for an alternate payee, if the QDRO does not specify otherwise), the plan will automatically make distributions to the beneficiary, surviving spouse or alternate payee in a lump sum in the following April or October, whichever comes first.

Notification will be sent to the beneficiary, surviving spouse or alternate payee before a distribution is made.

Payment to a Surviving Spouse or an Alternate Payee. Surviving spouses and alternate payees may elect to receive payment directly or roll payment over to an IRA, an employer's retirement plan or another eligible retirement vehicle. If payment is made directly to the surviving spouse or alternate payee, the payee may further elect to keep the payment or roll it over.

Payment to Another Beneficiary. A beneficiary other than a surviving spouse or alternate payee may elect to receive payment directly or roll payment over to an IRA.

As Your Needs Change

If You Take a Leave of Absence

If you take a leave of absence, call the Savings and Investment Service Line for information about how your participation and loan payments, if applicable, may be affected.

Military Leave

If you are on a leave of absence for military service, you remain a RAYSIP participant. For your RAYSIP contributions, you may choose:

- To deduct your RAYSIP contributions from the differential pay you receive from the company during your military service; or
- When you are eligible for re-employment under the *Uniformed Services Employment and Reemployment Rights Act of 1994* (USERRA) and return to employment, to make elective deferrals or after-tax contributions on a corrective basis to replace the deferrals or contributions that could have been made if you had not been on military leave.

  Any replacement contributions must be made on or after your date of re-employment and before the end of the period that is three times the period of the military service you are returning from, to a maximum of five years.

A Word about Withdrawals. While you are on a leave of absence for military service, you are permitted to take withdrawals of pre-tax and pre-tax catch-up contributions. This is in addition to your after-tax contributions and any rollover contributions, which are available for withdrawal at any time for any reason (see *Withdrawals During Employment* earlier in this section for more details).

If this applies to you, call the Savings and Investment Line.

If You Transfer

If you transfer to another business unit:

- *That has adopted the plan,* you will continue as an active participant.
- *Not covered by this plan,* your funds will remain in the plan and you will not be able to make future contributions to your account.
- *That has adopted the plan from one that has not adopted the plan,* you are immediately eligible to begin participating in the plan.

Note: If your company email address is on file at Fidelity and you leave the company, your email address will be deleted. If you wish to continue to receive Fidelity notices via your personal email address, you will need to update your profile (from NetBenefits, click on *Profile* in the upper right hand portion of the home screen and update your email address in the "Contact Information From You" area). If Fidelity does not have an email address on file, all correspondence will be delivered by regular mail.

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If You Are Laid Off

You may not make RAYSIP contributions if you are laid off. You may, however, continue to participate in RAYSIP in accordance with its terms:

- You may leave your money in the plan if the value of your RAYSIP account is more than $1,000.
- You may request an immediate distribution of all your vested RAYSIP funds.
- If you have a loan, you may make arrangements to continue to repay your loan either through NetBenefits or by calling the Savings and Investment Service Line. You also have the option of temporarily suspending your loan payments for up to 12 months or the length of your layoff period, whichever is less. For details about loan repayment options and guidelines, see *Borrowing Against Your Account* earlier in this section.

In addition, during the first 12 months following your layoff date:

- You may take a full layoff withdrawal of all your vested accounts; and
- If eligible, you may be able to take out a loan from your RAYSIP account.

You will receive information from Fidelity regarding loan repayments and distribution options for your RAYSIP account balances. To apply for a hardship withdrawal or loan, or if you have any questions, call the Savings and Investment Service Line.

If You Terminate Employment

If you terminate employment, you'll need to review your RAYSIP account. Specifically, if your RAYSIP account balance is:

- ***More than $1,000,*** you may leave your account in the plan or request a distribution. If you elect to take a distribution, you may:
  - Take a lump-sum or a partial distribution with the following options:
    - Recurring, automatic installment payments (as frequently as monthly),
    - Ad hoc, partial distributions withdrawn by selected source, e.g., employee pre-tax or Roth, or by fund, e.g., Janus Henderson Balanced Collective Fund Fee Class I, or withdrawn on a pro-rata basis across all sources and funds, or
  - Roll over your distribution to an IRA, Roth IRA, or another employer's plan.

  Note that if you have a RAYSIP account balance when you reach age 72, your account will be subject to a Minimum Required Distribution (MRD), which is an annual minimum amount that the IRS requires you to withdraw from your account starting with the year you reach age 72, or, if later, the year you retire. While you must take your first MRD for the year in which you turn age 72, you can elect to delay this first payment until April 1 of the following year. For all years following the year you turn 72, you must take the MRD by December 31 of each year. When applicable, Fidelity will calculate your MRD amounts.

  Note that the MRD rule for Individual Retirement Accounts (IRAs) requires that distributions begin in the year you turn 72 regardless of your employment status. In addition, note that if you reached age 70½ prior to January 1, 2020, you were/are required to take an MRD starting with the year you reached age 70½.
- ***$1,000 or less,*** you must take a distribution or roll over your account. You cannot leave it in the plan. If applicable, you will receive correspondence from Fidelity relative to this requirement.

Please note that you may take distributions of your company stock in cash, or, in the case of lump-sum or ad hoc distributions, in shares. Finally, you may change any of your prior installment "elections" at any time.

If you have one or more outstanding RAYSIP loans, Fidelity will send you instructions on how to continue repaying your loan(s) through ACH. Note that if no payments are made within 90 days of your retirement date, the loan will be defaulted. In this case, the outstanding balance will be treated as a taxable distribution from the plan and may be subject to applicable income taxes and penalties.

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If You Die

If you die, the value of your account is payable to your designated beneficiary(ies). If you have not named a beneficiary or your designated beneficiary does not survive you, payment will be made in the following order of priority:

- Your spouse. Note that the plan recognizes a common law marriage if the marriage was established at a time when the state in which it was established permitted common law marriages;
- Your children;
- Your parents;
- Your brothers and sisters; or
- The executor/administrator of your estate.

If no beneficiary can be located, the value of your account may be forfeited.

Other Important Information

Fees

RAYSIP charges the following types of fees:

- ***General administrative fees*** incurred for expenses such as recordkeeping, trustee, communication materials, education, retirement planning, audit, legal, consulting and other administrative expenses;
- ***Investment management fees*** associated with management and operating expenses of investment options; and
- ***Loan origination fees*** for those who take out a loan.

General administrative fees are deducted from each plan participant's account on a quarterly basis. All administrative fees for the quarter are divided equally among all plan participants. Your quarterly account statement will show the administrative fees charged to your account for the preceding quarter.

Investment management fees are deducted from each investment fund and are reflected in the fund's net asset value. For details on the management fees for a specific fund, refer to the fund's prospectus/investment facts, available on NetBenefits or by calling the Savings and Investment Service Line.

In addition, if you choose to participate in Professional Management, your RAYSIP account is charged 0.28% for the first $100,000 in your RAYSIP account balance (discounts apply for higher account balances). Fees are deducted directly from your account on a quarterly basis. There are no commissions or transaction fees for the program, and you can end your participation at any time. For more information about Professional Management, see *Professional Help Available through Edelman Financial Engines* earlier in this section.

To view a breakdown of fees, see the *RAYSIP Plan Administrative Costs* notice that is posted quarterly on the NetBenefits homepage or from *Quick Links* under *Plan Information and Documents*. The notice is also available by calling the Savings and Investment Service Line.

IRC Limits on Contributions

Under the IRC, the total amount that you can contribute to pre-tax and Roth 401(k) accounts combined during any calendar year is limited. For 2021, the maximum amount is $19,500. This amount is adjusted periodically. This limit applies to all pre-tax and Roth 401(k) savings plans in which you participate in one calendar year, even if the plans are with different employers. If you find you have exceeded this limit after the end of a year, contact Fidelity by March 15 of the following year and request a refund of excess contributions. You will need to provide a copy of all W-2 forms to Fidelity to document excess contributions due to you.

Note that RAYSIP is subject to various nondiscrimination limitations imposed under the IRC. These limitations may affect the amount you may contribute to your account. You will be notified if these restrictions affect you.

To help you determine your maximum RAYSIP contribution, the GPS HR Support Center offers the *401(k) Estimator* tool. To access the tool, go to https://myinfo.ray.com. From *MyInfo,* click on the 401(k) icon.

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Plan Security

Your account is held in trust for your exclusive benefit and is at all times invested according to your instructions, except for certain investment restrictions. However, unlike a pension plan, your account is not insured by the Pension Benefit Guaranty Corporation (PBGC). The *Employee Retirement Income Security Act of 1974* (ERISA), a federal law, specifically excludes individual account plans, such as RAYSIP, from PBGC coverage.

Your Rights

This section describes RAYSIP in general terms. If any conflict arises between this description and the plan document, or if any point is not covered, the terms of the plan document will govern in all cases. If you have any questions about RAYSIP, your participation in it or this section of your handbook, call the Savings and Investment Service Line at 800-354-3966 (TDD# 800-847-0348). Outside the United States, call Fidelity collect by dialing the International Access Code (IAC) and then 877-833-9900. IACs can be found at www.att.com/traveler.

See the *Administrative* section for information related to the administration of the plan.

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Administrative
at a glance

in this section

- The previous sections of this handbook describe the specific provisions of the various legacy Raytheon benefit plans and programs. In addition to understanding these provisions, it's important that you know about your rights as a participant in these plans.

- This section provides important information about those rights as they apply to the legacy Raytheon benefit plans currently in effect, how the plans are administered and your rights as a participant. This section, together with each of the specific plan sections included in this handbook, constitutes the summary plan description for each of your legacy Raytheon benefit plans. If there is any difference between the information contained in this document and the actual plan documents, the plan documents will always govern.

- This information is provided to meet the disclosure requirements for health, welfare and defined contribution plans under the:
  - *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA);
  - *Employee Retirement Income Security Act of 1974* (ERISA);
  - *Health Insurance Portability and Accountability Act of 1996* (HIPAA);
  - *Heroes Earnings Assistance and Relief Tax Act of 2008* (HEART);
  - *Family and Medical Leave Act of 1993* (FMLA);
  - *Uniformed Services Employment and Reemployment Rights Act of 1994* (USERRA);
  - *Newborns' and Mothers' Health Protection Act of 1996* (NMHPA); and
  - *Women's Health and Cancer Rights Act of 1998* (WHCRA).

Continued Coverage under COBRA

Medical, Vision and Dental Coverage

Under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA), you and your covered family members may extend your medical, vision and dental coverage if coverage ends because of a "qualifying event" (described in this section). You and your covered family members may extend coverage for a certain period of time by paying the full group rate plus an administrative charge (usually 2%).

You and your covered family members each have an independent right to elect extended coverage. You or your covered family members do not have to prove good health in order to continue coverage under COBRA. If you decide to extend coverage, you will receive the same coverage as active employees and their covered family members. After you have elected extended coverage, you have the same rights as similarly situated active employees to add dependents and make other changes in your coverage.

If you are enrolled in an HSA Advantage plan and your employment is terminated (including by retirement) and you choose to continue coverage, you may continue to make contributions to your health savings account (HSA). In addition, if you become enrolled in Medicare Part A, Part B and/or Part D, while you can continue your participation in an HSA Advantage plan, you can no longer make contributions to your HSA and company contributions must stop.

WHAT HAPPENS WHEN YOU ELECT COBRA COVERAGE

In all cases, assuming COBRA coverage begins within the same plan year, only claims for the person(s) electing COBRA coverage will transfer from an active plan to COBRA.

For example, if you have family coverage and one of your children elects COBRA medical coverage in July because he/she has aged out of your active plan, only his/her claims incurred while on your active plan—and not those of other family members—will transfer to his/her COBRA coverage (deductible(s) and out-of-pocket maximum(s)). In addition, since his/her claims are removed from your active plan, the deductible(s) and out-of-pocket maximum(s) for the family members remaining on the active plan are adjusted accordingly.

Note that if COBRA coverage crosses over into the next plan year, all deductible(s), out-of-pocket maximum(s), benefit maximums or plan allowances reset accordingly.

If You or a Covered Dependent Elects COBRA Coverage for This Plan …	… Keep in Mind the Following …
Medical	Assuming COBRA begins within the same plan year, any claims the person electing COBRA has incurred that apply toward the plan's deductible(s) and out-of-pocket maximum(s) while he/she was covered by the active plan will transfer and be applied to his/her COBRA coverage. ***To ensure an accurate accounting, contact the plan carrier.*** **If You Take a Personal Leave** • If you elect COBRA and return to work within the same calendar year, the cumulative totals will transfer back to your active plan. • You have two options when you return to work: Enroll in the same coverage you had before going out on leave (both the same plan and covering the same dependent(s)) or drop coverage completely. • If you did *not* elect COBRA coverage while on leave and you enroll in the same coverage you had before going out on leave, your plan's deductible(s) and out-of-pocket maximum(s) start over when you return to work.

(continued)

COVID-19 Update

During the national emergency related to COVID-19, the *Coronavirus Aid, Relief and Economic Security (CARES) Act* passed by Congress in 2020 allows for the extension of certain deadlines.

If you or a covered dependent is eligible to extend medical benefits through COBRA, you have until 120 days after the national emergency (or "outbreak period") ends to enroll in COBRA continuation coverage. If your COBRA enrollment deadline has already passed, call the RBC to enroll.

This section provides an overview of COBRA continuation coverage. For questions related to your specific situation, call the RBC.

When you elect continued coverage under COBRA, you have the same rights as an active employee to change your coverage options during the annual benefits open enrollment period or if you experience a qualified change in status.

Raytheon Benefit Center
https://raytheon.benefitcenter.com
800-358-1231

WHAT HAPPENS WHEN YOU ELECT COBRA COVERAGE (continued)

If You or a Covered Dependent Elects COBRA Coverage for This Plan …	… Keep in Mind the Following …
Dental, Vision	Assuming COBRA begins within the same plan year, any amounts the person electing COBRA has incurred that apply toward a plan's deductible, benefit maximum or plan allowance (as applicable) while he/she was covered by the active plan will transfer and be applied to his/her COBRA coverage. ***To ensure an accurate accounting, contact the plan carrier.*** **If You Take a Personal Leave** • If you elect COBRA and return to work within the same calendar year, the cumulative totals will transfer back to your active plan. • You have two options when you return to work: Enroll in the same coverage you had before going out on leave (both the same plan and covering the same dependent(s)) or drop coverage completely. If you return in the same calendar year and enroll in the same coverage, any previously accrued deductible, benefit maximum or plan allowance (as applicable) continues to apply.

Qualifying Events

The time period for which you may extend coverage is determined by the reason your coverage ends (called the "qualifying event") and by whether the coverage is for you or for your covered family members. It is important to note that only employees and family members who actually are covered under a company-sponsored medical plan, vision plan or dental plan on the date of the qualifying event are eligible to elect extended coverage. Only the coverage in effect on the date of the qualifying event can be extended.

You have a qualifying event if:

- Your employment is terminated (for any reason other than gross misconduct); or
- Your becoming ineligible for coverage is due to reduced work hours.

If one of these qualifying events occurs, you and each of your covered family members may extend coverage for 18 months. The company will notify you of your right to elect extended coverage under COBRA. Your cost for continuing coverage during this period will be no more than 102% of the group cost.

The following are considered qualifying events for your covered family member(s):

- Your enrollment for Medicare benefits (under Part A, Part B, Part D or all three);
- Your spouse, if he or she becomes divorced or legally separated from you, the employee;
- Your dependent no longer meets the plan's definition of a dependent (for example, if a dependent child reaches the maximum age limit for coverage); or
- Your death.

In the case of one of these qualifying events, your covered family members may continue coverage for 36 months, provided they remain eligible for coverage under the plan during that time.

If one of these events occurs during the 18 months that you have continued coverage, each of your covered family members (but not you) will be entitled to extend coverage for a total of 36 months.

SPECIAL CONSIDERATIONS FOR PARTICIPANTS IN CERTAIN LEGACY RETIREMENT MEDICAL PLANS

Retirement Plan	Reminder
• Raytheon Company Pension Plan for Salaried Employees, Exhibit B: E-Systems, Inc. Salaried Employees Retirement Plan **(ESY)** • Raytheon Company Pension Plan for Salaried Employees, Exhibit C: HRB Systems Salaried Retirement Plan **(HRB)** • Raytheon Company Pension Plan for Hourly Employees, Appendix L: Retirement Plan for Hourly Employees of Raytheon IIS–Garland **(GAR)** • Retirement Plan for Hourly Employees of Raytheon IIS–Greenville **(GRNV)** • Raytheon Company Pension Plan for Hourly Employees, Appendix M: Retirement Plan for Hourly Employees of Raytheon NCS–Florida **(NCS)** • Raytheon Company Pension Plan for Salaried Employees, Exhibit D: Raytheon E-Systems, Inc. Richardson/Waco Retirement Plan **(RIC)**	You must start your retiree medical coverage when you start your pension. While Raytheon is required to offer you the option of enrolling in COBRA coverage when you retire and start your pension, ***having COBRA coverage when you start your pension makes you ineligible for retiree medical coverage.***

For more information, see the applicable retiree Eligibility Summary *(available on* Desktop Benefits*) or call the RBC at 800-358-1231.*

If You Become Disabled While Covered under COBRA

If you are, or your dependent is, totally disabled at any time during the first 60 days of COBRA coverage, coverage for you and your covered dependents may continue beyond the initial 18 months (as long as you or your dependent remains disabled), up to an additional 11 months, for a total of 29 months.

To be eligible for 29 months of continued coverage, Social Security must determine that you or your dependent qualifies for disability benefits under the Social Security Administration's definition of disability. This determination must be made within the initial 18-month eligibility period. The cost for the additional 11 months of coverage will be 150% of the group cost.

Notification Period

If there is a dependent qualifying event (such as divorce, legal separation or loss of dependent status), you or your eligible family members must notify the Raytheon Benefit Center (RBC) at 800-358-1231 within the later of 60 days of the event or 60 days of the date coverage would otherwise end. You then will receive a *COBRA Continuation Coverage Election Notice* and full details about continuing your coverage. If you do not notify the RBC within this 60-day time period, your eligible family members will not be allowed to elect COBRA coverage.

Election Period

Once a qualifying event occurs and you or one of your covered family members has been notified of your right to continue coverage, you or your dependent will have 60 days in which to elect coverage. This 60-day period begins on the later of the date you were notified of the continuation option or the date coverage would otherwise end.

When COBRA Coverage Ends

COBRA continued coverage will end for you and each of your covered family members when the earliest of the following occurs:

- You or your covered family members fail to pay any required premium.
- You or your covered family members become entitled to Medicare benefits (under Part A, Part B, Part D or all three).
- You or your covered family members become covered under another health plan.
- The plan is terminated for all employees.
- The maximum continuation period expires.

If you have questions concerning COBRA coverage, contact the RBC:

Raytheon Benefit Center
PO Box 199422
Dallas, TX 75219-9422
https://raytheon.benefitcenter.com
800-358-1231

A SUMMARY OF COVERAGE OPTIONS UNDER COBRA

Note that this chart provides a summary of your coverage options under COBRA. For a more comprehensive description of COBRA, see the previous pages.

You may purchase continued coverage if you would otherwise lose coverage because	For up to*
Your employment ends or your hours are reduced (except for termination due to gross misconduct)	18 months for you and your eligible family members
You are or an eligible family member becomes disabled within the first 60 days of continued coverage and the Social Security Administration approves the disability	29 months for you and your eligible family members
You divorce or legally separate from your spouse	36 months for your spouse and eligible dependent children
Your dependent child is no longer an eligible dependent, as defined by the plan	36 months for your dependent child
You become entitled to Medicare and want to continue coverage for your dependents	36 months for your spouse and dependent children
You die	36 months for your spouse and dependent children

*For all qualifying events combined

Alternatives to COBRA

Besides COBRA, note that other coverage continuation options may be available for you and your covered family member(s) through the Health Insurance Marketplace (also known as the Health Insurance Exchange), which is operated by the federal government or your state, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Applying for Benefits

The previous sections in this document summarize the procedures for claiming benefits under the plans. You should follow those procedures when you are required to file a claim for a benefit. Note that claim procedures may vary by plan carrier. For more information and the appropriate claim form, see the applicable plan document or contact the applicable plan carrier.

If you do not receive benefits to which you feel you are entitled, you may file a written appeal with the appropriate claims administrator, listed in the *Plan Directory* later in this section. The information that follows outlines the steps you can take if your claim is denied.

The claims administrator for each company-sponsored benefit plan is also the claims fiduciary.

If Your Claim Is Denied

If your claim is denied in whole or in part, you will generally receive a written explanation within a specified number of days (varies by plan) following the receipt of your claim. The explanation will include, though may not be limited to, the specific reasons for the denial of your claim, the specific references in the plan documents that support the denial, a description of any material or information you must provide to perfect your claim, the reasons why that material or information is necessary and the procedure available for further review of your claim.

If more than the stated number of days are needed to review your claim, you will receive a written notice of the reason for the delay and the date by which you can expect to hear of a final decision. The claims administrator must request missing or incomplete information prior to the expiration of the time period in which the claims administrator is to rule on the claim.

ABOUT THIS SECTION

The Applying for Benefits *section provides information about appealing denied claims for the following plans:*

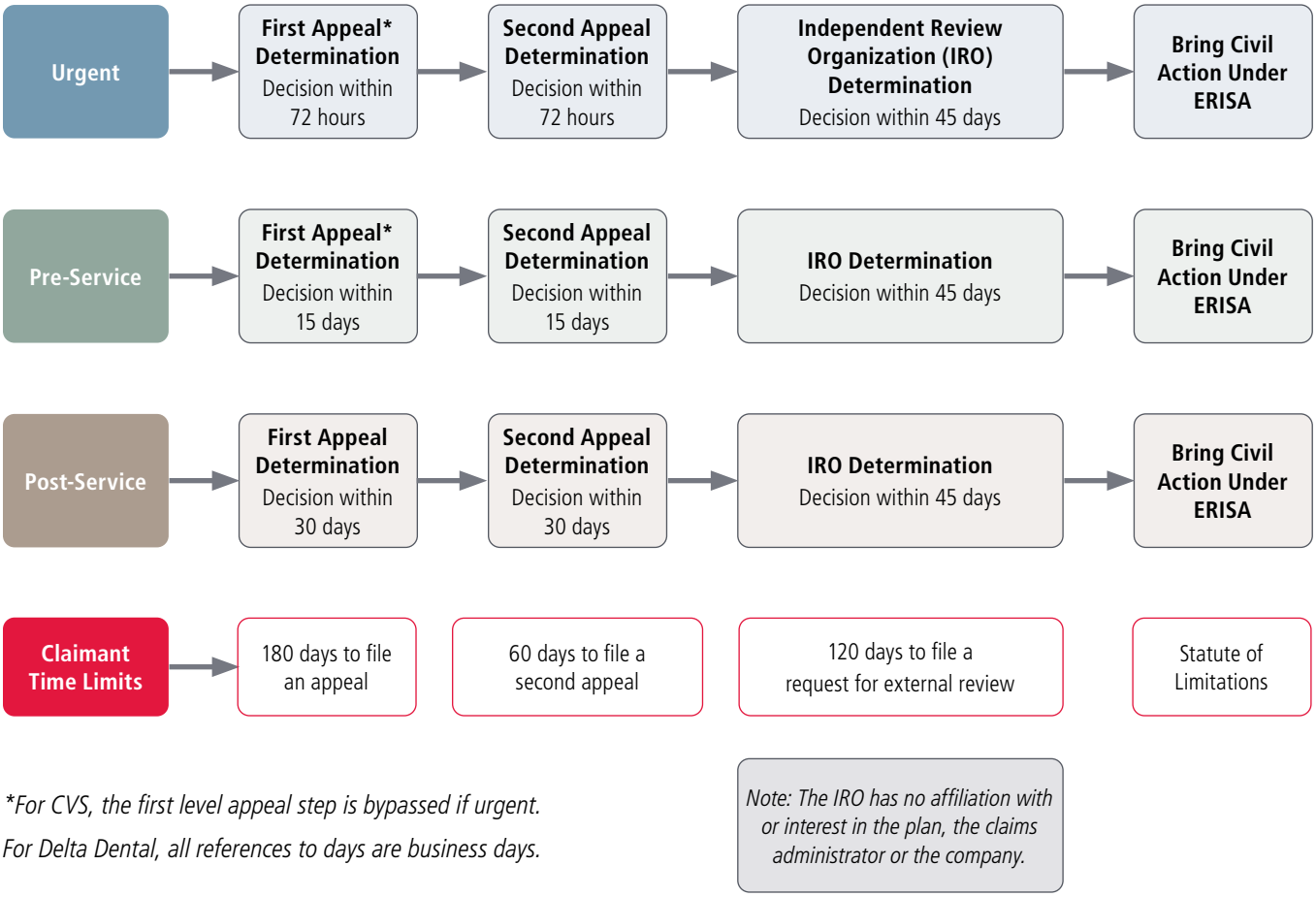
- *UnitedHealthcare (UHC),*
- *Prescription drug (CVS Caremark),*
- *Vision (VSP),*
- *Dental (Delta Dental),*
- *Business travel accident (BTA) (AIG), and the*
- *Raytheon Savings and Investment Plan (RAYSIP) (Fidelity).*

The following flow charts outline the appeals process for each of the above. For more information about these steps, a description of the external review process (by Independent Review Organizations (IROs)) for the health plans and information that applies only to RAYSIP, see later in this section.

For information related to:

- *Kaiser Permanente, see the plan's* Evidence of Coverage *booklet,*
- *Cigna (Global Choice), see the plan's* Certificate of Coverage *booklet.*

UnitedHealthcare (UHC), CVS Caremark and Delta Dental Benefit Determination Appeals Process



**For CVS, the first level appeal step is bypassed if urgent.*

For Delta Dental, all references to days are business days.

Note: The IRO has no affiliation with or interest in the plan, the claims administrator or the company.

SPECIAL RULES FOR CLAIMS WITH UHC, CVS CAREMARK AND DELTA DENTAL

As shown in the flow chart above, claims related to UHC, CVS Caremark and Delta Dental are divided into three categories: urgent, pre-service and post-service.

The timeframe within which you must submit a written application to appeal a denied claim is 180 days after you receive the claim denial notice. If the claims administrator provides a second level of internal appeal, the timeframe within which you must request that second level of appeal is 60 days after you receive the notice of denial of the first-level appeal.

An **urgent claim** *is where application of the time periods for non-urgent care determinations could either seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.*

A **pre-service claim** *is a claim for a benefit under a group health plan where the terms of the plan require approval of the benefit in advance of obtaining care.*

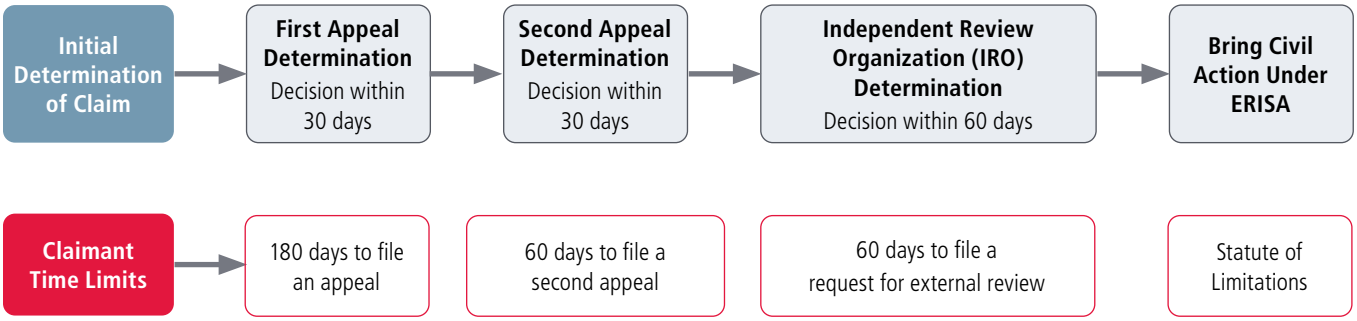
A **post-service claim** *is any claim that is not categorized as a pre-service claim, including claims involving reimbursement of the cost of care that has already been provided.*

For more information about UHC's, CVS Caremark's and Delta Dental's appeals process and how to appeal a claim, contact the plan (see the Plan Directory *later in this section for contact information).*

For more detailed information related to the external review process for the medical, prescription drug and dental plans, see *External Review (by Independent Review Organizations (IROs))* later in this section.

Raytheon Benefit Center
https://raytheon.benefitcenter.com
800-358-1231

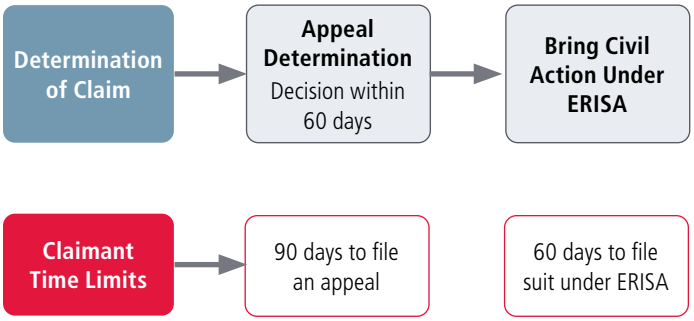
Vision (VSP) Benefit Determination Appeals Process



For more detailed information related to the external review process for the vision plans, see *External Review (by Independent Review Organizations (IROs))* later in this section.

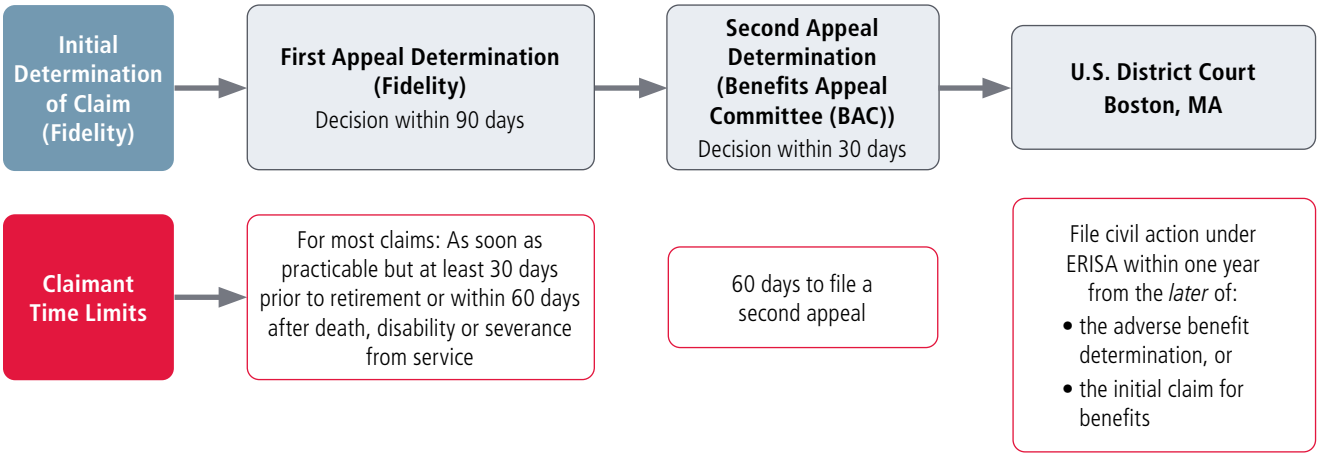
Note: The IRO has no affiliation with or interest in the plan, the claims administrator or the company.

Business Travel Accident (BTA) Insurance Benefit Determination Appeals Process



RAYSIP Benefit Determination Appeals Process

(See also *Additional Information About RAYSIP* later in this section.)



Raytheon Benefit Center
https://raytheon.benefitcenter.com
800-358-1231

Your Right to Appeal a Denied Claim

As outlined in the flow charts on the prior pages, you have a right to appeal a denied claim. You must submit a written application to the appropriate claims administrator within a specified number of days (varies by plan) after you receive the claim denial notice.

For the names and addresses of the claim administrators to contact for appeals, refer to the *Plan Directory* later in this section.

You have the right to submit written comments, documents, records and other information relating to your claim. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

The applicable administrator will conduct a full and fair review of your appeal and will generally notify you of the decision (or give notice if the decision is delayed) within a specified number of days (varies by plan). If more than the specified number of days are needed to review your appeal, you will receive a written notice of the reasons for the delay and the date by which you can expect to hear of a final decision. The decision will be in writing.

If the decision is adverse, it will contain the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and a statement of your right to bring a civil action under the *Employee Retirement Income Security Act* (ERISA).

Final Decision

Each claims administrator has the authority to make final decisions with respect to paying claims. The plan administrator is responsible for making final decisions with respect to all other issues that may arise under the plans. For some plans, the claims administrator and the plan administrator are the same.

In making a final decision, the applicable claims administrator and plan administrator have full discretionary power to interpret the meaning of plan provisions and determine all relevant questions arising under a plan, including, but not limited to, eligibility for benefits.

For more information, see *Your Rights under ERISA* later in this section.

Time Limit and Forum for Court Actions

Under the terms of the benefit plans, any civil action at law or in equity must be commenced within a specified number of days (varies by plan). In addition, if your benefits are provided under an insurance policy, that policy or the relevant insurance certificate may establish another limitations period for bringing a court action to challenge a benefit denial.

Additional Internal Review Provisions for Health Claims

These additional internal review provisions apply to health claims.

You have the right to review the file on your health plan claim. The claims administrator must provide you, free of charge, with any new or additional evidence considered by, relied on or generated by the claims administrator in connection with your claim as well as any new or additional rationale. This must be done as soon as possible and at a time that will give you a reasonable opportunity to respond before the final internal decision on your claim.

The claims administrator's notice of denial of your claim will contain information sufficient to identify the claim involved, including the date of service, the claim amount (if applicable) as well as a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

Requests for these codes do not constitute a request for an internal appeal or the external review described later in this section.

If the claims administrator fails to comply with the required internal claims review procedure, you will be deemed to have exhausted the internal claims and appeals process, and you may initiate the external review process described later or pursue any available remedies under Section 502(a) of ERISA. The exception is if the failures are de minimis and do

not cause, and are not likely to cause, prejudice or harm to you. If the claims administrator determines that the failures fall within this exception, you may request a written explanation of the failure, and the claims administrator must provide the written explanation within 10 days. If the external review described later or a court rejects your request for immediate review on the basis that the claims administrator's procedural failures were de minimis, the claims administrator must notify you (within 10 days after such rejection) of your right to resubmit and pursue internal appeal of your claim. The time for resubmitting your claim will begin to run from the time you receive the notice of your right to resubmit it. A decision to rescind your health plan coverage is subject to the same internal review procedures as the denial of a claim.

External Review (by an Independent Review Organization (IRO))

Medical, Prescription Drug, Vision and Dental Claims

These additional external review provisions apply to the health claims described in this section. If the claim arises under an insured health program, an external review may be conducted in accordance with the external review procedures applicable to the insurance company that provides the plan.

The External Review Program offers an independent process for a review of the denial of a requested administrative or clinical service or procedure, or of the denial of payment for an administrative or clinical service or procedure.

The external review will be performed through an Independent Review Organization (IRO) by an independent physician who is qualified to decide whether the requested service or procedure is a covered service under the plan. Neither the IRO nor the reviewing physician can have any material affiliation with or interest in the plan, the claims administrator or the company.

The particular IRO used for the review will be assigned by the claims administrator on a rotating basis from a list of accredited IROs that the plan has contracted to perform external reviews. Neither you nor the claims administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. The IRO acts as a claims fiduciary of the plan with respect to the external reviews that are delegated to the IRO and that are binding on the plan.

The program is available:

- After you exhaust the other appeal procedures described earlier in the *Applying for Benefits* section ***and*** you receive a decision that is unfavorable; ***or***
- If, after exhausting or being deemed to have exhausted your internal appeals on a health claim (for an administrative or clinical service or procedure), you are not satisfied with the final determination.

Even if you have not exhausted the internal appeal process, you may request expedited external review of a denied claim if you have requested expedited internal appeal and the claim involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize life or health or would jeopardize the ability to regain maximum function. You may also request expedited external review of a denied internal appeal if the appeal denial concerns an admission, availability of care, continued stay or health care service for which you received emergency services but you have not yet been discharged from the facility.

If the conditions for requesting external review are satisfied, you or an authorized representative may request an external review of the adverse benefit determination by contacting the toll-free customer service number on your plan ID card or by sending a written request to the address on your plan ID card. All requests for external review must be made within 120 days of the date you receive the adverse benefit determination. There is no charge to you for this external review.

Within five business days after receipt of your request for external review, the claims administrator will complete a preliminary review of your request to determine whether:

- You are or were covered under the plan at the time the health care item or service was requested or was provided;

A Note for Residents of California or Hawaii

Most disputes under health plans available in California and Hawaii and listed as fully insured in the *Plan Directory* must be resolved through arbitration rather than in court. You may contact the insurance carrier for more information about mandatory arbitration.

- The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the plan's eligibility requirements;
- You have exhausted the internal appeal process, unless you are not required to exhaust it for reasons described earlier; and
- You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the claims administrator will issue a written notice to you. If the request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete, and you may provide the needed materials by the end of the four-month filing period or the 48-hour period after receipt of the notice, whichever is later.

If there is any information or evidence that you or your physician wishes to submit in support of the request that was not previously provided, you may include this information with the request for an external review. Within five business days after assigning the request to an IRO, the claims administrator will forward your request for independent review to the IRO, together with:

- All documents and information relied upon by the claims administrator in making a decision on the case; and
- All other information or evidence that you or your physician has already submitted to the claims administrator.

The IRO will send you a notice that you may submit additional information in writing within 10 business days after receipt of this notice. The IRO will consider the additional information and forward it to the claims administrator.

The IRO will review the internal claim denial for which external review has been requested, without being bound by any decisions or conclusions reached during the claims administrator's internal review. The IRO will consider the documents and information that were provided in a timely manner as well as other information that the IRO considers relevant. The IRO will issue you and the claims administrator a written notice of its decision within 45 days after receiving the request for external review. If the reviewer needs additional information to make a decision, the prescribed time may be extended.

If you request expedited external review:

- The claims administrator's preliminary review to determine whether the request meets the requirements for standard external review must be performed expeditiously; and
- If the request meets the requirements, the claims administrator must notify you of such and send the relevant materials to the assigned IRO expeditiously.

The IRO will issue a notice of its external review decision as expeditiously as your medical condition or circumstances require but no later than 72 hours after receiving the request for expedited external review. If the notice is not in writing, the IRO will issue a written confirmation within 48 hours after notifying you of its decision.

The reviewer's decision will include the clinical basis (if appropriate) for the determination. The IRO will provide you and the claims administrator with the decision, a description of the qualifications of the reviewer as well as any other information deemed appropriate by the IRO or required by applicable law.

If the final external review decision is to approve your claim, the plan will provide benefits for the claimed service or procedure pursuant to the final external review decision and in accordance with the terms and conditions of the plan, regardless of whether the plan intends to seek judicial review of the decision and unless or until there is a judicial decision otherwise. If the final external review decision is to deny your claim, the plan will not be obligated to provide benefits for the service or procedure, but you may still have the right to bring a civil action under section 502(a) of ERISA.

For more information about your external appeal rights and the independent review process, contact the claims administrator at the toll-free customer service number on your plan ID card.

ADDITIONAL INFORMATION ABOUT RAYSIP

Except as otherwise outlined here, the plan administrator will make all determinations as to the right of any person to accounts under the plan. Any such determination will be made pursuant to the following procedures, which shall be conducted in a manner designed to comply with section 503 of ERISA:

1. *With respect to a RAYSIP account, claims should be filed by a claimant as soon as practicable after he/she knows or should know that a dispute has arisen with respect to an account, but at least 30 days prior to the claimant's actual retirement date or, if applicable, within 60 days after the death, disability or severance from service of the participant whose account is at issue. Claims should be mailed to:*

   Fidelity Institutional Retirement Services Company
   Raytheon Claims & Appeals Unit
   P.O. Box 770003
   Cincinnati, OH 45277-1060

2. *In the event a claim is wholly or partially denied by the claims administrator, the administrator will respond in writing within 90 days following receipt of the claim. The letter will include:*
   a. *The specific reason(s) for the denial;*
   b. *Specific reference to pertinent plan provisions on which the denial is based;*
   c. *A description of any additional material or information necessary for the claimant to perfect the claim;*
   d. *An explanation as to why such material or information is necessary; and*
   e. *An explanation of the plan's claim review procedure.*

3. *A claimant who wishes to appeal a denial should file a request for review by a Benefit Appeals Committee (BAC) within 60 days following receipt of the denial of a claim. The appeal should be mailed to:*

   Benefit Appeals Committee
   c/o Fidelity Institutional Retirement Services Company
   Raytheon Claims & Appeals Unit
   P.O. Box 770003
   Cincinnati, OH 45277-1060

   Members of the BAC will be appointed by the chief human resources officer of Raytheon Technologies, or his or her delegate. Neither the person who made the initial adverse determination nor a subordinate of this person will be appointed to the BAC.

4. *Within 30 days of receipt of a request for review, the BAC will hear the case. The claimant will have the opportunity to review pertinent documents and to submit issues and comments in writing. Within a reasonable amount of time following BAC's consideration of the claimant's position, typically not to exceed 30 days, the BAC will inform the claimant in writing of the decision. The letter will include the reasons for the decision and will cite pertinent provisions in the plan.*

Except as otherwise outlined above, the plan administrator is the fiduciary to whom the plan grants full discretion, with the advice of counsel, to interpret the plan; to determine whether a claimant is eligible for benefits; to decide the amount, form and timing of benefits; and to resolve any other matter under the plan that a claimant raises or the administrator identifies. All questions arising from or in connection with the provisions of the plan and its administration, not herein provided to be determined by the Board of Directors, shall be determined by the administrator, and any determination made will be conclusive and binding upon all persons affected thereby.

Exhaustion of Plan Remedies and Limitation of Action

No action at law or in equity may be brought to recover benefits under the plan unless and until the claims review procedures outlined above have been complied with and exhausted.

In addition, no action at law or in equity may be brought to recover benefits under the plan unless such action is brought within one year after the date the participant's initial claim for benefits or, if later, appeal of an adverse benefit determination, is denied by the BAC or deemed denied.

In the case of RAYSIP, any such action may be brought only in the United States District Court for the District of Massachusetts, Boston Division.

Coordination of Benefits

The company's benefit plans include non-duplication coordination of benefits (COB) provisions, under which payments from a company-sponsored plan may be reduced due to other coverage. Certain COB rules are described below. Check with your plan carrier for more detailed information about COB.

When You Are Covered by More than One Plan

If you're covered under another plan (for example, if you're covered as a dependent under your spouse's medical or dental plan), that plan's benefits will be coordinated with the benefits provided under your company-sponsored plan. The intent is to allow you to receive the maximum payments to which you're entitled—without overpaying you.

If you and/or your covered dependents are in another plan with a coordination of benefits provision, rules have been established to determine which plan is "primary"—meaning ***that*** plan will pay first. Then, if the other plan has a COB provision, the other plan will pay the difference, up to plan limits and customary amounts for that procedure or service (but no more than would have been paid if there was no other coverage). Usually, the plan that covers a person as an employee is primary for that person.

Birthday Rule

If both you and your spouse have family coverage and one of your dependent children incurs eligible expenses, the plan of the parent whose birthday (month and day—but not year) falls earlier in the year will be primary. For example, if your birthday is April 2, 1972, and your spouse's birthday is April 1, 1974, your spouse's plan will pay first. (If you and your spouse have the same birthday, the plan of the person who has had plan coverage for the longer time will be primary. Questions? Contact your plan carrier.)

The primary plan for dependent children is determined by the birthday rule—the plan of the parent whose birthday falls earlier in the year pays first.

For dependents of divorced or separated parents with coverage under two or more plans, the primary plan will be determined in the following order (unless stated otherwise by a divorce decree):

- The plan of the parent with a court order setting responsibility for health care expenses;
- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent not having custody of the child; and
- The plan of the spouse of the parent not having custody.

A plan without a COB provision will always be the primary plan.

You should first submit your claim to the primary plan. Once you receive an *Explanation of Benefits* (EOB) statement from the primary plan, any remaining expenses should be sent to the secondary plan for consideration.

DETERMINING WHICH PLAN IS PRIMARY

Note that in all cases, for purposes of COB, an allowable expense is a health care expense that is covered by one of your health plans (at least in part).

When a Covered Person Is Receiving COBRA Continuation Coverage Under a Company-Sponsored Plan or Another Plan

If you are receiving COBRA continuation coverage—whether through a company-sponsored plan or another plan—and also have active employee medical coverage elsewhere, such as through your spouse's employer, your coverage with the active plan is primary and your COBRA coverage is secondary.

When a Covered Person Qualifies for Medicare

As permitted by law, in most cases, your company-sponsored medical plan will pay benefits secondary to Medicare when you become eligible for Medicare, even if you don't elect it.

(continued)

DETERMINING WHICH PLAN IS PRIMARY (continued)

There are, however, Medicare-eligible individuals for whom the company-sponsored medical plan pays benefits first and Medicare pays benefits second:

- *Employees with active current employment status age 65 or older and their spouses age 65 or older (domestic partners are excluded as provided by Medicare);*
- *Individuals with end-stage renal disease, for a limited period of time; and*
- *Disabled individuals under age 65 with current employment status and their dependents under age 65.*

For additional information about how your active coverage coordinates payment of allowable expenses with COBRA or Medicare, contact your plan carrier.

Coordination with Other Types of Coverage

In addition to coordinating benefits with other group insurance plans, the plans will coordinate with "Personal Injury Protection" (PIP) (no-fault) coverage, and provisions of any motor vehicle or homeowner's policy covering hospital, medical, dental or other health care expenses. In all cases, the other coverage is primary.

If your coverage is with UHC and you are involved in an automobile accident in a no-fault state, UHC will send you a notice stating that you are required to complete a PIP summary payout sheet, which shows that maximum benefits under auto insurance have been paid. You must complete the PIP summary payout sheet and return it to UHC within 45 days of the date on the notice. If this information is not received within 45 days of the date on your notice, UHC will deny the claim(s).

If you're covered by more than one plan and need assistance determining which plan should receive bills first, contact your plan carrier.

Subrogation and Recoveries (All Plans Except UHC)

Claims Against Others

A participant or beneficiary who recovers from a third party, whether through voluntary payment, settlement or a court action, and without regard to the characterization of such recovery for pain and suffering, mental anguish, punitive damages, or any other basis for recovery, is obligated to repay the plan for amounts paid to or on behalf of the participant or beneficiary for claims (including, for example, claims for disability or lost wages) or for treatment of an injury or illness resulting from the wrongful conduct of the third party. In addition, the plan will be subrogated to, and have a lien against, all of the rights of the participant or beneficiary to any recovery.

The plan's right to recovery is not limited by the application of any "make whole" theory and the amount thereof is not limited or reduced because the third party is found to be liable only in part, because the third party's resources are limited, or for any other reason.

You (and your dependents, or, if you are not legally competent, your legal representative) must inform the plan administrator when it appears that a third party is or may be liable for any condition for which covered services or benefits are provided. If requested to do so, you must complete and sign the Subrogation Form and Assignment of Benefits Agreement before any benefits will be paid under the plan. You and your dependents must cooperate with the claims administrator and the plan administrator in the filing and processing of any and all claims you have from time to time.

At the plan's request, you and your dependents must take such action, furnish such information and assistance, and execute such documents as the claims administrator and the plan administrator may require to facilitate enforcement of the plan's rights. If you fail to do so, the plan will be entitled to deny your claim or any portion thereof. You and your dependents:

- Must do nothing after acceptance of benefits under the plan to prejudice the subrogation rights of the plan;

- Must not release any third party from any liability without the consent of the claims administrator or the plan administrator; and
- Must notify any third party and any other individual or entity acting on behalf of the third party of the plan's right to reimbursement.

If you or any of your dependents fail to cooperate with the claims administrator and the plan administrator and to satisfy your obligations under this provision, the applicable administrator may deny the claim or any portion thereof, and your coverage under the plan may be terminated.

If you or your dependent (or any trust established on behalf of you or your dependent) receives money from any third party in connection with a claim that implicates the plan's recovery rights, regardless of the characterization of the payment, you, your dependent or the trust shall hold such money in trust for the plan to the extent of the plan's recovery rights. The plan's rights shall not be affected by a release of any third party entered into without the consent of the plan administrator or by a judgment obtained in litigation in which the plan is not joined as a party. The plan may take any and all actions necessary or convenient to enforce its recovery rights.

Additional Rights of Recovery for Overpayments or Mistaken Payments

All company-sponsored health and welfare plans also have the right to recover benefits it has paid on your or your dependent's behalf that were:

- Made in error;
- Made due to a mistake in fact;
- Advanced during the time period of meeting the calendar-year deductible; or
- Advanced during the time period of meeting the calendar-year out-of-pocket maximum.

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the plan will:

- Require that the overpayment be returned when requested; or
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Subrogation and Reimbursement (UHC)

This section describes the subrogation process for UHC. For information related to Kaiser Permanente, see the plan's *Evidence of Coverage* booklet. For information related to Cigna (Global Choice), see the plan's *Certificate of Coverage* booklet.

The plan has a right to subrogation and reimbursement. Unless otherwise stated, references to "you" or "your" in this *Subrogation and Reimbursement* section include you, your estate and your heirs and beneficiaries.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that the plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the plan has paid that are related to the sickness or injury for which any third party is considered responsible.

SUBROGATION, AN EXAMPLE

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the plan to treat your injuries. Under subrogation, the plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment or other recovery from any third party, you must use those proceeds to fully return to the plan 100% of any benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

REIMBURSEMENT, AN EXAMPLE

Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The plan sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by the plan.
  - Signing and/or delivering such documents as the plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the plan is considered a breach of contract. As such, the plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan. If the plan incurs attorneys' fees and costs in order to collect third-party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.

- The plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the plan's recovery without the plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.
- Benefits paid by the plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the plan alleges some or all of those funds are due and owed to the plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits from the plan, you agree that:
  - Any amounts recovered by you from any third party shall constitute plan assets to the extent of the amount of plan benefits provided on behalf of the covered person,
  - You and your representative shall be fiduciaries of the plan (within the meaning of ERISA) with respect to such amounts, and
  - You shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the plan to enforce its reimbursement rights.
- The plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from the plan, you agree to assign to the plan any benefits, claims or rights of recovery you have under any automobile policy—including no-fault benefits, personal insurance protection/personal injury protection (PIP) benefits and/or medical payment benefits—other coverage or against any third party, to the full extent of the benefits the plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the plan, without its written approval.
- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death, the plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused 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 covered.
- In the event that you do not abide by the terms of the plan pertaining to reimbursement, the plan may terminate benefits to you, your dependents or the employee, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to your failure to abide by the terms of the plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.
- The plan and all administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to:
  - Construe and enforce the terms of the plan's subrogation and reimbursement rights, and
  - Make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

Right of Recovery

The plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar-year deductible; or
- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the plan.
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the plan.

Your Rights under ERISA

As a participant in the benefit plans of legacy Raytheon Company that are subject to the provisions of the *Employee Retirement Income Security Act of 1974* (ERISA), as amended, you are entitled to certain rights and protections. ERISA provides that all plan participants are entitled to:

The *Employee Retirement Income Security Act of 1974* (ERISA) provides you with certain rights and protections for benefits offered by the company.

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- With respect to the Raytheon Savings and Investment Plan (RAYSIP), you are entitled to obtain a statement that shows the value of your contributions to your account, including any investment earnings on those contributions. At any time, you can see the current value and vested status of your account online through Fidelity NetBenefits® at www.netbenefits.com/raytheon. Quarterly statements of your account also contain this information, and are available at NetBenefits or will be mailed to you if you have chosen not to receive them through NetBenefits. The plan must provide these statements free of charge.

Continue Group Health Plan Coverage

With respect to any group health plan, continue health care coverage for yourself and/or your 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 documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called *fiduciaries* of the plans, 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 pension or welfare benefit or exercising your rights under ERISA.

Raytheon Benefit Center
https://raytheon.benefitcenter.com
800-358-1231

Enforce Your Rights

If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from a plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a fine that accrues on a daily basis (based on amounts set by the Department of Labor, and subject to a cap) from the time the materials were due to you until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse a 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.

Assistance with Your Questions

If you have any questions about the plans, 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 the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Disclosure Information

ERISA also requires companies to disclose the following detailed information so that it is available for your reference:

Plan Directory

The *Plan Directory,* later in this section, provides a list of the benefit plans covered by this handbook and includes the plan name, number, type and claims administrator. Information about funding can be found under *Plan Costs* later in this section.

The *Plan Directory* also lists the names and addresses of insurance issuers that are involved in financing or administering the benefit plans and the extent to which benefits under a plan are guaranteed under a contract or policy of insurance issued by the issuer and the nature of any administrative services provided by the issuer.

Plan Sponsor

Raytheon Company
870 Winter Street
Waltham, MA 02451

Plan Administrator

Raytheon Technologies Corporation
c/o Corporate Benefits
870 Winter Street
Waltham, MA 02451-1219
781-522-3000

Raytheon Benefit Center

P.O. Box 199422
Dallas, TX 75219-9422
800-358-1231

Plan Year

The fiscal records of each plan are kept on the basis of a plan year. For all plans in this document, the plan year is January 1 to December 31.

Plan Documents

If you wish to receive a copy of a plan document or need additional information about any specific plan provision, contact the plan administrator.

Employer Identification Number

The Internal Revenue Service (IRS) assigns every employer an employer identification number (EIN). The company's EIN is 95-1778500.

Agent for Service of Legal Process

Secretary
Raytheon Technologies Corporation
870 Winter Street
Waltham, MA 02451-1449
Service of legal process may also be made upon a plan trustee or the plan administrator.

Your Rights under HIPAA

Medical Coverage

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) is a federal law that requires health plans to protect the confidentiality of your private health information, and to make it easier for you and your family members to have continued medical coverage when changing from one employer to another.

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) requires that health plans protect the confidentiality of your private health information.

Non-Discrimination Rules

Under HIPAA, no medical plan can have enrollment rules based on health factors. This means that a health plan cannot require evidence of insurability (proof of good health) and cannot exclude individuals who cannot pass a physical exam (including late enrollees).

Special Enrollment Opportunities

If you decline company-sponsored coverage for yourself or your eligible family members because of other medical or vision insurance coverage, you may be able to enroll yourself and/or your dependents in a company-sponsored medical or vision plan, or change your medical or vision plan election in the future, provided that you request enrollment within 31 days of when your other coverage ends.

This special enrollment right is available only if one of the following conditions is met:

- You or a family member becomes ineligible for coverage under another employer's medical or vision plan or other medical or vision insurance;

- An employer's contributions for the other coverage stop; or
- In the case of COBRA coverage (excluding the company's COBRA plans), because the maximum COBRA period has expired.

As with the scenario above, if you are on company-sponsored coverage and one of the above conditions is met, you will have the opportunity to drop your company-sponsored coverage. If you are enrolling in benefits coverage elsewhere, check the other plan administrator's rules regarding special enrollment opportunities.

In addition, if you or a dependent gains or loses eligibility for Medicaid, Medicare or a state children's health plan, or if you or a dependent becomes eligible or ineligible for state assistance for coverage under the plan, you may be able to enroll or end coverage for yourself or your dependents, provided you request enrollment within 31 days of the date eligibility was gained or lost *or* within 60 days in the case of a Medicaid or state assistance event.

You also have a special enrollment opportunity if:

- You marry; or
- You or your spouse acquires a dependent through your marriage or the birth, adoption or placement for adoption of the dependent.

Privacy Rights

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA's privacy rules can be found in the *HIPAA Notice of Privacy Practices for Protected Health Information,* which is available on *Desktop Benefits* at https://raytheon.benefitcenter.com (click on the link to *Notice of Privacy Practices* under *My Resources* in the *Other Benefits* section) or by calling the RBC at 800-358-1231.

The Health Benefits Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have any questions about the privacy of your health information or wish to file a complaint under HIPAA, contact:

HIPAA Privacy Officer
880 Winter Street
Waltham, MA 02451

Your Rights under FMLA

The *Family and Medical Leave Act of 1993* (FMLA) allows eligible employees in the United States to take up to 12 weeks (or more if required by state law or otherwise noted) of unpaid leave in a rolling 12-month period for certain family or medical reasons, including:

- The birth of a child;
- The placement of a child with you for adoption or foster care;
- The treatment of a serious health condition for yourself;
- The care of your child, your spouse, your same-sex domestic partner or your parent with a serious health condition;

The FMLA policy applies to all employees who are based in the United States or in a U.S. territory or possession, including employees in any business or subsidiary company. More information is available on oneRTN.

Raytheon Benefit Center
https://raytheon.benefitcenter.com
800-358-1231

- For any *qualifying exigency* that arises from your child's, spouse's or parent's active duty in the armed forces as a member of the National Guard or Reserves, including an order or call to duty. (For more information, contact your Human Resources representative); or
- An eligible employee who is the spouse, child, parent or next of kin of a current member of the armed forces who has a serious injury or illness incurred in the line of duty while on active duty is allowed to take up to 26 workweeks, in a single 12-month period, to care for such a service member. (Note that 26 workweeks is a maximum leave entitlement that would include FMLA leave taken for other reasons, within the 12-week limit for such other reasons.)

A *serious health condition* is any injury, illness or impairment that requires:

- Inpatient care in a hospital, hospice or residential medical facility; or
- Continuing care by a physician that consists of two or more visits or continuing treatments.

Provided there are at least 50 employees within a 75-mile radius of your worksite, you are eligible for FMLA leave if you are a part- or full-time employee who has:

- Been with the company for at least one year; and
- Worked at least 1,250 hours in the previous 12 months.

When the need for your leave is foreseeable, you must ordinarily provide the company with 30 days of advance notice of your need to take FMLA leave. The company may require medical certification of the need for a leave due to a serious medical condition and may request a second and third opinion, at the company's expense. A "fitness for duty" report might also be requested before you return to work.

Continued Coverage During FMLA Leave

During your FMLA leave, you are entitled to the following benefits:

- The company must maintain your group health plan coverage on the same conditions as coverage would be provided if you had been continuously employed during the entire period of your leave.
- You are entitled to new or changed group health plan coverage on the same basis as if you were not on leave.
- You must be given notice of any opportunity to change your group health plan coverage.
- If you do not retain your group health plan coverage during your leave, you are entitled to have coverage reinstated when you return from leave, without any requirements to requalify, such as any waiting period, physical examination or pre-existing condition exclusion.

Paying for Continued Coverage

During your FMLA leave, you must continue to pay any contribution toward the cost of your coverage that you were paying prior to your leave. If you are not required to contribute toward the cost of your coverage, you will not be required to do so while on FMLA leave (unless you fail to return after FMLA leave, as described later in this section). If, while you are on FMLA leave, employees are required to begin paying premiums or if the premiums are raised or lowered, you will be required to pay the new premium rates.

If you fail to return at the end of an unpaid FMLA leave, the company may recover premiums it paid for the cost of your coverage during the unpaid portion of that leave. The amount the company may recover would be limited to only the company's share of the allowable premiums as would be calculated under COBRA, less the 2% administrative fee. If permitted by applicable federal or state laws, the company's recovery of premiums would be through deductions from any sums owed to you by the company. The company could also initiate legal action to recover premiums. The company cannot recover premiums it pays for the cost of your group health plan coverage during a paid leave.

When Coverage May End

The company's obligation to provide group health plan coverage ends upon the earliest of the following:

- You inform the company of your intent not to return to work from FMLA leave.
- You fail to return from FMLA leave and terminate your employment.
- You exhaust your FMLA entitlement.

If one of these events occurs, you would become eligible for continued coverage under COBRA (see the section *Continued Coverage under COBRA).*

Your Rights under USERRA

The company's leave policies comply with the *Uniformed Services Employment and Reemployment Rights Act of 1994* (USERRA). USERRA applies to persons who perform service voluntarily or involuntarily, in the *uniformed services,* including the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. Federal training or service in the Army National Guard and Air National Guard also gives rise to rights under USERRA. In addition, under the *Public Health Security and Bioterrorism Response Act of 2002,* certain disaster-response work (and authorized training for such work) is considered service in the uniformed services.

Uniformed service includes active and inactive duty for training (such as drills), initial active duty training and funeral honors duty performed by National Guard and reserve members, as well as the period for which a person is absent from a position of employment for the purpose of an examination to determine fitness to perform such duty.

Once you know that you will be in uniformed service for more than 30 days, call the RBC at 800-358-1231 for more detailed information about your right to elect continued coverage under USERRA.

Medical, Vision and Dental Coverage

If you perform service in the uniformed services for more than 30 days, you may continue medical, vision and/or dental coverage for yourself and your covered dependents while performing uniformed service. Continued coverage becomes effective on the date your military leave of absence begins. You are required to pay the full cost of your coverage, plus a 2% administrative fee.

Coverage Following Reemployment

If you have continued medical, vision and/or dental coverage under USERRA, you are eligible to receive coverage under the plan as a regular employee for yourself and your covered dependents, provided you return to work before your reemployment rights expire, based on your period of uniformed service. If your period of uniformed service was:

- *Less than 31 days:* You must return to work by the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of service, plus the time required to return home safely and have an eight-hour rest period;
- *At least 31 days but less than 181 days:* You must return to work within 14 days of your release from uniformed service; or
- *181 days or more:* You must return to work no later than 90 days after your release from uniformed service.

Upon reemployment, you and your covered family members will not be required to complete any waiting period.

When USERRA Coverage Ends

Your continued coverage under USERRA ends on the earliest of the following dates:

- The last day of the 24-month period beginning on the effective date of your military leave of absence;
- The date you fail to make a required USERRA premium payment; or
- The date your reemployment rights expire.

Raytheon Benefit Center
https://raytheon.benefitcenter.com
800-358-1231

RAYSIP

If you take an authorized military leave of absence, you may choose to continue to have RAYSIP contributions deducted from the pay you receive from the company during your military service. Whether or not you choose to continue your RAYSIP deductions during your leave, you may make up the missed RAYSIP contributions, if eligible, within a certain timeframe after you return to active employment with the company.

In all cases, your RAYSIP contributions are based on the full compensation you would have earned from the company during your military leave. For more information about your rights under USERRA and the timeframe in which your makeup contributions must be made, call the Raytheon Savings and Investment Service Line at 800-354-3966.

Your Rights under HEART

RAYSIP

Under the *Heroes Earnings Assistance and Relief Tax Act of 2008* (HEART), if you die or become disabled while performing qualified military service, you will receive RAYSIP benefits as if you had returned to active employment on the day before the date of your death or disability and then terminated your employment on the date of your death or disability.

Your Rights under NMHPA

Medical Coverage

Under the federal *Newborns' and Mothers' Health Protection Act of 1996* (NMHPA), group medical plans, such as the Health Benefits Plan, and health insurance issuers offering group insurance coverage with maternity benefits generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the health insurance issuer for prescribing a length of stay not in excess of these periods.

Your Rights under WHCRA

Medical Coverage

The federal *Women's Health and Cancer Rights Act of 1998* (WHCRA) imposes certain requirements on group medical and health plans, such as the Health Benefits Plan, that provide medical and surgical benefits for mastectomies.

Under WHCRA, a participant in the Health Benefits Plan who elects breast reconstruction in connection with a mastectomy is entitled to coverage for the following services, in consultation with her attending physician:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- Prostheses and coverage of physical complications at all stages of the mastectomy.

Deductibles, coinsurance and/or copayments apply, consistent with other benefits under the plan. All other terms and conditions of the plan apply to this coverage.

Assignment of Benefits

The plans summarized in this document are used exclusively to provide benefits to you. Generally neither you nor Raytheon, nor anyone else can assign, transfer or attach your benefits or use them for collateral. Except for a very limited right of assignment of RAYSIP benefits under a qualified domestic relations order, generally neither you nor the company, nor anyone else can assign, transfer or attach your benefits or use them for collateral.

Qualified Domestic Relations Orders

Raytheon Savings and Investment Plan

Federal law generally prohibits assignment or attachment of your benefits from the Raytheon Savings and Investment Plan (RAYSIP), except under a qualified domestic relations order (QDRO). A QDRO is a court order, issued in connection with a divorce or family support proceeding, which orders the plan to pay benefits to someone other than you. The company must obey these court orders, and any such payment will not violate the rule of non-assignability of benefits. A QDRO applies only to RAYSIP.

The plan administrator may be required to begin making payments from your RAYSIP account while you are still working. These payments could even exhaust the total value of your account. The plan administrator has no discretion in these matters.

The plan administrator has delegated QDRO administration to the Raytheon QDRO Benefit Center. Each domestic relations order attempting to attach assets in an ERISA plan must meet certain qualification requirements. The Raytheon QDRO Benefit Center reviews all domestic relations orders received by the plan to determine whether they are qualified under ERISA. You may obtain a copy of the procedures that the plan uses to govern determinations on whether a domestic relations order is a QDRO from the plan administrator, without charge.

For additional information, call the Raytheon QDRO Benefit Center at 888-823-6512.

Qualified Medical Child Support Orders

Medical Coverage

As required by law, the company's medical plans recognize qualified medical child support orders (QMCSOs). A QMCSO is a court order or an order issued by a state administrative agency under state law that requires an alternate recipient (for example, a child or stepchild) to be covered as a dependent under a plan participant's group health plan. Generally, a QMCSO is issued as part of a paternity or divorce settlement or other determination of child support obligation.

The company's medical plans honor QMCSOs that meet the legal requirements for such orders. It's important to note that a QMCSO cannot require a type or form of benefit or an option that is not currently available under the plan to which the order is directed.

A QMCSO must be filed with the plan administrator, who reviews it to decide if it meets the conditions of a legally qualified QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee. If the plan administrator receives a QMCSO relating to you, you will be notified and then informed of the decision if the QMCSO is qualified. You can obtain a copy of the plan's procedures governing QMCSO determinations from the plan administrator, without charge. QMCSOs should be filed with the:

Raytheon Benefit Center
P.O. Box 199422
Dallas, TX 75219-9422

Important Information about the Defined Contribution (401(k)) Plan

Raytheon Savings and Investment Plan

The Raytheon Savings and Investment Plan (RAYSIP) is considered a defined contribution plan under ERISA. This plan provides you with an individual account.

If you participate in RAYSIP, you may make pre-tax, after-tax and/or Roth 401(k) contributions. The benefits you receive are determined by the amounts you contribute and any investment gains or losses less plan fees charged to your account. For a more detailed summary of RAYSIP features, see the *RAYSIP* section of this handbook.

All contributions to RAYSIP are held in trust and invested according to the terms of the plan documents. The trustee for the plan is:

Fidelity Management Trust Company
82 Devonshire Street, MM1M
Boston, MA 02129
800-354-3966 or 617-330-3050 (TDD# 800-847-0348)

Benefits under RAYSIP are not insured by the Pension Benefit Guaranty Corporation (PBGC), because the PBGC does not insure benefits under defined contribution plans.

IRS Approval

The Raytheon Savings and Investment Plan (RAYSIP) was established as a qualified retirement plan and has received a favorable determination letter from the Internal Revenue Service (IRS) with respect to its qualification.

The plan may change from time to time or be discontinued to comply with IRS regulations, any changes in the Internal Revenue Code (IRC) or any other applicable law or for any other reason. If material changes are made, you will be notified.

Plan Costs

Here is a summary of how each benefit plan described in this document is paid for:

- ***The company pays the full cost*** of your business travel accident (BTA) insurance.
- ***You and the company share the cost*** of your medical coverage (including HSAs), vision coverage and dental coverage.
- ***You pay the full cost*** of any employee contributions you make to RAYSIP.

Other Important Information

Right to Amend or Terminate Plans

The company reserves the right to amend or terminate any of the plans at any time. Such amendments or modifications may be retroactive to meet statutory requirements or for any other reason.

If RAYSIP were terminated, you would become fully vested in your account(s). The plan's assets would be divided among all participants as specified under ERISA. None of these assets could revert to the company or any subsidiary.

Each plan document describes the procedure for amending or terminating the plan.

- *RAYSIP* may be terminated by a vote of the Board of Directors. The Board of Directors or the Raytheon Technologies Pension Administration and Investment Committee, or its delegate, may amend the plan.
- *The welfare plans* may be amended or terminated by the Board of Directors or the Raytheon Technologies Pension Administration and Investment Committee or its delegate.
- The Raytheon Technologies Pension Administration and Investment Committee, or its delegate, has authority to adopt amendments to the benefit plans.

In contrast to decisions relating to administration of the plans, including the decision to grant or deny benefits, a decision to amend or terminate a plan is a business decision that can be made solely in the best interests of the company.

Discretionary Authority to Administer Plans

The plan administrator has authority to make decisions in connection with the administration of the plans (other than decisions regarding the payment of claims that are made by others acting as claims administrator, as described elsewhere in this section). In making those decisions, the plan administrator has full discretionary power to interpret the plan provisions and determine all relevant questions arising under the plans.

IMPORTANT NOTE

Your eligibility or your right to benefits under these plans should not be interpreted as a guarantee of employment. Participation in these plans does not interfere with the company's right to terminate your employment at any time, whether or not for cause, with or without notice.

Plan Directory

The *Plan Directory* lists the names and addresses of the companies that are involved in administering claims under the legacy Raytheon benefit plans and the extent to which benefits under a plan are guaranteed under a contract or policy of insurance issued by the issuer and the nature of any administrative services provided by the issuer.

Plan Name	Plan No.	Claims Administrator	Type of Plan
UnitedHealthcare HSA Advantage 1 **UnitedHealthcare HSA Advantage 2** **UnitedHealthcare Hawaii Plan** **UnitedHealthcare Out-of-Area Plan** Self-insured plans funded through employer and employee contributions	551	UHC P.O. Box 740809 Atlanta, GA 30374 800-638-8884 (TDD# available by appointment)	Welfare
Global Choice Plan **(For eligible expatriate employees on international assignments and their eligible dependents)** Fully insured plan funded through employer and employee contributions	551	Cigna Global Health Benefits ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850 800-441-2668 302-797-3100	Welfare
Kaiser Permanente HSA Advantage Plan (California) Fully insured plan funded through employer and employee contributions	551	*Northern California:* Kaiser Permanente Claims Administration Department P.O. Box 12923 Oakland, CA 94604-2923 800-390-3510 *Southern California:* Kaiser Permanente Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004 800-390-3510	Welfare
Kaiser Permanente HSA Advantage Plan (Colorado) Fully insured plan funded through employer and employee contributions	551	Kaiser Permanente P.O. Box 373150 Denver, CO 80237-7150 800-632-9700	Welfare
Kaiser Permanente HMO Plan (Hawaii) Fully insured plan funded through employer and employee contributions	551	Kaiser Foundation Health Plan, Inc. Attn: Claims Administration P.O. Box 378021 Denver, CO 80237 877-875-3805	Welfare
Kaiser Permanente HSA Advantage Plan (Mid-Atlantic) Fully insured plan funded through employer and employee contributions	551	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. P.O. Box 6233 Rockville, MD 20849-6233 800-777-7902 301-468-6000	Welfare
CVS Caremark-Administered Prescription Drug Program Self-insured plan funded through employer and employee contributions	551	CVS Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 866-329-4023	Welfare

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Plan Name	Plan No.	Claims Administrator	Type of Plan
Basic Vision and Vision Plus Plans Self-insured plans funded through employer and employee contributions	551	VSP® Vision Care Attn: Out-of-Network Claims P.O. Box 997105 Sacramento, CA 95899-7105 888-426-3937	Welfare
Delta Dental PPO *Plus Premier* Self-insured plans funded through employer and employee contributions	551	Delta Dental of Massachusetts 465 Medford Street Boston, MA 02129 877-335-8227 *Claims Appeals* Delta Dental of Massachusetts Attention: Appeals P.O. Box 9565 Boston, MA 02114	Welfare
DeltaCare Dental Maintenance Organization (DMO) (Available in Massachusetts) Fully insured plan funded through employer and employee contributions **DeltaCare USA DMO (Available in Arizona, California, Colorado, Florida, Indiana, Virginia and Texas)** Fully insured plan funded through employer and employee contributions	551	Delta Dental 465 Medford Street Boston, MA 02129 877-335-8227 *Claims Appeals: Massachusetts* Delta Dental of Massachusetts Attention: Appeals P.O. Box 9565 Boston, MA 02114 *Claims Appeals: Outside Massachusetts* Delta Dental Insurance Company Attention: Quality Management Department P.O. Box 6050 Artesia, CA, 90702	Welfare
Business Travel Accident Plan Fully insured plan funded through employer contributions	554	National Union Fire Insurance Company of Pittsburgh, PA (NUFIC) Claims Services An AIG Company P.O. Box 25987 Shawnee Mission, KS 66225-5987 800-551-0824	Welfare
Raytheon Savings and Investment Plan Funded through employee contributions to a trust *Trustee:* Fidelity Management Trust Company 82 Devonshire Street, MM1M Boston, MA 02109	026	Plan Administrator *For initial claims, contact:* Fidelity Institutional Retirement Services Company Raytheon Claims & Appeals Unit P.O. Box 770003 Cincinnati, OH 45277-1060 800-354-3966 *To appeal a denied claim, contact:* Benefit Appeals Committee c/o Fidelity Institutional Retirement Services Company Raytheon Claims & Appeals Unit P.O. Box 770003 Cincinatti, OH 45277-1060	Defined Contribution