

EXHIBIT 13

TEXTRON MEDICAL BENEFITS

Textron HRA Plan
Textron Low Deductible-HSA Plan
Textron High Deductible-HSA Plan
Textron Maximum Deductible-HSA Plan

Administered by UnitedHealthcare

Summary Plan Description

For the following eligible employees:

- Textron Enterprise Non-Bargained Employees
- Certain Bargained Employees, and
- Certain Retirees

Effective Date: 1-1-20

3.TT-H-830B.101

TABLE OF CONTENTS

Introduction	2
Eligibility	4
Qualified Medical Child Support Order (QMCSO).....	7
Enrolling for Coverage.....	8
Initial or Rehire Enrollment	8
Annual Enrollment.....	9
Special Enrollment.....	10
Cost of the Plan	12
Importance of Current Address	12
When Coverage Begins	13
When Coverage Ends.....	13
How the Plans Work.....	15
Health Coverage Benefit.....	20
Textron Medical Plans Detail	26
Textron Medical Plans Detail: Out-of-Area	28
Plan Details: HRA/HSA Company Funding Amounts, Deductibles, Coinsurance, Out-of-PocketMaximums	31
Prior Authorization.....	32
Personal Health Support.....	35
Understanding your Textron HRA Plan	36
What Expenses Are Covered under the HRA only?	38
What Covered Health Services expenses are covered under the HRA and Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options health coverage benefit?	40
The Women’s Health and Cancer Rights Act	44
Statement of Rights under the Newborns’ and.....	44
Understanding Your Health Savings Account and Your Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options	45
What Expenses Are Covered by the HSA.....	50
What Expenses Are Not Covered by the HSA	51
Alternatives to Using an HSA	51
Covered Health Services.....	53
Preventive Care	56
Additional Health Benefits and Programs.....	89
What Is Not Covered	93
Prescription Drug Benefits (Administered by CVS Caremark)	100
Your Prescription Drug Benefit and Medicare	107
Coordination of Benefits	110
Claims Procedures and Appeals Process.....	116
Leaves of Absence.....	135
Continuing Coverage Under COBRA.....	138
Subrogation and Reimbursement.....	154
Administrative Information	159
Notice of Privacy Practices	163
Your Rights Under ERISA.....	171

Terms to Know 173

Introduction

This Summary Plan Description (SPD) is a summary of the medical benefits administered by UnitedHealthcare (UHC) under a group health plan that is part of the Textron Non-Bargained Medical Plan (525) and the Textron Bargained Medical Plan (526) for certain employees, and the Textron Retiree Benefits Plan (528) for certain retirees (the "Plan"), of Textron Inc., its divisions and subsidiaries (the "Company"). This is a Self-Insured plan.

The benefits described in this SPD relate to a Consumer Directed Health Plan (CDHP) which is a health insurance plan that allows members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay routine health care expenses directly, while a high-deductible health insurance policy protects them from catastrophic medical expenses.

This SPD applies to you if you are an eligible employee or retiree (as described in the **Eligibility** section of this SPD or Retiree Supplement) on or after the applicable effective date listed in this SPD. *Retiree Supplements* summarize important information about your eligibility for benefits under the Textron Retiree Benefits Plan.

This SPD is incorporated in a more formal Plan document and summarizes the Plan's major provisions. Your benefits are described as clearly as possible. If there is a conflict between this SPD and the formal Plan document, the formal Plan document will control. Likewise, if any oral or written representations made by any Textron representative or any other person conflict with or are inconsistent with the provisions of this SPD or the Plan document, the Plan document will control and takes the place of any prior oral or written communication on the subject of the benefit.

It is important for you to read this SPD to understand what is covered under the Plan, when you are entitled to this benefit and the extent of your coverage.

If you have difficulty in understanding this benefit description in English, we will provide you with translation assistance. If you need assistance, please ask your supervisor or call the Textron Human Resources Service Center (HRSC) at 1-866-MY-TXT-HR (1-866-698-9847).

The information presented is not intended to be construed to create a contract between Textron Inc. and you as a Textron Inc. employee or former employee. This SPD is not intended to create a contractual right to employment by Textron. All employment is "at will."

In the event that the content of this document or any oral or written representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document control.

Textron Inc. reserves the right to amend, modify, suspend, replace or terminate any of its plans, policies or programs, in whole or in part, including any level or form of coverage by appropriate company action, without your consent or concurrence.

If you have any questions regarding eligibility, enrollment or contribution rates for this Plan, please contact the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847). If you have questions regarding benefit coverage or claims under this Plan, please contact the Claims Administrator.

This SPD describes the Plan in effect on January 1, 2020 and applies to you only if you are an eligible employee on or after this date.

Eligibility

Who Is Eligible for the Consumer Driven Health Plan (CDHP)

To be eligible for active medical coverage, you must be:

- A Salaried or Hourly Non-Bargained full-time employee scheduled to work at least 20 hours per week.
- A Bargained employee scheduled to work at least the number of hours per week as specified in your collective bargaining agreement.
- Part-time employees scheduled to work between 20 and 30 hours per week are eligible for benefits at an increased premium (currently 125% of the active full-time employee rate).
- An employee who meets the eligibility requirements, if any, effective on or after January 1, 2020 applicable to the Textron entity or Company where you work.

Note: The Affordable Care Act (ACA) requires that a full-time employee be defined as an employee who works, on average, at least 30 hours per week over the previous year, calculated on September 30 each year.

Eligible **Salaried, Hourly Non-Bargained or part-time employees** who work at one of the companies listed below:

If hired prior to May 1, 2016:

- Bell Helicopter
- Kautex, N.A.
- Textron Airborne Solutions Inc. (TAS)
- Textron Aviation
- Textron Corporate
- Textron Financial
- Textron Specialized Vehicles
- Textron Systems
- TRU Simulation + Training

Eligible **Bargained employees** who work at one of the companies listed below:

If hired prior to May 1, 2016:

- Bell Helicopter UAW Local 317

If hired prior to July 1, 2016:

- Kautex Detroit UAW 22 (Vitec)
- Textron Aviation
- TRU Simulation + Training- SCA Contracts

If hired prior to January 1, 2018:

- Bell BPEA
- Bell SPFPA Local 256

If hired prior to January 1, 2019:

- Bell UAW Local 218

Who Is Not Eligible

Even if you meet the above requirements, you are not eligible to participate in the Plan if:

- You are a leased employee of one of the Textron companies;
- You are classified by Textron as an independent contractor or other non-employee (even if you are later classified by Textron, the IRS or other government agency or a court as a common-law employee of one of the Textron companies);
- Your basic compensation for services is not paid directly by one of the Textron companies;
- You were retained by one of the Textron companies under a contract that states that you are not eligible to participate in the Plan;
- You are a seasonal, temporary or introductory employee of one of the Textron companies;
- You are student hired through a program that is designed to supplement classroom education, such as an internship program, a co-op program or a special program for at-risk students;
- You are a non-resident alien and you receive no earned income from any of the Textron entities that constitutes income from sources within the United States under the Internal Revenue Code;
- You are a self-employed individual, as defined in the Internal Revenue Code;
- You are an individual engaged as a consultant or advisor on a retainer or fee basis, as determined by the Plan Administrator; or
- You are a member of Textron's Board of Directors who is not otherwise eligible to participate in the Plan.

Note: *If you are employed by a Textron organization that supplies services to other Textron units, benefits will be received from the Company that employs and pays you.*

Dependent Eligibility

The following individuals may be covered as dependents under the Plan:

- Your spouse to whom you are legally married, and
- Your child— For purposes of the Plan, “child” means any of the following, subject to the requirements described below in the **Dependent Child Requirements** section:
 - Your natural or legally adopted child, including a child placed with you for adoption;
 - The child of your spouse, even if you have not legally adopted the child;
 - A foster child who is related to you by blood and who is a legal resident of the U.S. or is a U.S. citizen; or
 - A child for whom a court has appointed you the legal guardian.

Except as required to comply with a qualified medical child support order (“QMCSO”), your enrollment elections and coverage for dependent children are subject to change if necessary to ensure that coverage for your dependents will not be treated as taxable income to you. If your enrollment election must be changed, you will be notified.

Domestic partners were previously eligible for coverage under the Plan. In recognition of changes in the law, only legally married spouses are now eligible for coverage.

Dependent Child Requirements

To be eligible for coverage, your child must be:

- Under age 26, or
- Permanently and totally disabled.

Disabled Dependent

If your child is disabled when coverage would normally end because of age, you can apply to continue the child's medical coverage. A child is considered disabled if, due to a mental or physical handicap, the child is:

- Unable to earn a living,
- Unmarried, and
- Dependent upon you for support (i.e., you provide more than half of the child's support).

You must apply for this extended coverage by contacting the Textron Human Resources Service Center within **30 days** after the child's coverage normally would end. There may also be additional certifications required by Social Security Administration and UnitedHealthcare.

If, on your eligibility date, one of your children is disabled and fails to meet the age requirements for dependent coverage, you can apply for coverage for that child.

Application for the disabled child's coverage must be made to the Textron Human

Resources Service Center within **30 days** of your eligibility date.

You must provide proof of your dependent's continuing incapacity to the Claims Administrator from time to time.

Note: *The Plan Sponsor may request an examination of your child as often as needed; provided that, after the first two years from the date your child's coverage would otherwise have ended, the Plan Sponsor may not request an examination of your child more often than once a year.*

Coverage for a disabled child will end if he or she does not undergo any required exam, or if the child no longer meets the eligibility requirements for a disabled child. Coverage will also end if your child becomes covered under his or her employer's plan or if your coverage ceases.

If your child's coverage ends or would have ended in accordance with the terms of the Plan, and the child later becomes disabled, you may not enroll or re-enroll the child for coverage in the Plan.

Covering Grandchild

You may cover a grandchild as a dependent under the Plan only if your grandchild qualifies as your "child" under the rules described above (e.g., you have legally adopted your grandchild or you are your grandchild's legal guardian, and the grandchild is under age 26), **or** all of the following conditions are satisfied:

- The grandchild's parent is covered under the Plan as your dependent child;
- The grandchild is under age 26;
- The grandchild lives with you for more than half of the year; and
- You provide more than half of the grandchild's support.

If any of these conditions are not satisfied, your grandchild cannot be covered under the Plan.

Qualified Medical Child Support Order (QMCSO)

You may be required by an order issued by a court or administrative agency to provide coverage for your child under this Plan, even if the child does not live with you. If the order is a "qualified medical child support order" ("QMCSO"), Textron will be required to enroll the child in the coverage stated in the order and Textron will deduct payments for the coverage from your subsequent paychecks.

Note: *You may not disenroll this child while the order is in effect and the child still qualifies for coverage under the Plan.*

If Textron receives a medical child support order requiring you to provide healthcare coverage to your child, you will be notified promptly that the order has been received, and you will be sent a copy of the procedures that Textron will follow to determine whether or not the order is "qualified." If Textron determines that the order is

qualified, you will be notified that your child will be covered under the Plan and that you will be charged for the required coverage as if you had elected to cover your child under the Plan.

At any time, you may request a *free* copy of the procedures used by Textron to determine whether an order is a QMCSO.

Note: *In some cases, federal tax law requires Textron to report the value of coverage provided under a QMCSO as taxable income to you. In those cases, you will be taxed on the value of the health coverage provided to your child and Textron will be required to withhold income tax and employment tax (FICA) for the coverage that is treated as taxable income. In many cases, similar rules will apply under statelaw.*

This special tax rule will not affect you if, in the year (or years) coverage is provided, the covered child is an eligible dependent (as described above), or if:

- The covered child lives with you and/or the other parent for more than half the year **and** receives more than half of his or her support from you and the other parent; and
- You and the child's other parent either are divorced or separated under a written separation agreement **or** live apart at all times during the last six months of the year for which coverage is provided.

Enrolling for Coverage

You can choose from among the following coverage level options:

- Employee only;
- Employee plus one; or
- Family.

Your enrollment authorizes Textron to make any payroll deductions necessary for the coverage you elect. Your election will remain in force for the full calendar year and cannot be changed mid-year unless you experience a qualifying event (qualified change in status) as explained under the **Special Enrollment** section of this SPD.

Initial or Rehire Enrollment

Shortly after you are hired (or rehired), you will receive an enrollment kit that includes a Personal Fact Sheet (PFS), enrollment instructions and an enrollment sheet to help you make your selections. The PFS provides you with a list of benefits that you may enroll in and the required contribution for each benefit.

As an active employee, you must elect coverage and enroll through the Textron Human Resources Service Center within 30 days of becoming eligible or within 30 days from the date the Textron Human Resources Service Center is notified of your eligibility, whichever is later, as noted on the PFS you are provided.

You may enroll either by contacting the Textron Human Resources Service Center at

www.netbenefits.com or by phone at 1-866-MY-TXT-HR (1-866-698-9847). Your election will remain in effect through the end of that year, unless you have a qualified change in status (as described in the **Special Enrollment** section).

If you do not contact the Textron Human Resources Service Center and enroll in benefits by the enrollment deadline stated in your PFS (i.e., generally within 30 days of becoming eligible), you may subsequently enroll for coverage only during a designated annual enrollment period or during a special enrollment period (as described in the **Special Enrollment** section).

Annual Enrollment

Once each year, during the annual enrollment period, you will have the chance to review your existing coverage and think about your needs for the coming year. You must actively enroll for some of your Textron benefits, including flexible spending accounts.

If you do not enroll during annual enrollment, you and your previously covered dependents will be automatically enrolled in your current coverage or no coverage for all health plans, but not for flexible spending accounts. You will not be able to change this default coverage until the next enrollment period or until you have a qualified change in status that allows you to change your enrollment category.

To enroll, log on to www.netbenefits.com or call 1-866-MY-TXT-HR (1-866-698-9847).

The elections you make during annual enrollment will apply for the calendar year after the year in which the elections are made and will remain in effect for that entire year, unless you change your election mid-year due to a qualified change in status described in the **Special Enrollment** section.

Enrolling Your Dependent

You can elect coverage for your "eligible dependents" when you enroll. If dependent coverage is available, you may select coverage for the dependents under the same plan options in which you've enrolled.

Your dependent must qualify as an "eligible dependent" at the time you enroll. To the extent permitted by law, if it is later found that you have enrolled an ineligible individual as a dependent, his or her coverage will be terminated retroactive to the date coverage was initiated. Any additional premium that may have resulted from that individual being enrolled will be refunded, and you will be financially responsible for the full amount of any claims that may have been processed.

If you enroll any of your dependents in Textron's health plans, you will be subject to random dependent eligibility audits. **Providing false or misleading information may result in the loss of Textron's benefits and disciplinary action, up to and including termination of employment, and collection of all past paid claims dollars for the ineligible dependent(s).**

Special Enrollment

Qualified Change in Status

Generally, the choices you make during the annual enrollment period stay in effect for the entire Plan Year. However, you may be eligible to change your coverage elections mid-year during a special enrollment period if you have a qualified "change in status." If you have a qualified change in status, you must change your coverage election **before the applicable deadline** described below (30 or 60 days, depending on the qualified change in status) or the coverage you had before the change will remain in effect for the rest of the calendar year. The Plan generally does not accept late enrollees (but see "Late Enrollment Appeal Procedures" in the ***Claims Payment and Appeals Process*** section for extraordinary cases). If you enroll in coverage during a special enrollment period, the **effective date of coverage** will be the date of the qualified change in status.

The changes you make to your coverage elections during a special enrollment period must be on account of and correspond with the qualified change in status. For example, changing from individual to family coverage because you gain a dependent with the birth of your child is consistent with and corresponds to the qualified change in status.

The following qualified changes in status require you to change your coverage election within **30 days** after the qualified change in status occurs:

- o **Marital qualified change in status because:**
 - You marry.
 - You divorce.
 - You legally separate.
- o **You gain or lose a dependent due to:**
 - Birth.
 - Adoption or placement for adoption, or court-ordered guardianship.
 - Death (yours, spouse's or child's).

For example: If you get married and want to enroll your spouse, you must do so within 30 days of the date of your marriage. If you have a baby, you must enroll him or her within 30 days of the date of birth.

If you acquire a new eligible dependent on February 1, you must enroll that dependent by March 3 (or March 2 in a leapyear).

- o Your **Dependent Child loses eligibility** under a health and/or welfare plan other than Medicaid or the Children's Health Insurance Program (CHIP).
- o You, your spouse, or your dependent become(s) **eligible for Medicare or Medicaid**.

- You are required to make contributions for your child's healthcare expenses under an order that is a **Qualified Medical Child Support Order (QMCSO)**. You may also change your election when a QMCSO expires.
- **Qualified change in status applicable only to active employees** requiring you to change your coverage election within **30 days** after the qualified change in status occurs.
 - **Employment** qualified change in status because:
 - You take a leave of absence.
 - You return from a leave of absence.
 - You or a family member gains or loses benefits eligibility due to a work situation or change.
 - COBRA coverage from another employer expires (for a reason other than failure to pay the COBRA premiums).
 - **Change in residence** for you, your spouse or dependent because you relocate outside your current network service area.
- **Qualified change in status applicable to active employees and retirees** requiring you to change your coverage election within **60 days** after the qualified change in status occurs:
 - Effective April 1, 2009, a special enrollment period is available during the year to eligible employees and dependents if they lose eligibility for Medicaid or CHIP (Children's Health Insurance Program) coverage, or if they become eligible for premium assistance under Medicaid or CHIP. If you are eligible for a special enrollment period due to one of these changes, you must request enrollment within 60 days of the qualified change in status. If you do not enroll within this 60-day period, no changes can be made until the next annual enrollment period or when you have a different qualified change in status.

Special enrollment periods are not allowed if coverage or eligibility was lost because you:

- Failed to pay contributions on time,
- Submitted a fraudulent claim, or
- Intentionally misrepresented information.

The above list of qualified changes in status is not all-inclusive. If you would like to receive more information about qualified changes in status or if you think you have had a qualified change in status and would like to change your coverage elections, please contact the Textron Human Resources Service Center by phone at 1-866-MY-TXT-HR (1-866- 698-9847).

When you enroll, you may be required to provide proof of loss of coverage or any family qualified changes in status to the Textron Human Resources Service Center.

However, ***you must contact the Textron Human Resources Service Center about enrollment within the required special enrollment timeframe***, whether or not you have documentation in your possession at that time.

If Both Spouses Are Employed by Textron

In general, every eligible employee may enroll eligible dependents. If both you and your spouse are Textron employees, you may:

- Choose to enroll yourself as the employee and your spouse as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees.

You cannot be covered as both an employee and as a dependent. Eligible children may be enrolled as dependents of either you or your spouse, but not both.

Waiving Coverage

If you waive coverage when you are hired, rehired or during annual enrollment, you will not be eligible to elect coverage for you and your dependents until the next annual enrollment period, unless you experience a qualified change in status.

Cost of the Plan

You and the Company share the cost of this coverage. Your enrollment materials show the current premium contributions.

Your enrollment authorizes Textron to make any pre-tax payroll deductions necessary for the premiums associated with the coverage you have elected. Your election will remain in force for the full calendar year and cannot be changed unless you experience a qualified change in status as described elsewhere in this document.

Importance of Current Address

Benefit-related information is mailed to you. You must keep your contact information up to date in PeopleSoft if you have access to PeopleSoft. If you do not have access to PeopleSoft, you must notify the HR Service Center if your address changes. If you do not update your contact information with PeopleSoft or the HR Service Center, you may not receive important information about your benefits.

If you provided your email address, you will also need to update your email address.

If you terminate employment and are entitled to benefits under the Textron Benefits Program, you must keep the Textron Human Resources Service Center informed of your current mailing address. You may do this by contacting 1-866-MY-TXT-HR (1-866-698-9847). If you do not update the Textron Human Resources Service Center, your benefits information may not reach you.

The Company has no obligation or duty to locate a plan participant, beneficiary or dependent.

When Coverage Begins

Employee Effective Date

As an active employee, you must elect coverage and enroll through the Textron Human Resources Service Center within 30 days of becoming eligible. If you enroll within 30 days of your hire date, your coverage is effective on your eligibility date. If you are not a newly hired employee, your coverage will generally begin on the date you enroll. If you do not enroll within 30 days of becoming eligible, you can only enroll at the next annual enrollment period or when you have a qualified change in status.

Dependent Effective Date

Your dependent's coverage begins on your eligibility date (if he or she is enrolled when you enroll for coverage).

Note: *If you have a qualified change in status that allows you to enroll yourself or your dependents for coverage, the effective date of coverage under a special enrollment period will normally be the date of the qualified change in status.*

When Coverage Ends

Your coverage under the Plan ends with whichever of the following occurs first:

- At the end of the month in which the coverage period terminated,
- When you cease to be in an eligible position or are otherwise no longer eligible for coverage,
- When you fail to make any contribution or healthcare reimbursement required under the Plan (as applicable to your unit), or
- The date the Plan terminates.

If you are absent from work because of long-term disability or leave of absence, or if you retire, your coverage *may* continue. However, if you are covered as a retired individual or a disabled individual who is an inactive employee, your coverage under the Plan will automatically end if you enroll in Medicare prescription drug coverage. For more information, see the ***Your Prescription Drug Benefit and Medicare*** section.

If your coverage would otherwise end, your coverage may be continued under COBRA. For further information, see the ***Continuing Coverage Under COBRA*** section.

If You Retire

Depending on your eligibility, age and years of Textron service, you may be eligible to continue your coverage under the Plan after you retire. Please contact the Textron Human Resources Service Center for additional details on your eligibility.

If You Become Disabled

If your Textron employment ends and you are totally disabled, your coverage under the Textron Medical Plan *may* be continued.

Please contact the Textron Human Resources Service Center for additional details.

If You Take a Leave of Absence or Military Leave of Absence

If your Textron employment is suspended while you are on an authorized leave of absence or military leave of absence, your coverage may be continued. See the ***Leave of Absence*** section for more information or contact the Textron Human Resources Service Center.

When Dependent Coverage Ends

Coverage for your dependent(s) ends on the earliest of the date:

- He or she no longer meets the Plan's definition of an eligible dependent;
- Your coverage ends;
- You fail to make any contribution or health care reimbursement required under the Plan; or
- The Plan terminates.

If You Die

If you die while covered under this Plan and your dependents were covered immediately before your death, coverage for them may be continued under COBRA. For information on COBRA, see the ***Continuing Coverage Under COBRA*** section.

If your dependents were not covered by a Textron health plan when you died, the plan will not be available to them after your death.

How the Plans Work

The Textron Health Reimbursement Account (HRA), the Textron Low Deductible HSA, the Textron High Deductible HSA and the Maximum Deductible HSA Plan options (the "Plans") provide comprehensive medical coverage for a broad range of medical services through a managed care organization. Managed care is a way to receive medical care through networks of physicians, specialists, hospitals, clinics and other healthcare providers.

Like a Preferred Provider Organization (PPO), the Plans provide medical coverage and pays both network and out-of-network benefits. However, you will generally pay less out-of-pocket for network care because you receive lower, negotiated fees from network providers, and the Plans pay a higher coinsurance percentage for network care.

IMPORTANT

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

The Plans are made up of the following components and features:

Component	HRA Plan Option	HSA Low, High and Maximum Deductible
<p>Coverage Options</p>	<p>Employee Only Employee +1 Employee +2 or More</p>	<p>Same as HRA Option</p>
<p>Accounts to help pay for certain medical expenses</p> <p>For more information, see these sections of the SPD:</p> <p>Understanding Your Textron HRA Plan</p> <p><i>and</i></p> <p>Understanding your Health Savings Account and Your Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options</p>	<p>The Health Reimbursement Account (HRA) is an account that is owned and funded by the company to help you pay for qualified IRS health care expenses.</p> <p>The HRA Plan ceased to receive annual employer contributions effective January 1, 2019.</p> <p>See the Textron Medical Plans Detail chart for more information.</p> <p>Note: Covered Health Services expenses are paid first from your HRA, and then Covered Health Services expenses are generally counted toward your annual deductible under the Health Coverage component of the Plan.</p>	<p>The Health Savings Account (HSA) is a bank account that lets you put money aside, tax-free, to save and pay for qualified IRS health care expenses.</p> <p>Once you open a HSA account with Optum Bank, you can contribute to the account. If you are enrolled in either the HSA Low or High Deductible Plan Options, the company will make a contribution after you open the Optum Bank account.</p> <p>If you enroll in the Maximum Deductible Plan, the company will not make a contribution to your HSA; however, you can contribute to the account.</p> <p>You can use these funds toward your deductible and other Covered Health Services expenses.</p>
<p>Preventive Care Benefit</p>	<p>The Plan covers preventive care services, such as annual checkups, screenings, immunizations, etc. at 100% (when you receive specified preventive care services in-network). You do not need to meet the annual deductible to receive benefits for preventive care services.</p>	<p>Same as HRA Option</p>
<p>Health Coverage Benefit</p> <p>See the Health Coverage Benefit section below for further information.</p>	<p>You must use all the Benefit Dollars in your HRA and meet an annual deductible before the Health Coverage portion of the Textron HRA Plan begins to pay a percentage of eligible Covered Health Service expenses at a designated coinsurance level.</p>	<p>Eligible expenses are covered under the Health Coverage component of the Plan once you meet an annual deductible. Then the Plan pays for Covered Health Services expenses at a designated coinsurance level, up to your annual out-of-pocket maximum; and, at any time, reimbursement from your HSA can provide payment for the annual deductible or your portion of coinsurance.</p>

Component	HRA Plan Option	HSA Low, High and Maximum Deductible
<p>In-Network vs Out-of-Network Benefits</p> <p>See the <i>Health Coverage Benefit</i> and <i>Textron Medical Plans Detail</i> sections for differences in your Network and out-of-network benefits.</p>	<p>Although you are not required to use a network provider, physicians and other healthcare providers in the network have agreed to charge lower, negotiated fees for medical services to participants enrolled in the Plan. The Plan pays a higher percentage of Covered Health Services expenses for network providers and you will generally pay lower out-of-pocket costs when you stay in network.</p> <p>If you choose to see a physician or other healthcare provider that is out-of-network, your Plan pays that portion of Covered Health Services in accordance with your out-of-network Benefit reimbursement methodology.</p>	<p>Same as HRA Option</p>
<p>Out-of-Area (OOA) Plan Option</p>	<p>An Out-of-Area (OOA) plan option is available if you live more than 30 miles from a network provider. If this applies to you, you may choose the OOA Option. The OOA option generally will cover the same percentage of Covered Health Services expenses, whether you access care in the network or out-of-network.</p>	<p>Same as HRA Option</p>
<p>Deductibles</p>	<p>A deductible is the amount of Covered Health Services expenses that each person must incur out-of-pocket in a Plan Year before the Plan begins to pay benefits.</p> <p>Deductibles apply to In-Network and Out-of-Network benefits combined.</p> <p>Note: Some Pharmaceutical Products may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such Pharmaceutical Product where third party copayment assistance is used, the Member may not receive credit toward their Out-of-Pocket Maximum or Deductible for any copayment or Coinsurance amounts that are applied due to a manufacturer coupon or rebate.</p>	<p>A deductible is the amount of Covered Health Services expenses that each person must incur out-of-pocket in a Plan Year before the Plan begins to pay benefits.</p> <p>The deductible is comprised of Textron’s annual contribution (if applicable) plus the amount that you pay. This amount does not apply toward the coinsurance maximum. Deductibles apply to In-Network and Out-of-Network benefits combined.</p>

Component	HRA Plan Option	HSA Low, High and Maximum Deductible
Coinsurance	<p>After satisfying the deductible, when you incur a Covered Health Service expense, you and the Plan share the cost by each paying a set percentage, called coinsurance. This coinsurance amount may differ if you visit a network versus an out-of-network provider. Generally, your coinsurance amount- your share of the total cost-is lower when you stay in the network.</p>	<p>After satisfying the deductible, when you incur a Covered Health Service expense, you and the Plan share the cost by each paying a set percentage, called coinsurance. This coinsurance amount may differ if you visit a network versus an out-of-network provider. Generally, your coinsurance amount- your share of the total cost-is lower when you stay in the network.</p> <p><i>Note: There is no coinsurance for in-network services under the Maximum Deductible Plan. The company will pay 100% of your in-network costs once you reach your annual deductible. Coinsurance does apply to out-of-network services, however.</i></p>
Out-of-Pocket Maximum	<p>Your out-of-pocket maximum is the maximum amount you are responsible for paying out of pocket each Plan year for in-network health care costs; it is the sum of your coinsurance maximum plus the Member Responsibility portion of your deductible. After you reach your out-of-pocket maximum for in-network benefits, the Plan will pay 100% of Covered Health Service expenses for the remainder of the Plan Year.</p> <p>There is no out-of-pocket limit on your share of the cost of Out-of-Network Covered Health Services.</p> <p>Note: Some Pharmaceutical Products may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such Pharmaceutical Product where third party copayment assistance is used, the Member may not receive credit toward their Out-of-Pocket Maximum or Deductible for any copayment or Coinsurance amounts that are applied due to a manufacturer coupon or rebate.</p>	<p>Your out-of-pocket maximum is the maximum amount you are responsible for paying out of pocket each Plan year for in-network Covered Health Services costs; it is the sum of your coinsurance maximum (if applicable) plus the Member Responsibility portion of your deductible. After you reach your out-of-pocket maximum for in-network benefits, the Plan will pay 100% of Covered Health Services expenses for the remainder of the Plan Year.</p> <p>There is no out-of-pocket limit on your share of the cost of out-of-network covered services.</p>

Component	HRA Plan Option	HSA Low, High and Maximum Deductible
<p>Employed Spouse Medical Contribution (ESMC)</p>	<p>The Employed Spouse Medical Contribution (ESMC) applies if your spouse is eligible for medical coverage through his/her employer, but you choose to cover your spouse in a Textron medical plan. The contribution will vary according to your annual level of pay and is in addition to your medical paycheck contributions. (The ESMC does not apply to retirees and COBRA</p>	<p>Same as HRA Option.</p>
<p>Prior Authorization</p> <p>See the <i>Prior Authorization</i> section of this SPD for a list of services for which prior authorization is required.</p>	<p>Prior authorization for certain covered health services is required. In general, physicians and other health care professionals who participate in a network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network Provider, you are responsible for obtaining prior authorization before you receive the services.</p>	<p>Same as HRA Option</p>

Health Coverage Benefit

HRA Plan Option

If you spend all the Benefit Dollars in your HRA and need further medical care, the Health Coverage Benefit provides you with additional protection after you meet your annual deductible, as long as the expenses you incur are covered under the Plan.

- The Health Coverage Benefit begins to pay a percentage of Covered Health Services expenses after you spend all of the Benefit Dollars in your HRA and meet your annual deductible. The Covered Health Services expenses that are eligible for payment *only through the HRA* are limited to an annual maximum of 30% of your total annual HRA Benefit Dollars.

Note: *The Benefit Dollars in your HRA that you use to pay for Covered Health Services expenses will count toward your annual deductible.*

- Your coinsurance percentage depends on the coverage level and benefit level option you elected. See the **Textron Medical Plans Detail** chart for coinsurance amounts.
- You will pay your portion of the coinsurance up to the annual coinsurance maximum.
- After you have met your deductible and annual coinsurance maximum (for in-network), the Plan pays for Covered Health Services expenses at 100% of Eligible Expenses for the remainder of the Plan Year. There is no annual coinsurance maximum for Out-of-Network services.

If you use all the Benefit Dollars in your HRA and you have not yet reached your annual deductible amount, you must pay 100% of your remaining Covered Health Services expenses until you meet your annual deductible. The portion of the deductible which you must pay is your **Member Responsibility**. "Member Responsibility" may also be referred to as the "deductible corridor".

Note: *Your Member Responsibility can be less if you roll over HRA Benefit Dollars from the previous Plan Year(s), thus increasing the HRA amount available to you in the current year. However, the Member Responsibility also could increase, up to the full amount of your deductible, if you choose to spend your HRA Benefit Dollars on HRA-only Covered Health Services expenses. The Covered Health Services expenses that are eligible for payment only through the HRA are limited to an annual maximum of 30% of your total annual HRA Benefit Dollars.*

HSA Plan Options

With the Textron Low Deductible, High Deductible and Maximum Deductible-HSA Plan Options, Covered Health Services expenses are covered at the reimbursement methodologies described in this document, under the Health Coverage component of the Plan. The amounts vary depending upon whether you access care in-network or out-of-network. However, you must meet an annual deductible before the Health Coverage Benefit portion of the Textron Low Deductible, High Deductible and Maximum Deductible-HSA Options begin to pay a percentage of Covered Health Services expenses; and, at any time, reimbursement from your HSA can provide payment for the annual deductible or your portion of coinsurance.

Below is information about the components of the Health Coverage Benefit for the HRA and HSA Plan Options. These components also relate to the Preventive Care Benefit and Out-of-Area (OOA) option of this Plan.

Network

Although you are not required to use a network provider, physicians and other health care providers in the network have agreed to charge lower, negotiated fees for medical services to participants enrolled in the Plan.

The Plan pays a higher percentage of Covered Health Services expenses for network providers and you will generally pay lower out-of-pocket costs when you stay in the network. Once you reach the out-of-pocket maximum for the calendar year, the plan pays 100% of the charges for Covered Health Services expenses. See the ***Textron Medical Plans Detail*** chart for differences in your Network and out-of-network Benefits.

To determine whether your physician or other healthcare provider is in the network, contact your Claims Administrator. The Claims Administrator can provide you a copy of the provider directory, free of charge. You may also obtain provider directories by accessing the Claims Administrator's Website.

Out-of-Network

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense.

The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-network provider about their billed charges before you receive care.

Here's how your out-of-network benefit works:

- The Plan pays a lower percentage of Eligible Expenses, after you meet your annual deductible. (See the ***Textron Medical Plans Detail*** chart for deductible and coinsurance amounts.) However, if your Out-of-Network provider's charges exceed the Eligible Expenses, you pay any excess amount.

- You will pay a higher coinsurance percentage for out-of-network services and generally will pay higher out-of-pocket costs when you visit an Out-of-Network Provider.
- The out-of-network benefit has an unlimited out-of-pocket maximum. You will pay 50% of Eligible Expenses once you meet your out-of-network deductible with no maximum out-of-pocket.
- For reimbursement of out-of-network expenses, you must file your own claims with the Claims Administrator.
- If you require a specific Covered Health Service expense that is not available from a Network provider within 30 miles of your home, the Plan will pay for such covered expense from an out-of-network provider at the in-network provider benefit level (subject to the Deductible and other restrictions) subject to the limitation given below. Requests for this benefit should be made by calling the phone number on the back of your ID card before you obtain such services.
- Your selection of an Out-of-Network Provider is limited when you require a specific Covered Health Service expense that is not available from a Network Provider who is located within 30 miles from your home. The Plan will not pay for a Covered Health Service expense from an Out-of-Network Provider at the Network Provider benefit level when you must travel a greater distance to an Out-of-Network provider than to a Network Provider who is available to you at the same or shorter distance.

Eligible Expenses

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

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare (i.e., you do not choose to use a non-Network provider), Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
- When you choose to seek services from a non-Network Provider, the Benefits will be paid at the non-Network 50% coinsurance level, and Eligible Expenses will be determined based on:
 - 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - 50% of *CMS* for the same or similar laboratory service.
 - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
 - For Mental Health Services and Substance-Related and Addictive Disorders Services, the Eligible Expense is based on 110% of *CMS* published rates and will be further reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
- When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group.
 - For Pharmaceutical Products, UnitedHealthcare uses methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - When a rate is not published by *CMS* for the service and a methodology does not apply to the service, the Eligible Expense is typically based on 20% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

It is recommended that you utilize the services of an in-network provider whenever possible to maximize your healthcare benefits. However, if you require a specific covered service that is not available from an in-network provider, contact UnitedHealthcare at the number on the back of your ID card before you receive the services.

Deductibles

A deductible is the amount of Covered Health Services expenses that each person must **incur** out-of-pocket in a plan year before the plan begins to pay benefits. In the case of family coverage where more than one person is covered under the plan, the plan does not require that you or a covered dependent meet the individual deductible in order to satisfy the family deductible. Instead, one family member or a combination of family members together must incur out-of-pocket Covered Health Services to satisfy the family deductible, and no one in the family is eligible to receive Benefits until the family deductible is satisfied.

Part of your deductible can be met by your Benefit Dollars contribution to your HSA, while any remaining balance is your responsibility. The portion of the deductible you must pay out of pocket also is called the "deductible corridor."

Deductibles apply to in-network and out-of-network benefits combined.

Note: *You do not need to meet a deductible before you can begin to pay expenses through the HRA; however, your HRA expenses will generally count toward your deductible required for the Health Coverage Benefit.*

Note: Some Pharmaceutical Products may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such Pharmaceutical Product where third party copayment assistance is used, the Member may not receive credit toward their Out-of-Pocket Maximum or Deductible for any copayment or Coinsurance amounts that are applied due to a manufacturer coupon or rebate.

Coinsurance

After satisfying your deductible, when you incur a Covered Health Service expense, you and the Plan share the cost by each paying a set percentage, called coinsurance. This coinsurance amount may differ if you visit a Network Provider versus an Out-of-Network Provider. Generally, your coinsurance amount—your share of the total cost—is lower when you stay in the network.

Note: *You must meet your deductible before coinsurance begins.*

Until you meet your annual deductible, all Covered Health Services expenses above your HRA or HSA Benefit Dollar amount are your responsibility.

If you are enrolled in the Maximum Deductible Plan, there is no coinsurance for in-network services. The company will pay 100% of your in-network costs once you reach your annual deductible. However, coinsurance does apply to out-of-network services.

Out-of-Pocket Maximum

Your out-of-pocket maximum is the maximum amount you are responsible for paying out of pocket each Plan Year for in-network health care costs; it is the sum of your coinsurance maximum plus the Member Responsibility portion of

your deductible.

After you reach your in-network out-of-pocket maximum, the Plan will pay 100% of Covered Health Services expenses for the remainder of the Plan Year.

The out-of-network benefit has an unlimited out-of-pocket maximum. You will pay 50% of Eligible Expenses once you meet your out-of-network deductible with no maximum out-of-pocket.

Note: Some Pharmaceutical Products may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such Pharmaceutical Product where third party copayment assistance is used, the Member may not receive credit toward their Out-of-Pocket Maximum or Deductible for any copayment or Coinsurance amounts that are applied due to a manufacturer coupon or rebate.

Textron Medical Plans Detail

HRA Plan, Low/High/Maximum Deductible HSA Plans

Services	Medical Plans In-Network Benefit Option after deductible* (* = unless otherwise noted)	Out-of-Network Benefit Option after deductible, not to exceed Eligible Expenses)
Preventive Care		
Well Child Care	100% No HRA/HSA or deductible applies	50%
Well Adult Care	100% No HRA/HSA or deductible applies	50%
Inpatient Hospital		
Physician/Surgeon/Anesthesiologist	80%	50%
Hospital Ancillary Services incl. drugs, medications and supplies	80%	50%
X-ray, Laboratory & Pathology Services	80%	50%
Use of Operating Room, Recovery Room & Special Care Units	80%	50%
Room & Board (semi-private room rate)	80%	50%
Maternity Care for mother & child incl. delivery & recovery rooms & nursery charges – newborns must be enrolled within 30 calendar days of the birth	80%	50%
Outpatient Hospital		
Office Visits	80%	50%
Physician Services	80%	50%
Emergency Room	80%	80%
Urgent Care Center	80%	50%
Hospital Services & Supplies, incl. Surgery, Nursing Services, X-ray and Laboratory	80%	50%
Pre-Admission Testing	80%	50%
Mental Health Care/Substance-Related and Addictive Disorders Services		
Mental Health Services	80%	50%
Neurobiologic Disorders – Autism Spectrum Disorder Services	80%	50%
Substance-Related and Addictive Disorder Services	80%	50%

Services	Medical Plans In-Network Benefit Option after deductible* (* = unless otherwise noted)	Out-of-Network Benefit Option after deductible, not to exceed Eligible Expenses
Other Medical Expenses		
Home Health Care	80%; Subject to maximum limitation of 180 visits per calendar year.	50%; Subject to maximum limitation of 180 visits per calendar year.
Physical, Speech & Occupational Therapy	80%	50%
Hospice Care	80%	50%
Skilled Nursing/Convalescent Facility	80%; Subject to maximum limitation of 120 days per calendar year	50%; Subject to maximum limitation of 120 days per calendar year
Spine and Joint Surgeries	80%	50%
Cellular and Gene Therapy	80%	50%
Transplantation Services	80%	Not Covered
Ambulance (Emergency)	80%	80%
Infertility (Process of Diagnosis Only)	80%	50%
Chiropractor Care	80%; Subject to a maximum limitation of \$750 per calendar year.	50%; Subject to a maximum limitation of \$750 per calendar year.
Accident-related Dental Care	80%	50%
Durable Medical Equipment	80%	50%
Virtual Visits: Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	80%	Not Covered
Prescription Drugs		
Prescription Drugs	80%	Not Covered

**If you are enrolled in the Maximum Deductible Plan, there is no coinsurance for in-network services. The company will pay 100% of your in-network costs once you reach your annual deductible. However, coinsurance does apply to out-of-network services.*

Textron Medical Plans Detail: Out-of-Area HRA Plan, Low/High/Maximum Deductible HSA Plans

An Out-of-Area (OOA) plan option is available if you live more than 30 miles from a network provider. If this applies to you, you may choose the OOA Option. The OOA option generally will cover the same percentage of eligible medical expenses, whether you access care in the network or out-of-network.

Services (Out-of-Area)	Medical Plans In-Network Benefit Option after deductible* (* = unless otherwise noted)	Out-of-Network Benefit Option after deductible, not to exceed Eligible Expenses
Preventive Care		
Well Child Care	100% No HRA/HSA or deductible applies	100% No HRA/HSA or deductible applies
Well Adult Care	100% No HRA/HSA or deductible applies	100% No HRA/HSA or deductible applies
Inpatient Hospital		
Physician/Surgeon/Anesthesiologist	80%	80%
Hospital Ancillary Services incl. drugs, medications and supplies	80%	80%
X-ray, Laboratory & Pathology Services	80%	80%
Use of Operating Room, Recovery Room & Special Care Units	80%	80%
Room & Board (semi-private room rate)	80%	80%
Maternity Care for mother & child incl. delivery & recovery rooms & nursery charges – newborns must be enrolled within 30 calendar days of the birth	80%	80%
Outpatient Hospital		
Office Visits	80%	80%
Physician Services	80%	80%
Emergency Room	80%	80%
Urgent Care Center	80%	80%
Hospital Services & Supplies, incl. Surgery, Nursing Services, X-ray and Laboratory	80%	80%
Pre-Admission Testing	80%	80%

Services (Out-of-Area)	Medical Plans In-Network Benefit Option after deductible* (* = unless otherwise noted)	Out-of-Network Benefit Option after deductible, not to exceed Eligible Expenses
Mental Health Care/Substance-Related and Addictive Order Services		
Mental Health Services	80%	80%
Neurobiologic Disorders – Autism Spectrum Disorder Services	80%	80%
Substance-Related and Addictive Disorder Services	80%	80%
Other Medical Expenses		
Home Health Care	80%; Subject to maximum limitation of 180 visits per calendar year.	80%; Subject to maximum limitation of 180 visits per calendar year.
Physical, Speech & Occupational Therapy	80%	80%
Hospice Care	80%	80%
Skilled Nursing/Convalescent Facility	80%; Subject to maximum limitation of 120 days per calendar year	50%; Subject to maximum limitation of 120 days per calendar year
Spine and Joint Surgeries	80%	50%
Cellular and Gene Therapy	80%	50%
Transplantation Services	80%	Not Covered
Ambulance (Emergency)	80%	80%
Infertility (Process of Diagnosis Only)	80%	80%%
Chiropractor Care	80%; Subject to a maximum limitation of \$750 per calendar year.	80%; Subject to a maximum limitation of \$750 per calendar year.
Accident-related Dental Care	80%	80%
Durable Medical Equipment	80%	80%

Services (Out-of-Area)	Medical Plans In-Network Benefit Option after deductible* (* = unless otherwise noted)	Out-of-Network Benefit Option after deductible, not to exceed Eligible Expenses
Virtual Visits: Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	80%	Not Covered
Prescription Drugs		
Prescription Drugs	80%	Not Covered

**If you are enrolled in the Maximum Deductible Plan, there is no coinsurance for in-network services. The company will pay 100% of your in-network costs once you reach your annual deductible. However, coinsurance does apply to out-of-network services.*

Plan Details: HRA/HSA Company Funding Amounts, Deductibles, Coinsurance, Out-of-Pocket Maximums

Description	HRA Plan with Company Funding	Low Deductible Plan with Company Funding	High Deductible Plan* with Company Funding	Maximum Deductible Plan* No Company Funding
Employee Deductible (ee / ee+1 / family)	\$2,400 / \$3,600 / \$4,800	\$2,000 / \$3,000 / \$4,000	\$3,000 / \$4,500 / \$6,000	\$6,550 / \$13,100 / \$13,100
Company Funding	\$0	\$500 / \$750 / \$1,000	\$500 / \$750 / \$1,000	\$0
Employee Deductible Net of Company Funding	\$2,400 / \$3,600 / \$4,800	\$1,500 / \$2,250 / \$3,000	\$2,500 / \$3,750 / \$5,000	\$6,550 / \$13,100 / \$13,100
Maximum Employee Out-of-Pocket for In-Network Healthcare Costs (includes net deductible, excludes payroll contributions)	\$3,200 / \$4,800 / \$6,400	\$2,800 / \$4,200 / \$5,600	\$4,000 / \$6,000 / \$8,000**	\$6,550 / \$13,100** / \$13,100**
Coinsurance	In-Network: 20% Out-of-Network: 50%	In-Network: 20% Out-of-Network: 50%	In-Network: 20% Out-of-Network: 50%	In-Network: 0% Out-of-Network: 50%
Lifetime Maximum Benefits	Unlimited	Unlimited	Unlimited	Unlimited

* Only plans offered to new hires.

** 2020 IRS Individual embedded out-of-pocket maximum of \$8,150 (unless otherwise specified).

Note: All plans have a 50% out-of-network coinsurance and no out-of-network maximum.

Employees represented by a union should refer to their contract or local HR department for updates.

Prior Authorization

In-Network Services:

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, physicians and other health care professionals who participate in the UHC network are responsible for obtaining prior authorization from the Claims Administrator. Services for which prior authorization is required are identified below.

It is also recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a network provider, you may want to contact the Claims Administrator to verify that the hospital, physician and other providers are in the network and that they have obtained the required prior authorization.

Network facilities and network providers cannot bill you for services if they fail to obtain prior authorization as required.

Out-of-Network Services:

If you choose to receive Covered Health Services from an out-of-network provider, you are responsible for obtaining prior authorization *before* you receive the services. Services for which prior authorization is required are identified below.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The Claims Administrator also provides a program called Personal Health Support to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service. See **Personal Health Support** section below for further information.

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

Covered Health Services Which Require Prior Authorization

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

- Ambulance - non-emergent as soon as possible prior to transport.
- Bariatric surgery – as soon as the possibility of bariatric surgery arises.
- Cellular and Gene Therapy – as soon as the possibility of Cellular or Gene Therapy arises
- Clinical Trials as soon as the possibility of participation in a Clinical Trial arises.
- Congenital heart disease surgery as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises.
- Durable Medical Equipment – for items that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes.
- Gender Dysphoria - for surgical treatment as soon as the possibility of surgery arises and for non-surgical treatment depending on where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this section.
- Genetic Testing - BRCA.
- Home health care –five business days before receiving services, including nutritional foods, or as soon as reasonably possible.
- Hospice care – inpatient, five business days before admission or as soon as reasonably possible.
- Hospital Inpatient Stay – Benefits for all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery. For a scheduled admission, five business days before admission and for a non-scheduled admission (including Emergency admissions), as soon as reasonably possible.
- Lab, X-Ray and Diagnostics - Outpatient – for sleep studies, stress echocardiography and transthoracic echocardiogram, five business days before scheduled services are received.
- Lab, x-ray and major diagnostics – CT, PET scans, MRI, MRA, nuclear medicine and nuclear cardiology, five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.
- Mental Health Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), five business days before admission or, for a non-scheduled admission, as soon as is reasonably possible. In addition, the following services require prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with

or without medication management.

- Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders -inpatient services (including Partial Hospitalization/Daytreatment and services at a Residential Treatment Facility).
- Pregnancy, as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.
- Prosthetic Devices for items that will cost more than \$1,000 to purchase or rent.
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery.
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.
- Substance-Related and Addictive Disorder Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), five business days before admission or, for a non-scheduled admission, as soon as is reasonably possible. In addition, the following services require prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Surgery - Outpatient – examples include, but are not limited to, knee, hip and back surgeries, cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant, cochlear implant surgery and orthognathic surgery, blepharoplasty, uvulopalatopharyngoplasty, vein procedures and sleep apnea surgeries.
- Therapeutics - Outpatient – five business days before a scheduled service or, for a non-scheduled service, within one business day or as soon as is reasonably possible for the following outpatient therapeutic services: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If prior authorization is not obtained and if, as a result, the services are not received from and performed by a Designated Provider, no Benefits will be paid.

Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-network hospital as a result of an emergency.

Personal Health Support

The Claims Administrator provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents who reside in the United States.

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. The Personal Health Support program includes:

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

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

Understanding your Textron HRA Plan

The HRA is an individual account, funded by Textron with Benefit Dollars that you may use to pay for qualified IRS health care expenses that you incur while you are covered under the Textron HRA Plan. However, Benefit Dollars under your HRA may be used only for Covered Health Services expenses incurred by you and your covered dependents while enrolled in the Textron HRA Plan option.

You will lose your Benefit Dollars when you stop participating in a Textron HRA Plan.

HRA Contributions

You do not contribute to the HRA. Unlike a healthcare Flexible Spending Account (FSA) or Health Savings Account (HSA), you may **not** contribute to the HRA. Instead, Textron has made annual contributions to the HRA. However, the HRA plan ceased to receive annual employer contributions effective January 1, 2019. You may use the remaining Benefit Dollars in your HRA account to pay for qualified IRS health care expenses throughout the year if you continue to be enrolled in the Textron HRA Plan. If you decide to switch from an HRA plan to an HSA plan, you will not be able to transfer balances from your HRA account to an HSA account, and you have until December 31 of the current year to use your HRA balance.

Using Your HRA

Covered Health Services expenses are paid first from your HRA, and those expenses are counted toward meeting your annual deductible under the Health Coverage component of the Textron HRA Plan. You may use the Benefit Dollars in your HRA to pay for:

- Deductibles or other out-of-pocket expenses under the Plan, or
- Certain qualified IRS health care expenses that are not covered by the CHDP (i.e., HRA- only covered expenses, such as laser eye surgery, hearing aids, etc.), although these do not count toward your deductible.

Below are some scenarios that will help you understand how the HRA and deductible work when you have eligible expenses.

Scenario #1: When you receive care from a network provider, if you have an HRA balance, any Eligible Expense (except for preventive care which is covered at 100%) will be paid from your HRA and the amount will reduce your annual deductible.

Scenario #2: When you receive care from a network provider, if you do not have an HRA balance remaining, and you have not met your annual deductible, the Eligible Expense (except for preventive care) becomes part of your Member Responsibility.

The Claims Administrator will apply the amount of your Member Responsibility to your annual deductible; you will pay this Member Responsibility amount.

Scenario #3: When you receive care from a network provider, if you do not have a balance in your HRA but you have met your deductible, the Plan will pay at the 80%

coinsurance level (100% for preventive care) and you will be responsible paying for the balance (which is your 20% coinsurance amount).

The HRA does not pay for certain medical expenses that are covered under a Healthcare FSA. For more information on what expenses are covered under the HRA, see the ***What Expenses Are Covered*** section of this SPD.

Note: While your HRA is similar to a Healthcare FSA, the two are not the same and they are used for different purposes. You may participate in both if you feel that doing so best meets your family's needs, although **you must use up your HRA account before the Healthcare FSA is used for those expenses covered by both accounts.**

Each time you or a medical provider submits a claim for payment of qualified IRS health care expenses eligible for payment from the HRA, Textron will pay the claim in accordance with this SPD and decrease your HRA by the equivalent number of Benefit Dollars.

At the end of the year, any Benefit Dollars left in your HRA (up to a maximum of \$10,000) will remain in your HRA and be carried forward to the following year, **as long as you are still enrolled in the Textron HRA Plan.** See the ***Textron Medical Plans Detail*** chart for HRA maximums.

Note: The HRA is not a funded account, meaning benefits are paid from Textron's general assets.

Keeping Track of Your Benefit Dollars

You can keep track of the Benefit Dollars in your HRA by accessing your account online via the Claims Administrator's Web site; or Calling the Claims Administrator's toll-free customer service number, which is listed on the back of your ID card.

Taking Income Tax Deductions While Participating Health Reimbursement Account vs. Income Tax Deduction

Federal tax laws allow you to deduct certain health-related expenses from your taxable income—to the extent that the expenses exceed 7.5% of your Adjusted Gross Income. Expenses that are reimbursed through your HRA do not count as health-related expenses for purposes of the federal income tax deduction.

For most employees, using the HRA is more advantageous than taking the income tax deduction for medical expenses. You should contact your personal tax advisor to determine which approach is best for you.

If You and Your Spouse Change the "Primary Insured" During Annual Enrollment

If you and your spouse are both Textron employees enrolled in a Textron HRA Plan option and you decide for the upcoming Plan Year to change which spouse is the "primary insured," then you and your spouse (plus family, as applicable) will begin the new Plan Year with a newly-established HRA or a newly-established HSA, depending on which Plan you choose. You will not be able to access or roll over any unused HRA balance accumulated from coverage under the other primary insured (although the balance would remain "frozen" should you decide to re-enroll under the initial primary insured). For further information, you should contact UnitedHealthcare.

What Expenses Are Covered under the HRA only?

This is a partial listing of qualified IRS health care expenses covered by an HRA. The list does not include every eligible expense possible. For a complete listing, refer to IRS Publication #502 on www.irs.gov or call 1-800-829-3676.

Qualified IRS health care expenses covered under the HRA and eligible for payment from your HRA are listed below.

Qualified IRS Health Care Expenses

Please note:

- 1. These qualified IRS health care expenses are not covered by the Health Coverage benefit.**
- 2. Benefits for qualified IRS HRA only expenses are limited according to coverage level, up to an annual maximum of 30% of your total annual HRA Benefit Dollars. The deductible and out-of-pocket maximum do not apply to HRA only expenses.**
- 3. In addition to this HRA only list, Covered Health Services under the Health Coverage benefit are always covered under the HRA.**
 - Elective abortion
 - Alcoholics Anonymous (AA), travel costs to and from meetings subject to attendance in AA being pursuant to medical advice that membership in AA is necessary for the treatment of a disease involving the excessive use of alcoholic liquors
 - Acupuncture treatment
 - Braille books and magazines (i.e., the difference in cost compared to a regular printed edition)
 - Charges that exceed the allowed amounts and/or the usual and customary charge
 - Christian Science practitioners

- Conductive keratoplasty (CK) procedures when the procedure is performed within the guidelines prescribed by the FDA
- Expenses used to satisfy Plan deductibles and/or coinsurance
- Dental care, treatment, implants, surgery, dentures, or supplies are covered under the HRA only, if not covered under the health coverage component of the Plan; however, dental treatment which is for cosmetic purposes (e.g., teeth whitening) is not covered.
- Diaper service needed to relieve the effects of a certain disease
- Guide dog or other animal used by a visually or hearing-impaired person, or an animal trained to assist a person with other physical disabilities
- Hearing aids, whether external or implantable, or any related expenses – including, but not limited to adult hearing exams.
- Hospital room and board expenses that exceed the semiprivate room rate unless a private room is approved as medically necessary
- Infertility treatments, including donor ova and sperm and artificial or intrauterine insemination procedures and related services, surgical procedures and prescription drugs for infertility treatment.
- Services for, or related to, assisted reproductive technology (ART) procedures, including, but not limited to, in vitro fertilization (IVF), gamete intracryopreservation or frozen embryo transfer
- Laser eye surgery
- Massage therapy or rolfing
- Prescription drugs not covered under the Health Coverage benefit (those that are not in violation of federal law), including impotence medications; cosmetics (including anti-wrinkle and cosmetic therapies); weight loss-related prescription drugs, when prescribed and recommended by a physician to treat an existing disease, such as heart disease; and the difference between brand name and generic prescription drugs.
- Nursing home expenses, for medical reasons
- Nursing services
- Special telephones or televisions for hearing impaired individuals
- Services for reversal of sterilization
- Services and treatment of TMJ
- All services related to Experimental or Investigational and Unproven Services are excluded as determined by the Claims Administrator (this means the medical use of a service or supply that is still under study and that the service or supply is not yet recognized throughout the provider's profession in the U.S. as safe and effective for the diagnosis and treatment of the illness or injury. This includes but is not limited to surgery or treatment of an experimental or investigative nature; all phases of clinical trials; all treatment protocols based on or similar to those used in clinical trials; and drugs approved by the FDA under its Treatment Investigational New Drug regulation)

- Transportation (other than local ambulance service for a medical emergency to the nearest hospital that can provide care) that may be needed to obtain medical care (this may include bus or taxi fare, cost of gas, tolls, parking, etc.)
- Transportation and admission to a medical conference which concerns the chronic illness of a member
- Weight loss program when recommended by a physician to treat an existing disease, such as heart disease

What Covered Health Services expenses are covered under the HRA and Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options health coverage benefit?

- Therapeutic abortions
- Allergy injections, testing and serum
- Alternative care settings (such as skilled nursing facilities, hospice or home health care)
- Ambulance service to and from the nearest facility where you can receive needed medical care and services (air ambulance will be covered when it is the only acceptable means of transporting the patient)
- Anesthesia, including anesthesia for oral surgery when treatment is necessary due to accidental injury or for the treatment of a medical condition. See *Dental Services – Accident Only* section for further information.
- Anesthesia and facility fees are also covered for oral surgery when it is necessary to perform the procedure in a hospital or in an outpatient surgical center.
- Blood and blood plasma transfusions and blood not donated or replaced
- Chemical dependency treatment
- Chemotherapy
- Chiropractic care provided by a licensed chiropractor, including exams, manipulations, diagnostic x-rays and laboratory services, limited to a maximum benefit of \$750 per person per calendar year
- Circumcision
- Cochlear implants
- Contraception (oral contraceptives and contraceptive services such as IUDs, Norplant, Depo-Provera injections)
- Dialysis
- Diabetic supplies and insulin
- Disposable medical supplies are covered, except tape, gauze and sterile water

- Doctors' visits
- Emergency room and urgent care center
- Enteral feedings for sole source of nutrition and inborn errors of metabolism
- Genetic testing and counseling
- Home infusion therapy when ordered by a physician, including solutions and pharmaceutical additives; pharmacy compounding and dispensing services; ancillary medical supplies; nursing services to train you or your caregiver or to monitor the home infusion therapy, provide emergency care, collection, analysis and reporting of lab tests to monitor response to home infusion therapy, enteral feedings, or other eligible home health supplies and services provided during home infusion therapy
- Hospital charges for use of its surgical room on an outpatient basis
- Hospital services such as nursing care, drugs and medicines, x-rays and laboratory tests
- Infertility – Process of Diagnosis only
- Inhalation therapy (provided by a registered or licensed therapist) when needed to correct a functional disorder due to an illness or injury
- Inpatient physician care
- Inpatient rehabilitation
- Mammography
- Mastectomy coverage, as well as coverage for reconstructive surgery, as mandated by the Women's Health and Cancer Rights Act of 1998, to include the following. Coverage must be provided in a manner determined in consultation with the attending physician and the patient
- Ostomy Supplies- limited to:
 - Pouches, face plates and belts
 - Irrigation sleeves, bags and ostomy irrigation catheters (disposable)
 - Skin barriers
- Reconstruction of the breast that has been removed
- Reconstruction of the other breast for a symmetrical appearance, and
- Prosthesis and treatment of any physical complications of the mastectomy
- Maternity care (including services and supplies provided by a birthing center or midwife)
- Mental health care
- Nutritionists, when required to treat a medical condition
- Occupational therapy (by a licensed therapist)
- Optometrists

- Ophthalmologist for medical conditions of the eye
- Orthopedic shoes and other foot orthotics prescribed for medical reasons
- Orthotics
- Outpatient (ambulatory) surgery
- Outpatient cardiac rehabilitation services
- Outpatient x-ray and laboratory charges
- Oxygen and other gases
- Physical therapy (provided by a licensed physical therapist)
- Podiatric treatment of any condition resulting from weak, unstable or flat feet when an open cutting operation is performed; or for treatment of corns, calluses or toenails, when at least part of the nail root is removed. Treatment of bunions is covered when an open cutting operation or arthroscopy is performed
- Pre-admission testing
- Prescription drugs (see information elsewhere in this document)
- Prosthetic appliances
- Pulmonary rehabilitation
- Rental (not more than the purchase price) or, if less costly, purchase of durable medical equipment and related supplies
- Semi-private room and board for hospital stays and alternative care settings (private rooms are covered only if medically necessary)
- The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant
- Surgery for a clinically serious condition of morbid obesity when you meet the criteria established by UnitedHealthcare (You must contact UnitedHealthcare or the Claims Administrator in advance to determine if you are eligible for coverage under this benefit.)
- Substance-Related and Addictive Disorder Services
- Surgical care (if two or more surgical procedures are performed through the same incision or in the same operative field, the Plan will pay up to 100% of the major procedure and 50% of each additional procedure. No additional payment will be made for an incidental procedure performed through the same incision.)
- Wigs (when needed for hair loss due to cancer or alopecia areata)
- Virtual colonoscopy when the procedure is used for diagnostic purposes
- Vision therapy, only when rendered in connection with the following visual disorders: a) amblyopia; b) accommodative disorders; c) ocular motor and visual motor dysfunctions; and d) binocular vision disorders (e.g., strabismus)

- Virtual Visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions through the use of interactive audio and video telecommunication.
- X-ray, radium, radio, isotope treatments

See list of exclusions elsewhere in this document.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for any other illness. Payment for pregnancy-related expenses will not be withheld because the pregnancy occurred before coverage took effect. Federal law prohibits the Plan from:

- Limiting the length of a hospital stay for you and your newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean delivery (if you're discharged earlier, the Plan will pay for two post-delivery home visits by a healthcare provider);
- Requiring a provider to obtain authorization from the Plan for prescribing any length of stay required above;
- Denying mother or newborn eligibility or continued eligibility to enroll or re-enroll for coverage just to avoid legal requirements;
- Making financial payments or rebates to mothers to encourage them to accept a shorter stay than described above;
- Providing financial incentives to the provider to encourage him or her to provide care inconsistent with current law; or
- Restricting benefits for any portion of a hospital stay to be less than benefits for any stay before the birth.

However, if the mother chooses, she and the newborn may be released earlier. Newborns must be enrolled in the plan within 30 calendar days of the birth.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Textron medical benefit plans comply with this law.

Under this Act, the medical plans and the Claim Administrators that offer mastectomy coverage must, for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The covered procedures will be performed in a manner determined in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions as other procedures under the medical plans.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not 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 vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

Understanding Your Health Savings Account and Your Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options

A Health Savings Account (HSA) is an account to which you elect to contribute a fixed amount of money to pay for qualified IRS health care expenses for you, your spouse and any dependents you claim on your federal tax return. By contributing to an HSA, you can reduce the amount of taxes you pay and at the same time set aside money to cover eligible Covered Health Services expenses. For additional helpful information, you may also want to refer to the HSA User's Guide, which is available by contacting the Textron Human Resources Service Center.

Note: *Your HSA is not part of any Textron-sponsored employee benefit plan, and it is not regulated under the Employee Retirement Income Security Act (ERISA), a federal law that governs employee benefit plans.*

Here's how an HSA works:

Participation Requirements. Under IRS rules, you can open and fund an HSA if you meet the following three criteria:

- *You are enrolled in a qualified high deductible health plan (Textron Low Deductible-HSA Option, Textron High Deductible-HSA Option and Maximum Deductible-HSA Option are qualified high deductible plans);*
- You are not covered by another healthcare plan (unless it, too, qualifies as a high deductible health plan); for example, you cannot contribute to an HSA if you are covered by any of the following:
 - o A health plan sponsored by your spouse's employer (unless that plan also qualifies as a high deductible health plan);
 - o TriCare (a medical plan for certain Department of Defense or government retirees);
 - o Medicare; or
 - o A healthcare flexible spending account (FSA), including your spouse's healthcare FSA.

You may still contribute to an HSA if you have certain limited types of coverage, such as dental, vision and long-term care insurance. For HSA participants who wish to contribute to an FSA, Textron offers a "Limited Purpose FSA" (LPFSA) that allows you to reimburse yourself for selected types of expenses. For more information on the LPFSA please see the information in the ***Alternatives to Using an HSA*** section and the SPD for the Textron Flexible Benefits Plan.

- You are not claimed as a dependent on another person's tax return.

Note: *You must be covered under a high deductible health plan as of the first day of the last month of the taxable year to be eligible to participate in the HSA.*

You can use the HSA to bridge the gap between what your healthcare plans pay and what you pay out of pocket. Contributing to the HSA lets you:

- Spread the cost of eligible health care services over the year.
- Reduce the cost of eligible health care expenses through pre-tax contributions. The amount you save depends on the reduction in your income and Social Security taxes.

Opening Your HSA. The Plan offers you the option to open an HSA through a trustee (HSA custodian)—either OptumHealth Bank (with whom Textron has an agreement to forward payroll deductions to your HSA) or another HSA custodian of your choice (in which case Textron’s contribution and payroll deduction is not possible). A qualified HSA trustee can be a bank, an insurance company or other entity already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or Archer MSAs (medical savings account, most recently replaced by HSAs).

Funding Your HSA.

- **Textron Low Deductible-HSA and Textron High Deductible-HSA Options:** Textron will fund a portion of an HSA (in your name) whether or not you (the employee) choose to contribute to an HSA yourself. You also can contribute, either with pre-tax contributions made via payroll deduction (when OptumHealth Bank is your HSA custodian) or as after-tax contributions that later can be deducted on your federal income tax return. However, in order to receive the Textron employer contribution to your HSA, you must establish an HSA with the Textron-selected HSA custodian (OptumHealth Bank Group #714273). See more information about funding your HSA in the **HSA Contributions** section.
- **Textron Maximum Deductible-HSA Option:** Textron does not make a contribution to the HSA under the Textron Maximum Deductible Option. However, you can contribute, either with pre-tax contributions made via payroll deduction (when OptumHealth Bank is your HSA custodian) or as after-tax contributions that later can be deducted on your federal income tax return.

Investing Funds in Your HSA. Once your deposit account reaches a designated value, known as the investment threshold, you may, if you choose, set up a separate investment account to invest a portion of your savings in mutual funds.

Using Your HSA Funds. You can use the funds in your HSA to pay for current or future qualified medical (including prescription) expenses. For more information about the types of qualified expenses covered under an HSA, see the **What Expenses Are Covered by the HSA** section.

Note: *Funds in an HSA are "tax-preferred" or "tax-free" only when used for qualified medical expenses. HSA funds used for non-qualified medical expenses are not "tax-preferred" or "tax-free", and are subject to federal income tax and an additional tax penalty.*

Unused Amounts. Any unused amounts in your HSA, as well as accrued interest (or investment income), will roll over to the next year. Unlike a healthcare FSA, you do

not lose the money you do not use. So, you can save the money in your HSA and use it for qualified medical expenses now and in the future—even in retirement.

Ownership and Portability. Your HSA is owned by you, and the money in your HSA is portable, meaning that if you leave Textron or retire, you can roll the money into another employer's HSA or into an individual HSA.

HSA Enrollment

When you are first hired, if you choose to establish an HSA, you determine the amount to contribute by estimating your expected, eligible healthcare expenses for the rest of the year that will not be paid by the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options.

During each annual enrollment period, you estimate your expected eligible expenses for healthcare not paid by the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options for the following year.

You decide the amount you want to contribute up to the annual maximum allowed by the IRS.

The amount you choose to contribute to your HSA may be deducted from your income in two ways. For more information, see the **HSA Contributions** section of this SPD.

Unlike a Healthcare FSA, you must accumulate funds in your HSA before you can be reimbursed. You will be reimbursed only up to the amount of available funds in your HSA.

Note: *If you have a major Covered Health Service expense (such as a hospitalization) early in the year before your HSA has accumulated enough money, you can have the provider invoice you. Then, you can use your HSA dollars plus personal funds to pay the invoice, reimbursing yourself from your HSA as your contributions accumulate each month. Alternatively, if a very large bill presents a financial challenge, you may be able to set up a payment plan with the provider—especially with hospitals—to pay the bill over time in order to leverage the funds in your HSA as your account grows.*

Administrative Fees

HSAs work essentially like bank accounts for medical expenses, and some administrative fees apply for both the services you receive and the interest you may earn on your account. For example, there may be a monthly administrative fee.

For further information on administrative fees that may apply to your HSA, see the information provided by your HSA custodian.

HSA Contributions

Whether or not you decide to establish an HSA, Textron will contribute to an HSA through OptumHealth Bank when you enroll in one of the Textron Low

Deductible/High Deductible-HSA Options. (Textron does not make a contribution to the HSA under the Textron Maximum Deductible Plan Option.) Assuming you open an account, Textron will make its entire annual contribution in the beginning of the year, up to the maximums stated in the **Plans Details** chart. The funds contributed by Textron will be owned and controlled by you. If you are hired during the Plan year and enroll in a Consumer Directed Health Plan (CHDP) option; or, if you enroll during the year for other reasons, Textron will allocate a prorated contribution amount to your HSA. Proration is calculated on a monthly basis. Your CDHP deductible is not prorated for a partial year in order to comply with IRS requirements for HSA-eligible plans.

Note: *Only one full annual HSA contribution will be made to each eligible participant's account each year. For example, if an active employee receives the company contribution to his or her HSA account and retires from or leaves the company during the year, he or she will not receive an HSA contribution as a retiree or COBRA participant during that same year.*

In addition to Textron's contribution, you may contribute to the HSA in two ways:

- Pre-tax, via payroll deductions (if OptumHealth Bank is your trustee); or
- After-tax, with contributions deducted later from your federal income tax return.

When you enroll in your HSA, you may indicate your payroll contribution election. Additionally, at any time during the year, you may change or initiate contributions as often as once a month. Your changes are effective the first of the month following your election change.

You can make payroll deduction changes by calling the **HR Service Center at 1-866- MY-TXT-HR (1-866-698-9847)**.

Maximum HSA Contribution Amounts

The IRS limits the amount you can contribute to your HSA each year. The maximum contribution that you can make each year to an HSA is the IRS dollar limit (limits are updated annually).

If you participate in either the Textron Low Deductible-HSA or High Deductible-HSA Option and elect to contribute to an HSA, the amount the Company contributes to your HSA account reduces your employee contributions. To calculate your maximum allowed contribution, subtract the Company's contribution as noted in the **Plan Details** chart from the IRS maximum contribution allowed to your HSA.

If you are age 55 through 64, you also are allowed to make catch-up contributions to your HSA (in addition to your maximum allowed contribution).

Note: *The amount you contribute to an HSA is divided by the number of pay periods in the year or pay periods left in the year. If your contribution goal amount is not equally divisible by the number of pay periods, your actual contributions may be slightly more than your goal amount. If you contribute more than the maximum contribution amount allowed by the IRS, you will be charged a 6% excise tax on the excess amount. The excise tax applies to each year the excess contribution remains in the account. You may withdraw some or all of the excess contributions and not pay the excise tax on the amount withdrawn if you meet the following conditions:*

- *You withdraw the excess contributions by the due date (including extensions) of your federal tax return for the year the contributions were made, and*
- *You withdraw any income earned on the withdrawn contributions and include the earnings in "other income" on your federal tax return for the year you withdraw the contributions and earnings.*

Enrollment

When you enroll in the Textron Low Deductible-HSA, High Deductible-HSA or Maximum Deductible-HSA Options, you will receive information about how to open an HSA with OptumHealth Bank. While Textron does not endorse a particular HSA trustee or custodian, the Company has established an arrangement that gives OptumHealth Bank the right to market and advertise their HSA services to you.

Textron will make its contribution to your HSA to an HSA established at OptumHealth Bank. If you also choose to use Optum Health Bank as your HSA custodian your HSA contributions will be "pre-tax" and can be forwarded directly to them. However, you may select your own HSA custodian. No matter what custodian you choose, you determine how you save, spend and invest your HSA funds.

Tax Advantages

In general, HSAs save you money by allowing you to pay for eligible expenses with pre-tax or tax-preferred dollars. The amount you save depends on any reduction in the income tax and Social Security tax you pay. With HSAs, you figure out how much you want to contribute for the year, and the money is taken out of your paychecks in equal amounts before taxes (if you use OptumHealth Bank as your custodian). Ultimately, you do not pay federal income tax, Social Security tax and in most cases, state income tax on the amounts you contribute. However, if you withdraw money from the HSA without using the money to pay medical expenses, you are required to pay federal income taxes and an additional tax at the time you withdraw the funds.

Note: *Textron does not guarantee that any amounts paid from your HSA will avoid federal or state income or employment taxes, or Social Security taxes. Also, since Social Security taxes are not withheld on the pre-tax amounts that you contribute, your contributions could reduce the earnings that are used to calculate your Social Security benefits when you receive them. Questions relating to the tax or Social Security benefit implications of participating in an HSA should be directed to your personal tax advisor.*

Taking Income Tax Deductions While Participating

Health Savings Account vs. Income Tax Deduction

Federal tax laws allow you to deduct certain health-related expenses from your taxable income—to the extent that they exceed 7.5% of your Adjusted Gross Income. Expenses that are reimbursed through your HSA do not count as health-related expenses for purposes of the federal income tax deduction.

For most employees, the HSA is more advantageous than the income tax deduction for medical expenses. Consult your personal tax advisor to determine which approach is best for you.

What Expenses Are Covered by the HSA

You can use your HSA for qualified health expenses not covered by your healthcare plan as defined by Section 213(d) of the Tax Code. A list of these expenses is available on the IRS Web site: **www.irs.gov**.

You may use funds from your HSA to pay for eligible healthcare expenses that are not covered or only partially covered by your medical, dental and vision plans. Examples of eligible expenses include:

- Deductibles and coinsurance under the medical, prescription drug and dental plans;
- Vision care expenses, such as eye exams, glasses, contacts and laser eye surgery;
- Hearing care expenses, including exams and necessary hearing aids;
- Certain over-the-counter drugs that treat a particular medical condition and insulin. **Note:** *The Patient Protection and Affordable Care Act (PPACA) establishes that certain OTC medicines require a doctor's prescription or medical necessity statement.* You will not be able to use your HSA account to pay for most over-the-counter drugs (OTC) and medicines unless you have a doctor's prescription. **You will not need a prescription for insulin and diabetic supplies.**
- Individual long-term care insurance policy premiums;
- COBRA coverage;
- Health plan coverage while receiving unemployment benefits; and
- If age 65 or older, any health insurance other than the Medicare Supplement (A-J), such as Medigap coverage.

This is not a complete list of eligible HSA expenses. For more information about eligible expenses, refer to IRS Publication #969, Health Savings Accounts and IRS Publication #502, Medical and Dental Expenses. You can get a copy by visiting **www.irs.gov** or calling 1-800-829-3676. If you have a question about whether an expense may be reimbursed by your HSA, please contact the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options Claims Administrator.

What Expenses Are Not Covered by the HSA

The following are examples of expenses that are **not** eligible for reimbursement from your HSA. For a more detailed list, please contact the Claims Administrator:

- Cosmetic surgery that does not meaningfully promote the proper function of the body, or prevent or treat an illness or disease;
- Membership fees or costs of weight loss programs done for your general health;
- Expenses you deduct on your federal tax return;
- Expenses incurred before you were a participant; or
- Expenses that have been reimbursed under another plan.

HSA distributions used for any purpose other than qualified medical expenses are taxable, and the appropriate tax rules will apply. You will be required to pay federal income tax and an additional tax if you withdraw money to pay other than qualified medical expenses (unless you die, become disabled or become eligible for Medicare).

Taking Withdrawals from Your HSA

You may withdraw amounts from your HSA at any time; however, only those amounts used exclusively to pay for qualified medical expenses are tax free. Amounts that remain at the end of the year are generally carried over to the next year.

Alternatives to Using an HSA

Note: Although you may use a Limited Purpose FSA, General Purpose FSAs and HRAs apply only to certain medical plans that allow these special types of tax-advantaged savings and reimbursement arrangements. The information below is a summary of both the general and limited purpose of these plans. **Additional information regarding FSAs is provided in the Summary Plan Description (SPD) for the Textron Flexible Benefits Plan.**

Healthcare Flexible Spending Account (FSA)

Although Healthcare FSAs and HSAs both allow you to save money for healthcare expenses in a tax-advantaged way (i.e., on a pre-tax basis), they are different in the following ways:

- Certain expenses that can be reimbursed by your HSA, such as long-term care insurance premiums, cannot be reimbursed by your Healthcare FSA.
- Unused amounts in your HSA can be carried over to reimburse expenses in the future. In contrast, your FSA is subject to the "use it or lose it" rule. However, for 2013 and later years, you may carry over up to \$500 of your unused prior year

Healthcare FSA balance for reimbursement of eligible expenses incurred in the following year.

- When using a Healthcare FSA, your full, anticipated contribution amount is available on day one. In the HSA, you have to accumulate funds in your account before using them.

If you or your spouse has an HSA, you may not contribute to a regular Healthcare FSA (as described in this SPD). However, you may contribute to a Limited Purpose Healthcare FSA. Contributing to both a Healthcare FSA (that is not a Limited Purpose FSA) and an HSA would cause your HSA—or your spouse’s HSA if he/she has one—to lose its favorable tax treatment.

*A Limited Purpose Healthcare FSA (LPFSA) works like a regular Healthcare FSA, except that a LPFSA may reimburse expenses you incur after you reach your plan’s deductible (also known as coinsurance); or **preventive care, dental and vision expenses** that are not covered by the medical, dental or vision plans in which you are enrolled. Many expenses that are eligible for reimbursement under a Healthcare FSA (e.g., medicine for a purpose other than preventive care, physician’s visits for reasons other than preventive care) are generally ineligible for reimbursement under the Limited Purpose Healthcare FSA. For more information about enrolling in Textron’s Limited Purpose Healthcare FSA, please contact the Textron Human Resources Service Center at the phone number shown in the chart elsewhere in this document.*

Note: Please refer to the Textron Flexible Benefits Plan SPD for additional details regarding the LPFSA and the general purpose HCFSA.

Covered Health Services

The following sections apply to the Textron HRA Plan and Textron Low Deductible/High Deductible/Maximum Deductible-HSA health benefit options. For more detailed information about these benefits, please see the ***Textron Medical Plans Detail*** chart associated with your Plan.

Important Note Regarding Prior Authorization for Certain Services:

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization *before* you receive the services. In many cases, your non-network benefits will be reduced or denied if the Claims Administrator has not been provided prior authorization. To obtain prior authorization, call the number on the back of your ID card.

See ***Prior Authorization*** section of this SPD for further details and a list of services that require prior authorization.

Physician's Office Services – Sickness and Injury

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

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

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

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

Emergency and Urgent Care

Although emergency care may be necessary for either a "life-threatening" or an "urgent" condition, a true medical emergency ("emergency") differs from routine or urgent care in that treatment of a true medical emergency cannot be safely postponed for the time it takes to contact your physician for instructions on how you should obtain care. A "medical emergency" is any situation that requires immediate care in order to save a life or prevent permanent impairment. A life-threatening condition is the sudden or unexpected onset of a traumatic bodily injury or a medical condition that requires immediate medical attention. In addition, a life-threatening condition is one for which you should secure treatment immediately after the condition's onset, or as soon thereafter as possible, but in no case more than 24 hours after the onset. In the event of such a condition, you should seek treatment at the nearest emergency facility.

Note: *In connection with a pregnancy, a term delivery (whether vaginally or by caesarean section) inside or outside the service area is not an emergency.*

Examples of a "life-threatening" condition are:

- An apparent heart attack (severe chest pain or pressure in the chest);
- Stroke;
- Severe shortness of breath or difficulty breathing;
- Severe, uncontrollable bleeding;
- Sudden loss of consciousness;
- Convulsions, head injuries, or seizures;
- Severe or multiple injuries, including obvious fractures;
- Severe allergic reactions; and
- Apparent poisoning.

An "urgent" condition is an injury, or a sudden onset of an acute condition that is not life-threatening, but would reasonably be expected to cause serious health deterioration if treatment were delayed until you could schedule a regular appointment with your physician.

Examples of an "urgent" condition include, but are not limited to:

- Ordinary sprains and fractures,
- Severe headaches and earaches,
- Nausea or vomiting,
- Acute fever, and
- Minor bleeding and/or cuts requiring stitches.

If you need emergency medical care and cannot arrange for care from a network provider, the Plan pays your claims (once you have met your deductible) at the

network level, regardless of whether or not the provider is in the network. However, once you are able to direct your care, you must use a network provider in order to receive the highest benefit level under the Plan.

You are covered for emergencies anywhere in the world. If you have an emergency, you should immediately seek the emergency care you need at the nearest medical facility. The Claims Administrator will pay your claim at the network level (based on billed charges), regardless of the provider's network status.

All services for emergency care (whether "urgent" or "life-threatening") are subject to review by the Claims Administrator after the delivery of care. If the Claims Administrator determines that an emergency condition did not exist, the services will be paid, if they are covered benefits under the plan, at the coinsurance level that applies to the benefit level option which you have selected.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Ambulance services for an emergency that are provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services are covered at the coinsurance level that applies to the benefit level option which you have selected.

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

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

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

Note: In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you plan to receive benefits for non-Emergency air

ambulance services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

Preventive Care

The Textron Medical Plans cover preventive care services approved by the Patient Protection and Affordable Care Act (PPACA). The list below is not an inclusive list.

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

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

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

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

Well-Child Care:

Well-Child Care includes routine office visits and immunizations, as follows:

- Six visits: 0-12 months,
- Three visits: 12-24 months,
- Annual visits from 24 months through age 18.
- Benefits include Childhood immunizations, screenings including hearing and vision screenings, pap smear and routine pelvic exam annually beginning at the onset of sexual activity if prior to age 18, and necessary preventive care prescriptions, radiology and laboratory testing associated with routine office visits.

Well-Adult Care

Well-Adult Care, after age 18, includes an annual vision and hearing screening (when it is performed as a part of a Well-Adult Care office visit, in order to detect changes in vision and hearing or signs of impairment) and up to two office visits for the purpose of obtaining a routine physical examination; to also include immunizations, screenings, and laboratory charges associated with these routine office visits. In addition, the following are also included as preventive:

- Mammogram (both preventive and diagnostic is considered preventive regardless of age),
- Bone density test for osteoporosis every two years for women age 65 and over,
- Pap smear and routine pelvic exam annually beginning at age 18,
- Colorectal Cancer Screenings, with the choice of the following:
 - Fecal occult blood test (FOBT) annually and flexible sigmoidoscopy once every five years, both beginning at age 50; or
 - Colonoscopy once every year, regardless of age (does not apply to retirees); or
 - Double contrast barium enema once every five years starting at age 50
- The Plan also covers colon preparation products for patients age 50 through 75, regardless of diagnosis (covered as a prescription benefit),
- Pre-operative consultation prior to colonoscopy procedure if the attending provider determines that pre-operative consultation would be medically appropriate.

Note: For further information about preventive care and health and wellness-related services, visit www.myuhc.com or call their toll-free customer service line at the phone number listed on the back of your member ID card.

Hospital Inpatient Stay

In general, hospitalization (room and board in a semi-private room) and services received while hospitalized are covered by the Plan at the designated coinsurance levels.

While you generally receive a higher level of coverage from the Plan when you receive care at a network facility, coverage may vary depending on the coverage level option you elect. See the ***Textron Medical Plans Detail*** chart for more information.

Covered expenses for hospitalization include those shown on the ***Textron Medical Plans Detail*** chart.

Note: If you plan to receive benefits for an inpatient hospital stay, please make sure you follow the procedures explained in the ***Prior Authorization*** section of this SPD.

Pregnancy Coverage

Under this Plan, maternity benefits are provided for female employees who are covered by the Plan and for eligible dependents. The Plan will pay for maternity care the same way that it pays for any other medical condition.

Also, like any other hospital confinement, an admission for maternity may be subject to any notification (or pre-admission) program procedures under the Plan.

The Plan encourages pre-natal care. You should contact your physician during the first trimester to confirm your pregnancy and to start pre-natal care.

In addition, the following services related to maternity are covered:

- Hospital and physician care for the mother and eligible newborn,
- Delivery room,
- Recovery room, and
- Newborn nursery care.

Also see ***Women's Preventive Care*** and ***Healthy Pregnancy Program*** sections of this SPD.

Note: You must enroll your newborn in the Plan within 30 days of his or her birth by contacting the Textron Human Resources Services Center at 1-866- MY-TXT-HR (1-866-698-9847) or by logging onto www.netbenefits.com.

Note: If you plan to receive benefits for an inpatient hospital maternity stay, please make sure you follow the procedures explained in the ***Prior Authorization*** section of this SPD.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in *Terms to Know*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

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

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with cancer-related services received by a Designated Provider.

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

Mental Health Services

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

Benefits include the following levels of care:

- Inpatient treatment,
- Residential Treatment,
- Partial Hospitalization/Day Treatment,
- Intensive Outpatient Treatment,
- Outpatient treatment.

Services include the following:

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

The Mental Health/Substance-Related and Addictive Disorder Administrator determines coverage for all levels of care. You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorder Administrator for referrals to providers and coordination of care.

Note: *The provider must be licensed or approved by the state in which the services are provided.*

If you plan to receive benefits for a Mental Health services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

See **What is Not Covered – Exclusions** section of the SPD for services that are not covered under the Plan.

Neurobiological Disorders – Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorders including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

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

Benefits include the following levels of care:

- Inpatient treatment,
- Residential Treatment,
- Partial Hospitalization/Day Treatment,
- Intensive Outpatient Treatment,
- Outpatient treatment.

Services include the following:

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

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

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

Note: If you plan to receive benefits for Neurobiological Disorders – Autism Spectrum Disorder services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

See **What is Not Covered – Exclusions** section of the SPD for services that are not covered under the Plan.

Substance-Related and Addictive Disorder Services

Substance-Related and Addictive Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

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

- Outpatient

treatment. Services include

the following:

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

The Mental Health/Substance-Related and Addictive Disorder Administrator determines coverage for the all levels of care. You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorder Administrator for referrals to providers and coordination of care.

Note: If you plan to receive benefits for Substance-Related and Addictive Disorder services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

See **What is Not Covered – Exclusions** section of the SPD for services that are not covered under the Plan.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

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

Note: Some Pharmaceutical Products may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such Pharmaceutical Product where third party copayment assistance is used, the Member may not receive credit toward their Out-of-Pocket Maximum or Deductible for any copayment or Coinsurance amounts that are applied due to a manufacturer coupon or rebate.

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

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

Skilled Nursing (Convalescent) Facility

A qualified skilled nursing (convalescent) facility is one that meets all of the following tests:

- It maintains permanent and full-time facilities for bed care of ten (10) or more resident patients;
- It is licensed and operated in accordance with governing laws and regulations;
- It regularly provides skilled nursing care on an inpatient basis during the active or convalescent stage of an injury or illness. Therefore, other than incidentally, it is not a place for the aged, a facility for psychiatric treatment, drug addicts, or alcoholics, nor a place for custodial care;
- It is operated legally as a Skilled Nursing Facility or Inpatient Rehabilitation Facility in the jurisdiction where it's located and in accordance with medical procedures;
- It has available, at all times, the services of a medical doctor and is supervised and established by a legally-qualified physician (other than the patient's own physician);
- There is a physician or registered nurse on duty 24 hours a day; and
- It regularly maintains current, complete daily medical records of each patient.

Charges for confinement at a skilled nursing (convalescent) facility are covered on the same basis as hospitalization for any illness, except that the Plan covers all expenses for only the first 120 days of any confinement in a calendar year. ***Note: Days spent in network and/or out-of-network facilities count toward this limitation.*** A confinement must take the place of a hospital confinement or be immediately following a hospital confinement for the same illness.

Confinements in a qualified skilled nursing (convalescent) facility must be for the purpose of:

- Recovering from an acute condition,
- Treating a long-term condition, or
- Treating a terminal condition.

The covered person must be under active medical supervision during confinement.

Eligible expenses include:

- Semiprivate room charges by the facility, and
- All other eligible services and supplies provided by the facility when you are entitled to room and board allowance.

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

Benefits are available only if both of the following are true:

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

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

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

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

Expenses for the following are **not** covered:

- Private duty nursing, unless approved in advance by the Plan;
- Special nursing services or physician's services customarily provided by the facility; and
- Services for treatment of drug addiction, chronic brain syndrome, alcoholism, deafness, senility, mental retardation, or any other mental disorder.

For a more complete list of what is and is not covered, see the ***What's Covered*** and ***What's Not Covered*** sections of this SPD.

Note: If you plan to receive benefits for Skilled Nursing facility services, please make sure you follow the procedures explained in the ***Prior Authorization*** section of this SPD.

Spine and Joint Surgeries

Benefits for spine and joint surgeries which are ordered by a Physician. Spine and joint surgical procedures include the following:

- Spine fusion surgery.
- Spine disc surgery.
- Total knee replacement.
- Total hip replacement.

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

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Spine and Joint Solutions (SJS) Program

For Designated Network Benefits, you must enroll in the SJS Program to receive services from a Designated Provider. To enroll you can call the Claims Administrator at the telephone number on your ID card or you can call the SJS Nurse Team at 888- 936-7246.

Home Health Care Benefit

Your home health care benefit covers Covered Health Services expenses for skilled nursing and other therapeutic services provided by a home health care agency or program.

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

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in the *Terms to Know* Section.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to the *Terms to Know* section for the definition of Skilled Care.

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

A home health care agency is an organization primarily engaged in providing skilled nursing and other therapeutic services in accordance with the licensing requirements in its area, and it has contracted to provide home health care services. Policies for the agency must be established by a professional group, including at least one physician and one registered nurse, either of whom supervises the services of the agency. The agency must have a full-time administrator and maintain a complete medical record for each person.

A home health care program provides continued care and treatment of an individual at home, instead of in a hospital or skilled nursing facility, for treatment of a disease or injury. The program must be prescribed by a physician and given in the home under a "home health care plan."

The covered, medically necessary expenses of a home health care agency are paid by the Plan, according to your Plan, when expenses are incurred in accordance with an approved home health care program. Limitations associated with this benefit are listed in the **Medical Plans Detail** chart.

The following charges made by a home health care agency as part of a home health care program are covered:

- Part-time or intermittent nursing care by a registered nurse, or by a licensed practical nurse (L.P.N.) if the services of a registered nurse are not available;
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- Physical, occupational, speech, and inhalation therapy;
- Medical supplies and medicines prescribed by a physician;
- Services of a nutritionist; and
- Services of a medical social worker.

Expenses for the following are not covered:

- Services of a person who ordinarily resides in your home or is a member of your family or your spouse's family.
- Transportation services.
- Custodial care.

For a more complete list of what is and is not covered, see the **What's Covered** and **What's Not Covered** sections of this SPD.

Note: If you plan to receive benefits for Home Health Care services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

Transplantation Services

Organ and tissue transplants Benefits, including CAR-T cell therapy for malignancies, when ordered by a Physician are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow (including 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.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received at a Designated Provider.

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

Note: If you plan to receive this benefit, please make sure you follow the Prior Authorization procedures explained in the ***Prior Authorization*** section of this SPD.

Note: *The services described under **Travel and Lodging** are Covered Health Services only in connection with transplant services received by a Designated Provider.*

See the ***Terms to Know*** section of this SPD for a more complete definition of medically necessary.

Coverage is limited to two transplant procedures for the same condition per person per lifetime.

Travel and Lodging

Personal Health Support will assist the patient and family with travel and lodging arrangements related to transplantation services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at and provided by a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts. Travel and Lodging assistance is available for:

- Congenital Heart Disease (CHD)
- Bariatric Surgery Services
- Transplantation Services
- Cancer Resource Services (CRS)

For travel and lodging services to be covered, the patient must be receiving services by a Designated Provider. If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

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

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment of the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion; or
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to \$100 per day.

Lodging

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits that are required to hold a reservation or utilities for an apartment that may be needed during treatment, for example.

- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

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

Note: *Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Provider.*

UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Provider.
- The cancer, congenital heart disease surgery, bariatric surgery services and transplantation allowance maximum is per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures with up to \$5,000 allowed per transplant.
- The spine and joint program provides a maximum of \$2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

Hospice Care Benefits

In the past several years, programs have been developed to recognize the needs of terminally ill patients and their families. Known as hospice care, these programs provide a coordinated interdisciplinary approach approved by the terminally ill patient's physician and the medical director of a hospice. They provide medical, nursing, and other health care services for meeting the special physical, psychological, spiritual, and social needs of:

- The patient who has a limited life expectancy (generally less than 6 months).
- The immediate family of such patient.

A qualified hospice is an approved facility which provides short periods of stay for

either direct care or respite to a terminally ill person in a home-like setting. This facility may be either free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program. Such a facility must be licensed, certified, or registered, when required by state law, to be considered a qualified hospice.

A hospice care program is a formal program directed by a physician to help care for a terminally ill person. This may be through either:

- Confinements in a qualified hospice; or
- A centrally-administered, medically-directed, and nurse-coordinated program that:
 - Provides a coherent system primarily of home care,
 - Uses a hospice team, and
 - Is available 24 hours a day, seven days a week.

The hospice team must include at least a physician and registered nurse, and it may also include any of the following: social worker, clergyman, counselor, clinical psychologist, physiotherapist, or occupational therapist.

The Plan pays for the following expenses of a hospice care program according to your Plan and whether you use network or out-of-network providers:

- Confinement in a licensed hospice facility or skilled nursing facility,
- Home hospice care provided by an approved hospice team,
- Nursing care by or under 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.

If you plan to receive benefits for hospice care, make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

Besides the items listed in the **What's Not Covered** section of this SPD, expenses for the following are not covered:

- Charges for services not made or ordered by your physician,
- Charges for services provided by volunteers or individuals who do not regularly charge for their services, and
- Charges incurred after the death of the patient.

Note: If you plan to receive benefits for inpatient Hospice services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

Prosthetic Device Benefits

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

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

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

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

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

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

- Benefits are available for repairs and replacement, except that:
 - There are no benefits for repairs due to misuse, malicious damage or gross neglect.
 - There are no benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Note: If you plan to receive services for prosthetics, please make sure you follow the procedures explained in the ***Prior Authorization*** section of this SPD

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

Durable Medical Equipment (DME) Benefits

The Plan 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;
- not of use to a person in the absence of a Sickness, Injury or disability; and
- durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment that meets the minimum specifications for your needs. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- standard hospital-type beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services*;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure.
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage.
Dental braces are also excluded from coverage.; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.
- The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.
- Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

- Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

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

Note: If you plan to receive services for Durable Medical Equipment, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD

*Note: DME is different from prosthetic devices – see **Prosthetic Device Benefits**.*

Congenital Heart Disease (CHD) Surgeries

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

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

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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

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

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

Note: If you plan to receive services for Congenital Heart Disease Surgeries, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD

Note: *The services described under **Travel and Lodging** are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program and are payable only under the Health Reimbursement Account (HRA-Only Expense).*

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Facilities participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Provider is defined in ***Terms to Know*** Section.

In order to receive Benefits under this program, the Network Provider must notify NRS or Personal Health Support if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- call Personal Health Support; or
- call NRS toll-free at 1 (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

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

To take part in the NRS program, call a neonatal nurse at 1-888-936-7246. The Plan will only pay benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that network.)

Diabetes Services

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

Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a physician and provided by appropriately licensed or registered health care professionals. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes are based upon your medical needs. Insulin, syringes and needles are covered under the Plan. An insulin pump is subject to all the conditions of coverage stated under ***Durable Medical Equipment***.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than \$1,000. You must purchase or rent the DME from the vendor the Claims Administrator or Personal Health Support identifies.

Bariatric Surgery (through Bariatric Resource Services)

The Plan covers surgical treatment of obesity provided by or under the direction of a physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40
- You have a minimum BMI of 35 with at least one complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria, the following must also be true:

- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND Tanner State of 4.
- You have completed a 6-month physician supervised weight lost program within the last two (2) years.
- The surgery is performed at a Bariatric Resource Service (BRS) Designated Provider by a network surgeon, even if there are no BRS Designated Facilities near you.

For bariatric surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant *prior to receiving services*. You can contact Bariatric Resource Services by calling 1-888-936-7246.

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

All authorization information and enrollment for bariatric surgery must be initiated through OptumHealth's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should notify OptumHealth as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth at 1-888-936-7246 to enroll in the program.

Note: If you plan to receive services for bariatric surgery, please make sure you follow the procedures explained in the ***Prior Authorization*** section of this SPD

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray; and
- Mammography.

Benefits under this section include:

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

Note: *Prior authorization from the Claims Administrator is required for certain lab, x-ray and diagnostic services. Please see **Prior Authorization** section of this SPD for a list of services that require prior authorization.*

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

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility under this section include:

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

Note: *Prior authorization from the Claims Administrator is required for certain lab, x-ray and diagnostic services. Please see **Prior Authorization** section of this SPD for a list of services that require prior authorization.*

Dental Services - Accident Only

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

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or

dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.) Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

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

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, 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. The Plan pays for treatment of accidental Injury only for:

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

Note: For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to obtain prior authorization before the initial Emergency treatment.

Dental Services – Oral Surgery

Anesthesia and facility charges for oral surgery due to an accidental injury or performed as medical treatment are covered under the plan when it is necessary to perform the oral surgery in a hospital or in an outpatient surgical center.

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
- Cross-sex hormone therapy.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria.

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

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

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

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

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

real- life experience in the desired gender.

- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement- *For non-network Benefits you must obtain prior authorization as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises.*

For a list of exclusions, see "**What is Not Covered**" section of this SPD.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as the Claims Administrator determines, a clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as the Claims Administrator determines, a clinical trial meets the qualifying clinical trial criteria stated below; and
- Other diseases or disorders which are not life threatening for which, as the Claims Administrator determines, a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

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

arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain Category B devices;
 - Certain promising interventions for patients with terminal illnesses; and
 - Other items and services that meet specified criteria in accordance with our medical and drug policies;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

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

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

Clinical trial costs associated with the device, medication, or data collection are not covered.

Experimental or investigational items or services are generally not covered.

Note: If you plan to partake in a Clinical Trial, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Physician Fees for Surgical and Medical Services

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

Reconstructive Procedures

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

Improving or restoring physiologic function means that the organ or body part is made

to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

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

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

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

Note: If you plan to receive benefits for Reconstructive Procedures, please make sure you follow the procedures explained in the ***Prior Authorization*** section of this SPD.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy*.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

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

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

*For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, Sickness, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

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

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

Surgery - Outpatient

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

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

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

Note: If you plan to receive benefits for outpatient surgery services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

Therapeutic Treatments – Outpatient

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

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

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
- Benefits under this section include:
 - The facility charge and the charge for related supplies and equipment.
 - Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

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

Note: If you plan to receive benefits for outpatient therapeutic services, please make sure you follow the procedures explained in the **Prior Authorization** section of this SPD.

Virtual Visits

The plan pays Benefits for virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

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

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

Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis when needed for hair loss due to cancer or alopecia areata.

Cellular and Gene Therapy

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

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

Additional Health Benefits and Programs

Clinical Programs and Resources

Textron has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

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

Note: *Information obtained through UnitedHealthcare support programs is based on current medical literature and physician review. However, it is not intended to replace the advice of a doctor. The information is intended to help people make better healthcare decisions and to take a greater responsibility for their own health. **The Claims Administrator and Textron are not responsible for the results of your decisions that may ensue from the use of this information, including but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.***

Consumer Solutions and Self-Service Tools Activation Campaigns

To help support you in your health care decisions, UnitedHealthcare may send you and your covered Dependents materials focused on the following topics:

- your health care experience;
- your health and wellness; and
- value for your health care dollar.

Health Survey

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

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

To find the health survey, log in to myuhc.com. After logging in, access your personalized Health & Wellness page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

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

Online coaching is available for:

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

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders.

Treatment Decision Support

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

This program offers:

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

Conditions for which this program is available include:

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

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

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

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

www.myuhc.com

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

With [myuhc.com](http://www.myuhc.com) you can:

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

Registering on www.myuhc.com

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

Visit myuhc.com and:

- make inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Wellness Programs

Healthy Pregnancy Program

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

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

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

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

What Is Not Covered

Exclusions

As with most medical benefit plans, certain expenses are not covered under the Plan. Your coverage under the Plan does not cover expenses for charges that are not medically necessary. In addition, payment will not be provided for the expenses or supplies listed below.

In addition to the Exclusions listed below, you should refer to the applicable Summary of Benefits for the benefit level option which you have selected, and you should note any Plan Year limitations and/or maximum individual limitations applicable to certain covered expenses.

Plan Year limits are met by:

- (a) *Days/visits/dollar limits paid by your HRA (if you participate in the Textron HRA Plan); or***
- (b) *Days/visits/dollar limits paid by you as part of your Member Responsibility (if you participate in the Textron HRA Plan) or by your HSA (if you participate in one of the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options); and/or days/visits paid by the Health Coverage component under the Plan.***

Note: Some Pharmaceutical Products may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such Pharmaceutical Product where third party copayment assistance is used, the Member may not receive credit toward their Out-of-Pocket Maximum or Deductible for any copayment or Coinsurance amounts that are applied due to a manufacturer coupon or rebate.

- Adoption expenses
- Any charges by a provider that are prohibited under federal statute.
- Any charge by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency.
- Any and all expenses related to surrogate parenting.
- Any care not recommended and approved by a licensed physician.
- Any care of military service-connected conditions for which an employee is legally entitled to service and for which facilities are reasonably accessible. This includes any charges incurred while on active duty with the armed services of any country or international organization.
- Any charges for treatment, services or supplies that are not Covered Health Services as determined by the Claims Administrator's medical staff or an independent medical physician review panel.
- Any charges of a physician or health professional for services he or she provides to herself or himself or to any close relative (close relative means spouse,

brother, sister, parent, grandparent or child and the spouse's brothers, sisters, parents, grandparents or children).

- Any diagnostic admission if the test can be performed on an outpatient basis.
- Any illness for which any benefits are received or could be received if claims were made under any automobile insurance policy, to the extent that the policy provides benefits for covered services under the Plan.
- Any illness or injury for which benefits or payments are received (or could be received if claims were made) under any worker's compensation law, employer's liability law or similar act.
- Any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community.
- Arch supports or foot orthotics not prescribed by a medical doctor, and orthopedic shoes, such as biomechanical evaluation, range of motion measurements and reports, and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a medically necessary condition.
- Autopsies
- Augmentative communications devices
- Charges for any illness or injury arising from a non-covered procedure.
- Charges for cosmetic or reconstructive surgery and related services, except for the following:
 - Reconstructive surgery following a mastectomy
 - Surgery to repair a defect caused by an accidental injury resulting in a functional impairment
 - Reconstructive surgery related to or following surgery that was needed due to an injury, sickness, or other disease of that part of the body
 - Cosmetic or reconstructive surgery to repair a dependent child's congenital or developmental defect
- Charges for duplicating and obtaining medical records.
- Charges for or related to fetal tissue transplants.
- Charges for failure to keep a scheduled visit; for any mailing, shipping and handling expenses; for completing any form; or for obtaining medical information.
- Charges for the treatment of compulsive gambling.
- Charges related to organ transplants except as specified elsewhere in this document.
- Custodial care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional.
- Elective abortions.
- Expenses eligible for consideration under any other Plan, including Medicare.

- Expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling.
- Expenses not specifically listed as covered under this Plan.
- Fees or direct payment to a donor for sperm or ovum donations.
- Full body scans, EBCT (heart scans).
- Gene therapy as a treatment for inherited or acquired disorders.
- Health services connected with the removal of an organ or tissue from you for the purpose of transplanting to another person.
- Hypnotism and other forms of alternative treatments as defined in the Office of Alternative Medicine of the National Institutes of Health.
- Infertility – All treatment for infertility procedures and services are not covered by this Plan. Coverage is provided for “Infertility: Process of Diagnosis only” according to the Option that you have selected; see benefit details charts and other lists found elsewhere in this document.

Please note: As applicable, it can be your choice to use the non-traditional HRA only part of the Plan to cover infertility treatment. If/when you exhaust your available Benefit Dollars, the Plan provides no further coverage.

- Lenses, frames and contact lenses; other fabricated optical devices or related professional services, including the treatment of refractive errors such as radial keratotomy and laser refractive surgery.
- Liposuction
- Marriage counseling
- Monthly fees for maintenance and/or storage of frozen embryos.
- Non-emergency admissions greater than 24 hours in advance of procedure, unless specified by your physician.
- Non-medical counseling or training services.
- Over-the-Counter pharmaceuticals that you can buy without a prescription (except for insulin, syringes, and needles) are not covered under the Plan, except as required by the Affordable Care Act.
- Non-prescription drugs or medicines; prescription drugs that have not been classified as effective by the FDA; bio-engineered drug therapy that has not received FDA approval for the specific use being requested; prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
- Personal comfort items while hospitalized, such as telephone or television.
- Physician charges for injections that can be self-administered.
- Private duty nursing services.
- Phototherapy devices for Seasonal Affective Disorder.
- Products purchased outside of the U.S., unless in an unexpected, emergency situation.

- Recreational or educational therapy or forms of non-medical self care or self-help training, including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related services or diagnostic testing.
- Habilitative services for maintenance/preventive treatment.
- Hyperhydrosis (excessive sweating).
- Routine physical exams and immunizations for employment, travel or insurance purposes.
- Sales tax
- Services, chemotherapy, supplies, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered.
- Services for, or related to, systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not medically necessary.
- Services of the clergy.
- Services or confinements ordered by a court (or law enforcement officers) that are determined not medically necessary health services [performed before the effective date or after the termination of coverage under this Plan] (Note: an initial court-ordered exam for a dependent child under age 18 is considered medically necessary).
- Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in the *Terms to Know* section. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Service in this SPD
 - Not otherwise excluded in this SPD under this Section.
- The following items are excluded even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
 - Over-the-counter drugs and treatments.
- A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
- A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
- Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

- Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product.

- Services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a physician.
- Services performed before the effective date or after the termination of coverage under this Plan.
- Services provided mainly for rest cures, the ease of a household, or sanitarium care.
- Services rendered by anyone other than a covered healthcare provider.
- Services that are prohibited by law or regulations.
- Speech therapy to treat stuttering, stammering, or other articulation disorders.
- Travel and/or lodging expenses of a physician or a patient, except as specified in the organ transplant section.
- Treatment of an injury or sickness resulting from taking part in the commission of a felony, assault, terrorist action, or any illegal act.
- Treatment while confined in a state, federal or Veterans Administration hospital for which charges are not imposed.
- Ventilator-dependent communication services while confined in a hospital or other medical facility.
- Vision therapy for all behavioral health disorders, including learning and reading disabilities and attention deficit/hyperactivity disorder, traumatic brain injury or dyslexia – vision therapy for these disorders is considered investigative.
- Vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs.

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

The exclusions listed below apply to services described under **Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance-Related and Addictive Disorder Services (Substance-Related and Addictive Disorders Services)**:

In addition to all other exclusions listed in this Section, *What is Not Covered, Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance-Related and Addictive Disorders Services in Covered Health Services*.

- 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 *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 disorders.
- 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 required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
- 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*.
- Transitional Living services.

Please note: *The fact that a provider has performed, prescribed or recommended a service, or that a service is available, does not mean that the service is medically necessary or a covered benefit.*

*Prior authorization from the Claims Administrator is required for certain neurobiological disorder services. See **Prior Authorization** section of this SPD for a list of services that require prior authorization.*

If you have any questions, you should call the Claims Administrator's toll-free customer service number on the back of your member ID card.

Prescription Drug Benefits (Administered by CVS Caremark)

When you enroll in this Plan, you'll automatically receive prescription drug coverage. Your prescription drug coverage is integrated into this Plan and is administered by CVS Caremark.

Under this Plan, you have the opportunity to obtain your medications through both participating retail pharmacies as well as **CVS Caremark mail**. Information about how your prescription drug benefits work through retail pharmacies and the mail order program is provided below.

Your cost for prescription drugs is based on:

- Whether you purchase your prescription drugs through an in-network pharmacy or an out-of-network pharmacy. Out-of-network prescription claims are not covered; and
- Whether your prescription is filled with a generic or a brand-name drug.

You can access the CVS Caremark website at www.caremark.com. CVS Caremark also has an interactive telephone service that gives you a convenient way to get information or materials, at any time of day or night. You should always have your member ID number (which is on your CVS Caremark ID card) with you, along with any other critical number (like your prescription number). You can call CVS Caremark directly at 1-855-656-0359.

Prescription Drug – Prior Authorization Program: Certain drugs will only be covered with prior approval. If you do not receive this approval, you will pay full price if you fill a prescription, and these expenses will not be applied to the deductible and out-of-pocket maximum. A list of drugs that require prior approval can be accessed at www.NetBenefits.com.

CVS Caremark Specialty Pharmacy Program– specialty drugs for treatment of diseases like cancer, multiple sclerosis, and rheumatoid arthritis. The purpose of the CVS Caremark Specialty Pharmacy Program is to help you and your family members feel confident that these medications are the best course of treatment and are working as expected. The Program features personal nurse care management services and access to an on-call pharmacist 24x7. Use of the CVS Caremark Specialty Pharmacy Program is required. Specialty drugs must be filled at CVS Specialty Pharmacy and are subject to prior authorization; specialty drugs can be sent via mail order or picked up at a CVS Pharmacy.

Note: Some medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such medication where third party copayment assistance is used, the Member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Types of Prescription Drugs

Prescription drug benefits provide coverage for many different types of prescribed medications. For more specific information on the benefits associated with these types of medications, see the ***Textron Medical Plans Detail***.

Generic Drugs

A generic drug is identified by its chemical name rather than an advertised brand name. FDA-approved generic drugs are as effective as their brand-name counterparts but cost significantly less. You will generally pay the least out of pocket when you purchase generic drugs.

Under the generic prescription program, Textron will pay 100% of the cost of medication for targeted conditions when purchased at these retail locations - CVS/pharmacy, Wal-Mart, Dillons (in Kansas) as either a 30 or 90 day supply or, through CVS Caremark mail service pharmacy as a 90 day supply.

Additionally, if you are enrolled in any one of Textron's CDHP options (Health Reimbursement Account, Low, High or Maximum Deductible Plan) you will not be charged for certain medications which are considered preventive. Targeted conditions are posted on the Preventive Generic List. Medications in this category include generics for the following health conditions:

- Cardiovascular Conditions,
- Chronic Kidney Disease,
- Coronary Artery Disease,
- Diabetes, Hypertension,
- Mental Health,
- Osteoporosis,
- Respiratory Disorders, and
- Seizure Disorder.

A copy of the Preventive Generic List can be accessed at www.caremark.com and www.NetBenefits.com.

Mandatory Generics: if you take a brand-name medication that has a generic available, you must use the generic to get the drug plan price. If you use the brand name medication, you will pay the full cost of the medication, "Dispense as Written" will not be covered by the plan. However, CVS Caremark has an exception process if you require the brand-name medication due to medical necessity such as an allergic reaction to the generic. You can ask your doctor to complete and submit a "Brand Penalty Exception Request Form" for a clinical review by a CVS Caremark medical professional.

Your prescription drug benefit encourages the use of generic drugs; it pays for generic drugs at the benefit level option that you select. Otherwise, if you or your doctor selects a brand-name drug when a generic equivalent is available, you must pay the cost difference between the generic and brand-name drugs plus

your applicable co-insurance. **Note:** *This cost difference amount will not count toward the deductible or out-of-pocket maximum. Further, if you are enrolled in one of the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options, this difference will not be eligible for coverage under the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options; however, if you are enrolled in the Textron HRA Plan, you can request reimbursement for this difference from your HRA. You may also use HSA funds to cover the difference.*

Formulary/Preferred Brand-Name Drug

The **Performance Drug List** is a list of brand-name and generic medications that are preferred by your prescription program. This formulary contains a list of medications for most medical conditions that are treated on an outpatient basis. The formulary is created with the help of an independent Pharmacy & Therapeutics Committee consisting of doctors and a pharmacist. The prescription drugs that are considered for the formulary are subject to rigorous clinical analysis. The committee, which meets at least quarterly to evaluate new medications, looks at each medication's FDA approval status, effectiveness, safety, side effects, potential drug-to-drug interactions, and dosage. The professionals on the committee work to ensure that formularies and formulary policies are medically sound, they support the health of members, and that members have a choice of medications in all therapeutic categories.

Non-Formulary/Non-Preferred Brand-Name Drug

A non-formulary brand-name drug is a brand-name drug *not* on the Performance Drug List. These prescription drugs are covered by the Plan; however, you will generally pay a higher cost than if you purchase an alternative generic drug or formulary/preferred brand-name drug.

Retail Pharmacy Benefit

Your pharmacy benefit is designed to cover medications for most diseases, including short-term illnesses such as an ear infection, as well as long-term conditions, such as high blood pressure. It provides for a prescription to be filled for up to a 34-day supply of medication.

You will receive maximum value from your pharmacy benefit if you take your CVS Caremark ID card to a participating retail pharmacy in-network. If you do not have your CVS Caremark ID card with you when you fill your prescription at retail, you will need to pay for your prescription up front and then file a claim for reimbursement with CVS Caremark.

Exclusive Choice Network (ECN)

The Pharmacy Exclusive Choice Network (ECN) is made up of CVS/pharmacy, Walmart, Dillons and some independent pharmacies. These pharmacies provide you with better discounts and certain generic preventive maintenance medications at no cost. Prescriptions must be filled at an Exclusive Choice Network (ECN) pharmacy (e.g., CVS pharmacy, Walmart, Dillons). Participants who do not have ECN retail

pharmacies within 15 miles of their home may be able to use a non-ECN retail pharmacy.

To find a participating retail pharmacy in your area, you can Visit the CVS Caremark website at www.caremark.com and look under the Pharmacy Locator section, or Call CVS Caremark Customer Care at the phone number on the back of your ID card.

Paying for Your Prescription at a Retail Pharmacy through the HSA

When you want to use your HSA to pay for prescription drugs, you pay the full discounted rate up front at the pharmacy until you reach your deductible; once you reach your deductible, you are responsible for your applicable coinsurance amount—payable at the time of service— until you reach your out-of-pocket maximum.

You may use your Optum Health Bank debit card (if your HSA has a sufficient balance) to cover prescription drug charges (i.e., costs before you reach your deductible and co-insurance after you reach your deductible). Alternatively, you may pay the expense out of your pocket and reimburse yourself from your HSA.

Paying for Your Prescription at a Retail Pharmacy through the Plan

Under the Plan, you should always show your CVS Caremark member ID card at the pharmacy. Then, prescription drugs of up to a 34-day supply are covered according to each of the following scenarios:

Scenario #1 – For the Textron HRA Plan: When you go to an in-network pharmacy, if you have an HRA balance, the prescription will be paid from your HRA and the amount will be applied to your annual deductible.

Scenario #2 – For the Textron HRA Plan: When you go to an in-network pharmacy, you do not have an HRA balance and you have not met your annual deductible, the cost becomes part of your Member Responsibility which you pay at the point of sale. This amount will be applied to your annual deductible.

Scenario #3 – For the Textron HRA Plan: When you go to an in-network pharmacy, if you do not have a balance in your HRA but you have met your deductible, the Plan will pay at the benefit level that you have selected and then you pay the remaining responsibility which is your coinsurance amount, if any.

Scenario #4 – For the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options: When you go to an in-network pharmacy, if you have met your deductible, the Plan will pay at the benefit level that you have selected and then you will be responsible for paying the remaining coinsurance at the pharmacy. (You may seek reimbursement from your HSA for the cost of the drugs, to the extent that funds are available.) Once you have reached your out-of-pocket maximum, the Plan will pay the entire amount of the pharmacy claim.

Scenario #5 – For the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Options: When you go to an in-network pharmacy and you have not met your annual deductible, you will be responsible for paying the cost of the drugs at the pharmacy. The cost of the drugs will be applied to your deductible. You may seek reimbursement from your HSA for the cost of the drugs (to the extent that funds are available); or, use your HSA debit card to access available HSA dollars at the point of sale.

How to Obtain a Claim Form

Claim forms are available online at **www.caremark.com**. You can also request claim forms by calling the phone number on the back of your ID card 24 hours a day, seven days a week.

CVS Caremark Mail-Order Prescription Program

If you use maintenance medications such as those used to treat high cholesterol or high blood pressure, your Plan offers a mail order service– **CVS Caremark mail service**. **CVS Caremark mail service** offers convenience and options for saving money through negotiated prices that may result in discounts. Also, it allows you to order larger supplies—up to 90 days, and refills of up to one year. **Note:** *When you use this service, you should plan to have at least a 14-day supply of medication on hand at the time you initiate your mail order.*

With **CVS Caremark mail service**:

- Your medications are dispensed by one of our home delivery pharmacies and delivered to your home within approximately two weeks after you mail your order. Orders placed via the website, telephone, or fax may be received even faster.
- Medications are shipped by standard delivery at no additional cost to you. (Express shipping is available for an added charge.)
- You can order and track your prescriptions online through **www.caremark.com**. You can also use CVS Caremark’s toll-free number to call in the prescription.
- Registered pharmacists are available around the clock for consultation when you order through CVS Caremark mail service.

For a new prescription, you can order by mail, fax, or online, each as described below:

- **To order by mail:** Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to one year. Mail the new prescription to CVS Caremark in the return envelope, along with the completed mail order form. Be sure to also include the Health, Allergy & Medication Questionnaire (HMQ) and mail in the return envelope marked “HMQ”. This information will help CVS Caremark in filling prescriptions and alerting your doctor about possible medication problems.
- **To order by fax:** Ask your doctor to write a new prescription for up to a 90-

day supply, plus refills (if appropriate) for up to one year and then have him or her call 1-800-378-5697. Directions for faxing your prescription to CVS Caremark will be given over the phone.

- **To order through the Internet:** Log on to www.caremark.com/faststart. Use the ID number on your ID card to register. Have your doctor's information, your prescription ID number, the names of your medicine and your payment information ready.

For a refill, you can order by mail, phone or through the internet, each as described below:

- *To order by mail:* Include your refill slip and the mail order form (which you will receive with your original mail-ordered prescription). Mail as indicated on the form.
- *To order by phone:* Call 1-855-656-0359 to use the automated refill system. You must be ready with member ID number and your refill slip with the prescription information.
- *To order through the Internet:* Log on to the CVS Caremark website, www.caremark.com. If you are a first-time visitor, you will need to register online and create a password; the next time you visit, you need only enter your email address and password. Have ready your member ID number, plus the prescription number for your medication (which can be found on your refill slip) and follow the online instructions. Each time you log in, available prescription refills will be displayed in the personalized information sections of the website.

You can order additional **CVS Caremark mail** order forms and envelopes, as well as prescription drug claim forms, through the website or by calling the phone number on the back of your ID card, 24 hours a day, seven days a week.

Please access CVS Caremark's website or call the toll-free number on your ID card for advice and assistance. See your **Textron Medical Plans Detail** chart for more details.

Clinical Features of the Prescription Drug Program

Several clinical features are included as part of your prescription drug benefit. Information about your prescriptions is shared within the **CVS Caremark mail service** to promote the safe and effective use of medications, so that pharmacists can consider many important clinical factors such as drug selection, dosing, interactions, duration of therapies, and allergies. They also have information available from your retail network pharmacy, and similar information is provided to the retail pharmacy when a prescription is filled.

All prescriptions filled through **CVS Caremark mail service** are checked for potential problems, such as interference with other medications you may be taking. Occasionally, CVS Caremark may contact your doctors to discuss certain clinical factors, benefit management matters, or potential problems.

If you have any questions about your prescriptions, you can call Customer Care at the phone number on the back of your ID card, select the Pharmacy option, and talk to a pharmacist 24 hours a day, seven days a week.

Covered Prescription Drugs

In general, the following types of prescription drugs are covered, depending on the Plan's benefit provisions:

- Legend drugs as approved by the U.S. Food and Drug Administration (FDA) (i.e., any medical substance required by law to be dispensed only by prescription).
- Other drugs that, by law, are obtainable solely by prescription, subject to the Plan's benefit provisions and the exceptions listed under **What Prescription Drugs Are Not Covered** section below.

Note: *When you fill a prescription at a network retail pharmacy or through the Plan's mail order program, you will be notified if the Plan does not cover your medication. To find coverage details online, visit the [CVS Caremark website](http://www.caremark.com) at www.caremark.com and visit the Plan & Benefits section.*

What Prescription Drugs Are Not Covered

The prescription drug benefit does not cover any drug that is not described above under "Covered Prescription Drugs." To determine if a medication is covered under the plan, visit the [CVS Caremark website](http://www.caremark.com) at www.caremark.com and use the Check Drug Cost & Coverage tool.

Some drugs that are excluded from this benefit may be reimbursed, in part, under the HRA (if you are enrolled in the Textron HRA Plan) or from your HSA.

Over-the-Counter pharmaceuticals that you can buy without a prescription (except for insulin, syringes, and needles) are not covered under the Plan, except as required by the Affordable Care Act.

Coverage for all new-to-market FDA-unapproved products and certain existing FDA-unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA) will be excluded from coverage under the pharmacy benefit. However, coverage will be provided for select FDA-unapproved products that are legally marketed¹ or deemed clinically necessary (e.g., because no alternatives exist).

¹As reported by the manufacturer to CMS and utilized in making a determination of coverage under the Medicaid program.

Your Prescription Drug Benefit and Medicare

Important Notice from the Plan Administrator About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Textron under this Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Textron has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage*. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

***Textron Maximum Deductible HSA Option: The prescription drug benefit under the Maximum Deductible HSA option is not considered "creditable" for purposes of Medicare Part D. Because this coverage is not creditable, if you are covered under this plan and Medicare, you must have other prescription drug coverage that is creditable (through your spouse or another employer plan) or you should obtain coverage under a Medicare Part D plan. If you do not obtain other creditable coverage timely, you may be subject to a late Part D enrollment penalty if and when you do enroll in a Part D plan.**

When Can You Enroll In A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Enroll in A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Textron coverage will not be affected. An explanation of the prescription drug coverage plan provisions and options appears above in this section of the summary plan description.

If you enroll in a Part D plan and are covered under the Textron Medical Plan as an active employee or are the spouse of an active employee, the Textron Medical Plan would be primary and the Medicare Part D prescription drug plan would be secondary. If there are prescription drug claims that are not covered or partially covered by the Plan, Medicare may pay for expenses that are not paid by the Plan.

If you enroll in a Part D plan and are covered under a Textron Medical Plan as:

- A retired or disabled employee and are not an active employee of a Textron Company, or
- As the spouse (or other dependent) of a retiree or inactive disabled individual, the Part D plan will pay primary and the Textron Medical Plan will pay secondary. If there are prescription drug claims that are not covered or are partially covered by the Part D plan, the plan may pay for eligible expenses that are not covered by the Part D plan.

If you do decide to join a Medicare drug plan and drop your current Textron coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Textron and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You

may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Note: Since the coverage under the Maximum Deductible Plan is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Textron Human Resources Service Center toll-free at 1-866-MY TXT HR (1-866-698-9847), Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m., to speak with a Customer Services Associate. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Textron changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Coordination of Benefits

This Plan contains a coordination of benefits (COB) provision that applies when you or your covered dependent(s) have coverage under a Textron Plan and one or more other plans. The purpose of this provision is to avoid duplicate payments.

The amount of benefits this Plan will pay may be reduced if you or your dependents have other coverage. You must, if applicable, provide information about other coverage, when requested by your employer or the Claims Administrator.

In this case, one of the plans will pay the benefits first, making that plan primary. Other plan(s) will pay benefits next, making those secondary or even tertiary. The rules below help determine which plan pays first.

How Coordination Works

If the Textron Medical Plan is **primary**, it will pay benefits first. Benefits will be paid in accordance with the Plan, as if there were no other plan involved. Therefore, benefits paid by the Textron Medical Plan will not be reduced due to benefits payable under the other plan.

If the Textron Medical Plan is **secondary**, the other plan will pay first. Benefits under the Textron Medical Plan will be reduced by benefits payable under other plan(s) so that the total benefits paid or provided by all plans are not more than 100% of the total allowable expenses. This Plan will not pay more as a secondary plan than it would have paid if it had been the primary plan.

Your bills and receipts must first be filed with the primary plan before being filed with the secondary plan. A copy of the primary plan's Explanation of Benefits (EOB) should be included with the secondary plan claim.

For example: If you and your spouse work at different companies and you both enroll in each other's medical plans:

	Your Coverage	Your Spouse's Coverage
Textron Medical Plan	Primary	Secondary
Your Spouse's Company Plan	Secondary	Primary

Which Plan Pays First

When two or more plans provide benefits for the same covered person, the benefit payment will follow the following rules in this order, subject to the other plan's provisions:

For You and Your Spouse

- If one of the plans does not provide for coordination of benefits, that plan will pay its benefits first.
- If you (or your spouse) is covered as an employee or former employee by one plan

and as a dependent by another, the plan that covers a person as an active or former employee will pay its benefits first

- If you or your spouse is covered as an active employee and also as a retired or laid-off employee (one of you through another employer), the plan that covers the person as an active employee will pay its benefits first.

Note: *If you or your spouse are eligible for Medicare, please refer to **Coordination of Your Plan with Medicare** below.*

For Your Dependent Children

When a child is covered by the plans of both parents, and the parents are **not** divorced or legally separated, the following rules are used to determine which plan is primary:

- The plan of the parent whose birthday occurs earlier in the calendar year (regardless of the year of birth) will pay first. For example, if the father’s birthday is in March and the mother’s birthday is in September, the father’s plan is primary for the child. This is called the “birthday rule.”

Note: *If the parents have the same birthday, the plan that has covered a parent longer will pay benefits first for the child.*

For example: If the father has had coverage under his plan for 5 years and the mother has had coverage under her plan for 7 years, the mother’s plan is primary for the child.

- However, if the other plan’s COB provisions do not use the birthday rule, but base the order of benefits on the gender of the parent so that the plans do not agree on the order, then the rules of the other plan will determine which plan pays benefits first.

When a child is covered by the plans of both parents and the parents *are* divorced or legally separated, the following rules are used to determine which plan is primary:

- If, under a court decree, the parents have joint custody, but the decree does not state which parent is responsible for the child’s healthcare expenses, benefits will be coordinated in the same manner as for the children of married parents, as previously described.
- The medical plan of the parent who has a court decree of financial responsibility will be primary.
- If no court decree exists, and
 - The parent with custody has not remarried, the medical plan of the custodial parent will be primary.
 - The parent with custody has remarried, the plan of the custodial parent will be primary, the plan of the stepparent will be secondary, and the plan of the non-custodial parent will be third.

When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, the Plan determines the amount it will pay for a Covered Health Service by going in order through the following steps. (Rules for when the Plan is secondary to Medicare appear below.)

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

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

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

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

Coordination of Your Plan with Medicare

Note: The rules that follow apply to this Plan, which does not include an integrated prescription drug plan. Prescription drug benefits are provided under a separate plan.

The following rules apply to you or any family member who is eligible for Medicare.

Active Employees

- If an individual over age 65 participates in the Textron Medical Plan either (1) as an active employee of a Textron Company or (2) because the individual's spouse is an active employee of a Textron Company, the Textron Medical Plan will provide primary coverage, and any Medicare benefits will automatically be secondary. If the individual chooses not to enroll in the Textron Medical Plan, the individual may still receive Medicare coverage; but there would be no secondary coverage.
- If a disabled individual under age 65 participates in the Textron Medical Plan as either (1) an active employee of a Textron Company or (2) a spouse or other dependent of an active employee of a Textron Company, the Textron Medical Plan will provide primary coverage, and any Medicare benefits will automatically be secondary. In most cases, a disabled individual who receives Medicare benefits will not be an active employee unless the individual returns to work for a "trial work period" following a period of disability.
- If you remain eligible to participate in the Textron Medical Plan after you retire (or after you become an inactive disabled individual), the rules described below apply.

Note: The special rules that follow apply only when the Textron Medical Plan does include an integrated prescription drug benefit—and if you or a family member is eligible for Medicare.

Retired Individuals and Inactive Disabled Individuals

If you are Medicare-eligible, you may not participate in the Textron Medical Plan and Medicare hospital and general medical coverage (Medicare Parts A and B); there is no post-age 65 coverage.

In general, the following coordination rules apply:

- If a disabled individual under age 65 participates in the Textron Medical Plan as an inactive employee of a Textron Company, Medicare hospital and general medical coverage (Medicare Parts A and B) will be primary; the Textron Medical Plan will provide secondary coverage. In most cases, an individual who receives Medicare benefits as a result of being disabled will be an inactive employee, unless the individual returns to work for a "trial work period" following a period of disability.

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

When calculating the Plan's benefits in these situations, for administrative convenience the Claims Administrator in its sole discretion may treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Right to Receive and Release Needed Information

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

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

Refund of Overpayments in Coordination of Benefits

If the amount of payments made by the Claims Administrator or the Plan is more than it should have paid under the COB provisions specified in this summary plan description, the Claims Administrator or Plan may recover the excess and interest from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other plans, including workers' compensation.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

End Stage Renal Disease

If you have end-stage renal disease, the Textron Medical Plan generally provides primary coverage for the first 30 months. After the first 30 months, Medicare coverage becomes primary and the Textron Medical Plan is secondary—even if the Textron Medical Plan would be primary under the rules listed above.

If you believe you are eligible for Medicare due to end-stage renal disease, you should contact the Claims Administrator for more information.

Claims Procedures and Appeals Process

Maintaining Records

It is important that you keep accurate records and receipts of the expenses associated with your benefit plan. The records will be required when you submit requests for claims to be paid under the Plan.

Filing and Submitting a Claim

In general, there may be instances when you may be responsible for submitting a claim to the Plan's Claim's Administrator. Examples include, but are not limited to, the following:

- If you incur health expenses that are not covered under the Plan; or
- If you receive care from any provider or facility (whether a network or out-of-network one) who will not submit a claim to the Claims Administrator for you; or
- If you use an out-of-network pharmacy.

You should submit claims to your Claims Administrator at the address noted on the claim form. Most plan providers provide an online venue for printing claim forms. Check with your Claims Administrator.

Note: *When filing a claim, you must include a receipt for services from your provider; a cancelled check is not sufficient.*

You must report claims to the Claims Administrator promptly (but no later than 12 months) after the date of the service. If, through no fault of your own, you cannot meet the filing deadline, your claim will still be accepted if you file within two years of the date of service. If you are legally incapacitated, late claims will be covered when they are filed within two years after the 12-month deadline.

Note: *By your enrollment in the Plan, you have agreed to allow all providers to give the Plan any needed information about the care they provide to you. The Plan keeps all such information strictly confidential. If a provider requires specific authorization to release records, you must agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.*

Benefits will be paid as soon as the necessary proof to support the claim is received. All benefits are payable to you. However, the Claims Administrator has the right to pay any healthcare benefits to the provider of services and will do so, unless you have informed the Claims Administrator otherwise by the time you file the claim.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which the Claims Administrator makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Payment of Benefits

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

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Textron reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Textron (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments in Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Refund of Overpayments

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

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Explanation of Benefits (EOB)

You can view and print all of your EOBs online at www.myuhc.com. You may request that the Claims Administrator send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the number on your ID card to request them.

Appeals Procedures

The Claims Administrator follows Department of Labor (DOL) regulations for the claims process and appeals procedures of group health plans. These procedures ensure that Plans must provide for a uniform method to:

- Verify that benefit claim determinations are made in compliance with the terms of the Plan, and
- Have Plan terms be applied consistently on behalf of claimants requesting or receiving benefits.

Specifically, the regulations establish:

- Four different classifications of benefit claims:
 - o Post-service claim,
 - o Pre-service claim,
 - o Concurrent care claim,
 - o Urgent care claim.
- Predetermined timeframes for claims processing, depending upon the claim's classification, and
- Defined notice and disclosure requirements.

Classification of Claims

There are four types of claims that allow different time periods for making a determination of benefits. They are as follows.

Post-service Claim: A post-service claim is a traditional, standard claim for payment of benefits after services have been rendered.

Pre-service Claim: A pre-service claim is a claim for a benefit which requires approval in advance of obtaining medical care, possibly due to your Plan's predetermination benefit.

Note: *If a benefit requires preauthorization and obtaining such prior approval is impossible, or is a situation where doing so could seriously jeopardize the individual's life or health, the benefit cannot be denied for lack of prior approval.*

Concurrent Care Claim: A concurrent care claim is a claim involving an ongoing course of treatment to be provided over a period of time or number of treatments, which has been previously approved under the Plan. Any reduction or termination of the course of treatment (unless due to Plan amendment or Plan termination) would require advance notification to you and allow sufficient time for you to appeal the determination before the actual reduction or termination occurs.

Urgent Care Claim: An urgent care claim is about care that, if you do not receive it within a narrow window of time, you could (a) seriously jeopardize your life or health

or your ability to regain maximum function, or (b) cause yourself severe pain which (in the opinion of a physician who knows your health condition) could not be managed without the requested services.

If you have a question or concern about a claim denial, you may informally contact the Claims Administrator's customer service representatives before requesting a formal appeal. The customer service telephone number is usually shown on your ID card. If the customer service representative cannot resolve the issue to your satisfaction, you may appeal it as described in this notice. When you submit your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. The information that you submit with your appeal will be considered as part of the appeal process, even if you did not submit the information with your initial claim.

For appeals of denied claims, a qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your claim was denied based in whole or in part on a medical judgment, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator (for first-level appeals) and the Plan Administrator (for voluntary second-level appeals) may consult with, or seek the participation of, medical or vocational experts as part of the appeal resolution process. Upon request and free of charge you have the right to reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits, including the identification of medical or vocational experts that were consulted as part of the adverse benefit determination.

The time limits and other rules governing your appeal are different depending on what type of claim you have submitted.

Note: *If you are appealing an urgent care claim denial, please refer to the **Urgent Care Claim** section and contact customer service immediately.*

If Your Claim Is Denied

Post-Service Claim

A post-service claim is a claim for payment of benefits after services have been received. The Claims Administrator must notify you of its determination on a post-service claim within 30 days of receipt of the claim. The Claims Administrator may secure one 15-day extension for the determination, as long as they notify you before the expiration of the initial 30-day period and the reasons for the extension are provided. If an extension is required due to your failure to provide sufficient information from which to make a determination, the notice of extension must provide detail of the additional information required and you will be provided at least 45 days to respond.

If your claim is denied, you will be notified in writing or electronically. The notice will include the following information:

- An explanation of the specific reason(s) for the denial;
- Reference to the specific plan provisions on which the denial is based;
- A description of any additional material or information necessary for your claim to be approved and an explanation of why that material or information is necessary;
- An explanation of the steps to file a first-level appeal, including the time limits, and a statement of your right to bring a lawsuit under section 502(a) of ERISA after your second-level appeal is finally decided;
- If the denial is based on an internal rule, guideline, protocol, or other similar criterion, a copy of that rule, guideline, protocol, or other criterion or a statement that you may receive a copy, free of charge, upon request;
- If the denial is based on a scientific or clinical judgment (for example, a decision that a treatment is not covered because it was not medically necessary or because it was experimental), an explanation of the scientific or clinical judgment; and
- The statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."

If you have not received a decision on your claim within the time period described above, you should consider your claim to have been denied. You may contact the Claims Administrator for this Plan to ask for confirmation that your claim has been denied, appeal the denial as described below, or bring a lawsuit under section 502(a) of ERISA.

First-level Appeal for Post-Service Claim

If your claim is denied, you will have up to 180 days after you received a claim-denial notice to file a first-level appeal with the Claims Administrator. Before filing a first-level appeal, you may informally ask your Claims Administrator's customer service representative why your claim was denied. However, calling a customer service representative will not extend the 180-day period to file a first-level appeal; your first-level appeal must be filed within 180 days after you receive your claim-denial notice.

Your first-level appeal must be in writing and should include:

- The claim number, a copy of denial notification, or a copy of the Explanation of Benefits;
- The item of medical coverage that you believe was misinterpreted or inaccurately applied; and
- Any comments, documents, and other information from the provider (or any other source) that support your appeal, such as medical and/or financial records.

You have a right to receive, upon request and free of charge, access to, and copies of all documents, records, and other information relevant to your claim.

Your written letter of appeal should be mailed to the Claims Administrator at the following address:

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

If you do not file your request for appeal by the end of the 180-day period described above, your appeal will be automatically denied—even if you contact a customer service representative before the end of the 180-day period.

All of the information that you submit with your first-level appeal, including any information that was not submitted with your initial claim, will be considered by a qualified individual who did not review your initial claim (and who is not a subordinate of any individual who reviewed your initial claim). If the decision is based in whole or in part on a medical judgment, the individual reviewing the claim will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The healthcare professional who is consulted will not be an individual (or a subordinate of the individual) who was consulted in the review of your initial claim.

The Claims Administrator will notify you in writing of its decision, within 30 days after it receives your appeal. If the appeal is denied, you will be notified in writing or electronically. The notice will include the following information:

- An explanation of the specific reason(s) for the denial;
- Specific references to pertinent Plan provisions on which the denial 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.
- An explanation of the steps to file a second-level appeal, including the time limits, and a statement of your right to bring a lawsuit under Section 502(a) of ERISA;
- If the denial is based on an internal rule, guideline, protocol, or other similar criterion, a copy of that rule, guideline, protocol, or other criterion or a statement that you may receive a copy, free of charge, upon request; and
- If the denial is based on a scientific or clinical judgment (for example, a decision that a treatment is not covered because it was not medically necessary or because it was experimental), an explanation of the scientific or clinical judgment.

If you have not received a decision on your claim within the time period described above, you should consider your claim to have been denied. You may (1) contact the Claims Administrator for this Plan to ask for confirmation that your claim has been denied, (2) appeal the denial as described below, or (3) bring a lawsuit under section

502(a) of ERISA.

Second-level Appeal for Post-Service Claim

If your first-level appeal is denied, you may appeal that decision, within 60 days from the date of the denial. Before filing a second-level appeal, you may informally ask the Claims Administrator why your first-level appeal was denied. However, calling the Claims Administrator or their customer service representatives will not extend the 60-day period to file a second-level appeal.

Your second-level appeal must be in writing and should include:

- The claim number and a copy of the first-level appeal denial notification;
- The item of medical coverage that you believe was misinterpreted or inaccurately applied; and
- Any comments, documents, and other information from the provider (or any other source) that support your appeal, such as medical and/or financial records.

You have a right to receive, upon request and free of charge, access to, and copies of all documents, records, and other information relevant to your claim. Your written request for a second-level appeal should be mailed to:

**Textron Inc.
Benefits Strategy & Compliance Department
40 Westminster Street
Providence, RI 02903**

If you do not file your request for appeal by the end of the 60-day time period described above, your appeal will be automatically denied unless you demonstrate circumstances that make it unfair to enforce the 60-day time period.

All of the information that you submit with your second-level appeal, including any information that was not submitted with your initial claim or first-level appeal, will be considered by a qualified individual who did not review your initial claim or first-level appeal (and who is not a subordinate of those reviewers). If the decision is based in whole or in part on a medical judgment, the individual reviewing the claim will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The healthcare professional who is consulted will not be an individual (or a subordinate of the individual) who was consulted in the review of your initial claim or first-level appeal.

Textron will notify you in writing of its decision, within 30 days after it receives your appeal.

The decision on a second-level appeal is final. If the second-level appeal is denied, the notice will include the following information:

- An explanation of the specific reason(s) for the denial;

- Specific references to pertinent Plan provisions on which the denial 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;
- Statement of your right to bring a civil action under Section 502(a) of ERISA;
- If the denial is based on an internal rule, guideline, protocol, or other similar criterion, a copy of that rule, guideline, protocol, or other criterion or a statement that you may receive a copy, free of charge, upon request;
- If the denial is based on a scientific or clinical judgment (for example, a decision that a treatment is not covered because it was not medically necessary or because it was experimental), an explanation of the scientific or clinical judgment; and
- The statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."

If you have not received a decision on your second-level appeal within the time period described above, you should consider your second-level appeal to have been denied. You may contact the Textron Human Resources Service Center or Textron to ask for confirmation that your claim has been denied or you may bring a lawsuit under section 502(a) of ERISA.

Pre-service Claim

A pre-service claim is a claim for payment of benefits when the Plan requires approval in advance of obtaining medical care, such as due to a utilization review or pre-authorization program.

Note: *If a benefit requires pre-authorization and obtaining such prior approval is impossible, or is a situation where doing so could seriously jeopardize the individual's life or health, the benefit cannot be denied for lack of prior approval.*

If your claim is a pre-service claim and is submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you file a pre-service claim improperly, the Claims Administrator will notify you of the improper filing, and how to correct it, within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and, once notified of the extension, you then have 45 days to provide this information.

The Claims Administrator may request a one-time extension not longer than 15 days, and they may pend your claim until all information is received. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 days period, your claim will be denied.

First-level Appeal for Pre-Service Claim

If your claim is denied, you will have up to 180 days after you receive a claim-denial notice to file a first-level appeal with the Claims Administrator. Before filing a first-level appeal, you may informally ask your Claims Administrator's customer service representative why your claim was denied. However, calling a customer service representative will not extend the 180-day period to file a first-level appeal; your first-level appeal must be filed within 180 days after you receive your claim-denial notice.

Your first-level appeal must be in writing and should include:

- The claim number, a copy of denial notification, or a copy of the Explanation of Benefits;
- The item of medical coverage that you believe was misinterpreted or inaccurately applied; and
- Any comments, documents, and other information from the provider (or any other source) that support your appeal, such as medical and/or financial records.

You have a right to receive, upon request and free of charge, access to, and copies of all documents, records, and other information relevant to your claim.

Your written letter of appeal should be mailed to your Claims Administrator, as noted

previously in this document.

If you do not file your request for appeal by the end of the 180-day period described above, your appeal will be automatically denied—even if you contact a customer service representative before the end of the 180-day period.

All of the information that you submit with your first-level appeal, including any information that was not submitted with your initial claim, will be considered by a qualified individual who did not review your initial claim (and who is not a subordinate of any individual who reviewed your initial claim). If the decision is based in whole or in part on a medical judgment, the individual reviewing the claim will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The healthcare professional who is consulted will not be an individual (or a subordinate of the individual) who was consulted in the review of your initial claim.

The Claims Administrator will notify you in writing of its decision, within 15 days after it receives your appeal. If the appeal is denied, you will be notified in writing or electronically. The notice will include the following information:

- An explanation of the specific reason(s) for the denial;
- Specific references to pertinent Plan provisions on which the denial 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.
- An explanation of the steps to file a second-level appeal, including the time limits, and a statement of your right to bring a lawsuit under Section 502(a) of ERISA;
- If the denial is based on an internal rule, guideline, protocol, or othersimilar criterion, a copy of that rule, guideline, protocol, or other criterion or a statement that you may receive a copy, free of charge, upon request; and
- If the denial is based on a scientific or clinical judgment (for example, a decision that a treatment is not covered because it was not medically necessary or because it was experimental), an explanation of the scientific or clinical judgment.

If you have not received a decision on your claim within the time period described above, you should consider your claim to have been denied. You may (1) contact the Claims Administrator for this Plan to ask for confirmation that your claim has been denied, (2) appeal the denial as described below, or (3) bring a lawsuit under section 502(a) of ERISA.

Second-level Appeal for Pre-Service Claim

If your first-level appeal is denied, you may appeal that decision, within 60 days from the date of the denial.

Before filing a second-level appeal, you may informally ask the Claims Administrator why your first-level appeal was denied. However, calling the Claims Administrator or their customer service representative will not extend the 60-day period to file a second-level appeal.

Your second-level appeal must be in writing and should include:

- The claim number and a copy of the first-level appeal denial notification;
- The item of medical coverage that you believe was misinterpreted or inaccurately applied; and
- Any comments, documents, and other information from the provider (or any other source) that support your appeal, such as medical and/or financial records.

You have a right to receive, upon request and free of charge, access to, and copies of all documents, records, and other information relevant to your claim. Your written request for a second-level appeal should be mailed to Textron at the address noted previously in this document.

If you do not file your request for appeal by the end of the 60-day time period described above, your appeal will be automatically denied unless you demonstrate circumstances that make it unfair to enforce the 60-day time period.

All of the information that you submit with your second-level appeal, including any information that was not submitted with your initial claim or first-level appeal, will be considered by a qualified individual who did not review your initial claim or first-level appeal (and who is not a subordinate of those reviewers). If the decision is based in whole or in part on a medical judgment, the individual reviewing the claim will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The healthcare professional who is consulted will not be an individual (or a subordinate of the individual) who was consulted in the review of your initial claim or first-level appeal.

Textron will notify you in writing of its decision, within 15 days after it receives your appeal. The decision on a second-level appeal is final. If the second-level appeal is denied, the notice will include the following information:

- An explanation of the specific reason(s) for the denial;
- Specific references to pertinent Plan provisions on which the denial 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.
- A statement of your right to bring a civil action under Section 502(a) of ERISA;
- If the denial is based on an internal rule, guideline, protocol, or other similar

criterion, a copy of that rule, guideline, protocol, or other criterion or a statement that you may receive a copy, free of charge, upon request;

- If the denial is based on a scientific or clinical judgment (for example, a decision that a treatment is not covered because it was not medically necessary or because it was experimental), an explanation of the scientific or clinical judgment; and
- The statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."

If you have not received a decision on your second-level appeal within the time period described above, you should consider your second-level appeal to have been denied. You may contact the Textron Human Resources Service Center or Textron to ask for confirmation that your claim has been denied or you may bring a lawsuit under section 502(a) of ERISA.

Urgent Care Claim

An urgent care claim is a claim for medical care or treatment that, if you do not receive it within a narrow window of time, you could (a) seriously jeopardize your life or health or your ability to regain maximum function, or (b) cause yourself severe pain, which (in the opinion of a physician who knows your health condition) could not be managed without the requested services. Accordingly, the Claims Administrator's physician reviewer must make, in consultation with the treating physician, a determination of benefits on an expedited basis.

Initial Claim for Urgent Care

The Claims Administrator must notify you (or your representative) if your claim is denied or approved within 72 hours of their receiving the request for benefits. However, if they require you to submit additional information, they must request this within the first 24 hours, and you must provide it within the next 48 hours. Then, the Claims Administrator must notify you within 48 hours after receiving the additional information or the end of the 48-hour period, whichever occurs first.

If your claim is denied, by law you have up to 180 days after receiving the notice of denial to file an appeal with the Plan Administrator (i.e., Textron). However, if you wish, you may submit a request for an expedited appeal orally or in writing. If you request an expedited appeal, all necessary information will be transmitted between you and the Plan Administrator by rapid methods of communication such as telephone, facsimile or email. You will be notified of the Plan Administrator's decision as soon as possible, taking into account your medical situation, but no later than 72 hours after the Plan Administrator receives your request for an expedited appeal.

Note: Only this one level of appeal is permitted, and there are no provisions for extension.

Notice and Disclosure Requirements

The Claims Administrator may provide an expedited determination orally as long as it also follows this by written or electronic notification within three days.

Concurrent Care Claim

A concurrent care claim is one that arises when the Claims Administrator has previously approved an ongoing course of treatment that is to be provided over a period of time (or number of treatments) and then the Claims Administrator subsequently reduces or terminates benefits before the end of the period of time (or number of treatments).

If the Claims Administrator subsequently reduces or terminates benefits before the end of the approved period of time (or number of treatments), the Claims Administrator's action is considered an "adverse benefit determination" (unless it is the result of a Plan amendment or termination). The Claims Administrator must notify you before the reduction or termination of the approved course of treatment becomes effective, allowing you time to make an appeal and obtain a determination on review before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you ask to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

A concurrent care claim can also include any request involving urgent care that extends a course of treatment beyond the period of time (or number of treatments) originally approved.

The Claims Administrator must decide a concurrent care claim involving urgent care within 24 hours, provided the claim is received at least 24 hours prior to the expiration of the approved treatment.

Federal External Review Program

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

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

- medical judgment or clinical reasons;
- the exclusions for Experimental or Investigational Service(s) or Unproven Service(s);
- rescission of coverage (coverage that was cancelled or discontinued)

retroactively); or

- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received the Claims Administrator's decision.

An external review request should include all of the following:

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

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

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

Standard External Review

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

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

Within five business days after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- the adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

Within one business day after the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request

is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification should describe the information or materials needed to make the request complete, and you will have at least 48 hours (or, if longer, until the end of the four-month filing period) to complete the request. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review. The Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. Within 5 business days after the date of assignment of the IRO, the Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination. The documents include:

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

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

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

Expedited External Review

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

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

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

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets the following requirements:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- the adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

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

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

You may contact the Claims Administrator at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

**UnitedHealthcare Appeals
ATTN: External Review Process
PO Box 740810
Atlanta, GA 30374-0810**

Late Enrollment Appeal Procedures

Although the Plan does not allow late enrollees, Textron recognizes that there may be *rare* occasions where extraordinary circumstances occur that are beyond your control, which prevent you from enrolling by the enrollment deadline. In these circumstances, you may file a *written* appeal requesting late enrollment, provided you can adequately support the existence of such extraordinary circumstances that prevented you from enrolling by the published deadline.

To be considered a valid appeal, your appeal must meet *all* of the following conditions:

- The appeal must be written.
- The appeal must be submitted by you or your duly authorized representative to the address below:

**Textron Inc.
Benefits Strategy & Compliance Department
40 Westminster Street
Providence, RI 02903**

or you may Fax to: (401) 457-2593

- The appeal must be submitted to Textron within **30 days** of the enrollment deadline.
- The appeal must clearly demonstrate that the circumstances preventing you from enrolling by the published enrollment deadline were *extraordinary* and beyond your control (i.e., you must demonstrate that they were the result of an administrative error or process breakdown on the part of Textron, including Textron's HR Service Center and the Textron Human Resources Service Center); supporting documentation is highly recommended and critical in order to succeed on appeal. Approving or denying an appeal is the sole discretion of the Plan Administrator.

Please note that the enrollment deadlines are required under federal tax laws. Accordingly, approval of a claim related to a missed deadline is very rare.

Timing of Review on Appeal

Textron will advise you of its decision within a reasonable period, but not later than **60 days** after receipt of your written appeal/request for late enrollment. This period may be extended for up to another 60 days if Textron determines that special

circumstances require an extension of time for an adequate and thorough review of the appeal. In such case, you will be notified in writing before the end of the initial day period that an extension is necessary and by what date a decision is expected.

The period for reviewing and making a decision on the appeal shall begin when the appeal is filed in accordance with the procedures outlined above, without regard to whether all the information necessary to make the requested determination on appeal accompanies the filing. However, if the period for deciding the appeal is extended due to your failure to submit the information necessary to decide the claim, the period for making the determination on review shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Upon completing its review, Textron will notify you, in writing, of its decision. The written decision will include:

- A summary of the review and follow-up conducted by Textron in reviewing your appeal;
- Textron's decision, including the specific reason(s) for Textron's decision;
- Citations of the pertinent provisions of the Plan on which the approval or denial is based;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal for late enrollment; and
- A statement on the finality of Textron's decision—Textron's decision on late enrollment appeals shall be considered final.

Note: *The appeal process for late enrollment requests is a **one-level** appeal process; late enrollment appeals are reviewed only by Textron, and its decision is final. If your appeal is denied, you will not be allowed to submit a second-level appeal; however, you may submit an amended appeal within 30 days of the original appeal denial, if there is new information available that would have impacted Textron's decision had it been available and included with your original appeal. It is in Textron's sole discretion to consider the pertinence and relevance of any additional information presented to substantiate the amended appeal. Upon completion of this review, Textron's decision is final and there will be no further review of the appeal.*

Leaves of Absence

There are two different provisions under which you can take a leave of absence. Information regarding these two provisions, eligibility and your benefits during a leave of absence is explained below.

Your Rights Under the Uniformed Services Employment and Reemployment Act (USERRA)

If you voluntarily or involuntarily serve in the uniformed services, you and your covered dependents will have special rights under the Plan.

You are eligible for the special rights only if you serve in the uniformed services performing any of the services listed below, and you or an authorized officer of your branch of the uniformed services notify your employer as far in advance as practical. In general, at least 30 days' advance notice is requested. However, less notice might be acceptable if you are unable to provide 30 days' notice. Also, the notice requirement might be waived in case of certain emergencies.

In general, the uniformed services include the following:

- The Armed Forces (including the Reserve components);
- The Army National Guard and the Air National Guard;
- The commissioned corps of the Public Health Service;
- Service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System;
- Enrollment in a military service academy (i.e., the Army Academy in West Point, NY; the Naval Academy in Annapolis, MD; the Air Force Academy in Colorado Springs, CO; and the Coast Guard Academy in New London, CT); and
- Any category designated by the President of the United States as a uniformed service.

In general, uniformed services *do not* include service or membership in:

- A state National Guard or another state military organization,
- ROTC,
- The Commissioned Corps of the National Oceanic and Atmospheric Administration,
- The Civil Air Patrol, or
- The Coast Guard Auxiliary.

To be eligible for the special rights, your work for the uniformed services generally must fall into one of the following categories:

- Active duty,

- Active duty for training,
- Initial active duty for training,
- Inactive duty training,
- Taking tests or completing exercises needed to determine your fitness for duty in the uniformed service, and
- Under certain circumstances, performing funeral honors duty.

If you meet the conditions described above, and you are on a paid military leave of absence, your benefits are continued at active rates for 6 months. At the end of the 6 month period, you and your dependents would be de-enrolled from benefits and offered COBRA for up to 30 months (or until you stop serving in the uniformed services, if earlier). If your leave to serve in the uniformed services is for less than 31 days, you may continue your coverage by paying the premiums you would be required to pay if you had not been on leave. After the first 30 days, you will continue to pay the active employee premium rate just as you would under any other paid leave.

Contact the Human Resources Service Center for information about how long your coverage would continue at the active employee rates while out on paid military leave. Once you have reached the end of that period, COBRA coverage will be offered to you. The cost of COBRA requires you to pay for the full cost of coverage (your share and your employer's share) plus a 2% administrative fee. **If you do not pay your required premium, your coverage will end.**

You and your dependents may also be eligible to continue medical coverage under COBRA while you are on a military leave of absence. **Continuation coverage under COBRA and USERRA will run concurrently.**

If you return to your old job after serving in the uniformed services for five years or less, and you are not discharged from the uniformed services under dishonorable conditions, you may be reinstated in the Plan, generally without any waiting period or exclusion. However, there may be limitations on coverage for service-related illnesses or injuries.

For additional information about special rights under USERRA, please contact the Textron Human Resources Services Center.

Family and Medical Leave Act of 1993 (FMLA)

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

Continuation of Health Coverage During Leave of Absence

Depending on your situation, you may be eligible to continue participating in the Plan during a leave or disability.

Your health coverage (medical, dental, vision and prescription drug) will be continued

during a leave of absence for up to 12 weeks in the applicable 12-month period, if:

- That leave qualifies as a leave of absence under the FMLA, and
- You're an eligible employee under the terms of the FMLA.

In addition, you may be able to take up to 26 weeks of unpaid leave during a 12-month period to care for a service member under certain circumstances.

If you are on a leave of absence covered by the FMLA, you may continue to participate in and receive coverage under the Plan during the leave if the following two conditions are met:

- Your leave has been approved in writing by the employer; and
- You pay the required contributions for the cost of your coverage (as applicable to your business unit) when due.

While on your approved leave, the regular employee portion of the cost of your health coverage will be held in arrears. Once you return from leave to active service, the accrued regular employee portion of the cost of our health coverage will be deducted from your paycheck at a rate of 1.5 X your normal deductions until the amount in arrears is recovered.

You may continue to participate in the Plan until the end of the leave period required by the FMLA. If you cancel your coverage while you are on an approved FMLA leave and you return to work as an eligible employee after your approved leave of absence, you can restore coverage as an employee.

Coverage will be restored as soon as you return to work for one full day.

If you do not return to work following an approved FMLA leave, you (and your spouse and dependent children, if any) may be eligible for COBRA continuation coverage as of the date your employment terminates, even if you did not elect to continue coverage under FMLA or if you ceased participation in the Plan during an approved FMLA leave. Please call your Textron Human Resources Service Center, toll-free, at 1- 866-MY-TXT-HR (1-866-698-9847) for details.

Under the National Defense Authorization Act (NDAA), eligible employees may take up to 12 weeks of job-protected leave in the applicable 12-month period for any "qualifying exigency" arising out of the active duty or call to active duty status of a spouse, son, daughter, or parent. Employees may take up to 26 weeks of job-protected leave in a single 12-month period to care for a covered service member with a serious injury or illness.

Reinstatement of Canceled Coverage After Leave of Absence When you return to work after your FMLA leave, any canceled coverage will be reinstated as soon as you return to work for one full day.

You will not be required to satisfy any eligibility or benefit waiting period if you had met them before your leave began.

Upon request, Textron will give you detailed information about the FMLA and its effect on your benefits.

Continuing Coverage Under COBRA

Introduction

This section of the SPD has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage, such as the Health Insurance Marketplace noted below.

COBRA Continued Healthcare Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. Under COBRA, you and your dependents may be eligible to extend group healthcare benefits under the Plan for a certain period of time. COBRA can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the COBRA Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan). For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov or call 1-800-318-2596.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. To continue coverage, you or your covered dependents ordinarily must pay the full cost of that coverage (your share and your employer's share) plus a 2% administrative fee, if applicable. In certain situations, however, your employer pays part of the cost of continued coverage. Please see contact the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847) for information about the cost of COBRA continuation coverage in your situation.

Qualifying Events

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct,
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both),
- The parents become divorced or legally separated, or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Note: *A child born to, adopted by, or placed for adoption with the parent-employee during the period of COBRA coverage would also be a qualified beneficiary.*

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Textron, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

COBRA Notification and Election: When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Textron Human Resources Service Center and the COBRA Administrator have been notified that a qualifying event has occurred. The employer must notify the Plan Administrator **within 30 days** of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you *must* notify the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847) within 60 days after the qualifying event occurs. You must follow the procedures specified in the *Notice Procedures for Notice of Qualifying Event* section.

How is COBRA continuation coverage provided?

Once the Textron Human Resources Service Center is notified that a qualifying event has occurred, they will notify the COBRA Administrator who, in turn, will notify you, your spouse and/or dependent (s) of your (their) right(s) to elect and purchase COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children.

Once you receive notification from the COBRA Administrator of your right to elect and purchase COBRA continuation coverage, you must notify them that you want to elect COBRA continuation coverage, within 60 days of the later of:

- The date your coverage ends, or
- The date that you are notified of your right to COBRA continuation coverage.

Note: *When determining whether to elect COBRA continuation coverage, the following apply:*

- You do not have to show that you are insurable to elect COBRA continuation coverage.
- If you elect COBRA continuation coverage, Textron is required to allow you to purchase coverage that is identical to the coverage being provided under the Plan to similarly situated active employees or family members. If coverage under the Plan is modified for such similarly situated individuals, your coverage will also be modified.

- If you are Medicare-eligible, the Plan will pay secondary to Medicare, as described in the ***Coordination of Your Plan with Medicare*** section.
- For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

Length of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. The continuation coverage period that you, your covered spouse, and any dependent children will be entitled to depend on the type of qualifying event, as illustrated and explained in the chart below.

Length of COBRA Coverage

Qualifying Event	Maximum COBRA Continuation Period
Termination of employment (other than for gross misconduct)	Up to 18 months*
Reduction in hours of employment*	Up to 18 months*
Death of employee	Up to 36 months
Divorce or legal separation	Up to 36 months
Employee's entitlement to Medicare	Up to 36 months
Dependent child ceasing to be a dependent under the plan	Up to 36 months

*If you (employee) became entitled to Medicare within 18 months before the date of your qualifying event (i.e., termination of employment or reduction in hours of employment), your spouse and any dependent children are entitled to elect COBRA continuation coverage for up to the **greater of**:

- 36 months from the date of Medicare entitlement, or
- 18 months from the date of the (employee's) qualifying event.

For example: If a covered employee becomes entitled to Medicare 8 months before the date on which his employment ends, COBRA coverage (under the Plan) for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

There are two ways in which an 18-month period of COBRA continuation coverage (which would follow a termination of employment or reduction in hours of employment) can be extended:

- If a qualified beneficiary is disabled; or
- A secondary qualifying event occurs.

Further information on these two types of extensions and the related notice procedures for them is provided in the ***Extension of 18-Month Period of Continuation Coverage Due to Disability*** and ***Extension of 18-Month Period of Continuation Coverage for Second Qualifying Event*** sections.

Extension of 18-Month Period of Continuation Coverage Due to Disability

If the qualifying event for COBRA continuation coverage was a termination or reduction in hours of employment, and if you or anyone in your family covered under the Plan is determined to be disabled by the Social Security Administration within 60 days of the COBRA continuation period, you and your entire family may be entitled to have the 18-month COBRA continuation period extended up to an additional 11 months, for a total maximum of 29 months. To qualify for this extension, the disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Additionally, you must follow the proper notice procedures, as outlined below.

Notice Procedures

You must provide notice of disability **within 60 days of the latest of:**

- The date of the Social Security Administration's disability determination,
- The date of the covered employee's termination of employment or reduction in hours, or
- The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction in hours, **and**
- Prior to the end of the 18-month COBRA continuation period (following the covered employee's termination of employment or reduction in hours).

You must notify the COBRA Administrator of the disability determination, either in writing or by telephone (address and phone number are provided under both the General Notice Procedures section and in the ***Contact Information*** section). Your notice must include the information outlined below:

- The name of the Plan;
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA coverage (the covered

- employee's termination of employment or reduction in hours);
- The date that the covered employee's termination of employment or reduction in hours happened;
 - The name(s) and address(es) of all qualified beneficiary (ies) who lost coverage due to the termination or reduction in hours and who are receiving COBRA coverage at the time of the notice;
 - The name and address of the disabled;
 - The date that the qualified beneficiary became disabled;
 - The date that the Social Security Administration made its determination of disability;
 - A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
 - The signature, name and contact information of the individual sending the notice.

You may be asked to provide the COBRA Administrator with a copy of the Social Security Administration's determination of disability.

Extension for 18-Month Period of Continuation Coverage for Second Qualifying Event

If you are, or if a member of your family is, a qualified beneficiary as a result of a termination or reduction in hours of employment, and your family experiences another qualifying event (as noted below) during the 18 months of COBRA continuation coverage, the 18-month COBRA continuation period may be extended up to an additional 18 months, for a total maximum of 36 months. This extension is available to a qualified beneficiary who is the spouse or a dependent child receiving continuation coverage if:

- The employee or former employee dies,
- The employee becomes entitled to Medicare benefits,
- The employee becomes divorced or legally separated, or
- The dependent child stops being eligible under the Plan as a dependent child, **or**
- If the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event **not** occurred.

Additionally, you must follow the proper notice procedures, as outlined below.

Notice Procedures

You must provide this notice within 60 days of the later of:

- The date of the second qualifying event (i.e., divorce or legal separation, the covered employee's death or entitlement to Medicare benefits, or a child's loss of dependent status); or
- The date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event

had occurred while the qualified beneficiary was still covered under the Plan).

You must notify the COBRA Administrator of a second qualifying event (i.e., divorce or legal separation, the covered employee's death or entitlement to Medicare benefits, or a child's loss of dependent status), either in writing or by telephone.

Your notice must include the information outlined below:

- The name of the Plan;
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction in hours);
- The date that the covered employee's termination of employment or reduction in hours happened;
- The name(s) and address(es) of all qualified beneficiary (ies) who lost coverage due to the termination or reduction in hours and who are receiving COBRA coverage at the time of the notice;
- The second qualifying event (a divorce or legal separation, the covered employee's death or eligibility for Medicare benefits, or a child's loss of dependent status);
- The date that the divorce or legal separation, the covered employee's death or eligibility for Medicare benefits, or a child's loss of dependent status happened; and
- The signature, name and contact information of the individual sending the notice.

You may also be asked to provide the COBRA Administrator with the appropriate documentation, as outlined in the chart below, to determine whether you gave timely notice of the second qualifying event—and, therefore, are entitled to an extension of COBRA coverage.

Documentation

Qualifying Event	Documentation to Be Provided to COBRA Administrator
Death of employee	If requested by the COBRA Administrator, you must provide documentation of the date of death that is satisfactory to the COBRA administrator, such as a death certificate or obituary.
Divorce or legal separation	You must include a copy of decree of divorce or legal separation.
Employee's entitlement to Medicare	If requested by the COBRA Administrator, you must provide documentation to support the date employee became entitled to Medicare.
Dependent child ceasing to be a dependent under the Plan	If requested by the COBRA Administrator, you must provide documentation of the date of the qualifying event that is satisfactory to the COBRA Administrator, such as a birth certificate to establish the date that a child reached the limiting age.

Notice Procedure for Notice of a Qualifying Event: Divorce, Legal Separation or Child's Loss of Dependent Status

If you are a qualified beneficiary as a result of a divorce, legal separation or child's loss of dependent status, you will be eligible to receive COBRA continuation coverage for a 36 month period provided that you elect the coverage and follow the proper notice procedures, as outlined below.

Notice Procedures

You must provide this notice **within 60 days of the later of:**

- The date of the qualifying event (i.e., divorce, legal separation or a child's loss of dependent status); or
- The date on which the qualified beneficiary (i.e., covered spouse or dependent child) loses (or would lose) coverage under the Plan as a result of the qualifying event.

You must notify the Textron Human Resources Service Center of the qualifying event (i.e., divorce or legal separation, or a child’s loss of dependent status) by contacting the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847) and providing the information outlined below.

- The name of the Plan;
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction in hours and who are receiving COBRA coverage at the time of the notice;
- The qualifying event (a divorce or legal separation, the covered employee’s death or eligibility for Medicare benefits, or a child’s loss of dependent status);
- The date that the divorce, legal separation or a child’s loss of dependent status happened; and
- The signature, name and contact information of the individual sending the notice.

Additionally, you may be asked to provide the COBRA Administrator with the appropriate documentation (as outlined in the chart below) to determine if you gave timely notice of the qualifying event.

Documentation

Qualifying Event	Documentation to Be Provided to COBRA Administrator
Divorce or legal separation	<p>You must include a copy of decree of divorce or legal separation.</p> <p>Note: <i>This will allow the COBRA Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA.</i></p>
Dependent child ceasing to be a dependent under the Plan	<p>If requested by the COBRA Administrator, you must provide documentation of the date of the qualifying event that is satisfactory to the COBRA Administrator, such as a birth certificate to establish the date that a child reached the limiting age.</p> <p>Note: <i>This will allow the COBRA Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA.</i></p>

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying the COBRA Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation, in accordance with these Notice Procedures. You must also provide evidence satisfactory to the COBRA Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

COBRA continuation coverage, if any, will begin on the date of the divorce or legal separation, not the date that your coverage is reduced or eliminated.

Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

As a qualified beneficiary who has elected COBRA continuation coverage under the Plan, you should notify the Plan's COBRA Administrator when any one of the events outlined in the chart below occurs.

Note: When one of these events occurs, your COBRA continuation coverage under the Plan will terminate (retroactively if applicable) effective with the date of the event, regardless of whether or when you provide the notice to COBRA Administrator.

Event	When to Notify COBRA	Notice to Be Provided (Including Contents)
As a qualified beneficiary, you become covered under other group health plan coverage (after you elected COBRA coverage under Textron's Plan).	You must provide notice within 30 days of the other coverage becoming effective.	Notice of Other Coverage* <i>Notice should also include:</i> <ul style="list-style-type: none"> • Name and address of the qualified beneficiary who obtained other coverage; • Date that the other coverage became effective; and • Evidence of the effective date of the other coverage (such as a copy of insurance card or application for coverage).
As a qualified beneficiary, you become entitled to Medicare (after you elected COBRA coverage under Textron's Plan).	You must provide notice within 30 days of becoming entitled to Medicare coverage (as shown on the Medicare card).	Notice of Medicare Entitlement* <i>Notice should also include:</i> <ul style="list-style-type: none"> • Name and address of the qualified beneficiary who became entitled to Medicare, • Date that the Medicare entitlement occurred, and • A copy of Medicare card showing date of Medicare entitlement.

Event	When to Notify COBRA Administrator	Notice to Be Provided (Including Contents)
As a disabled qualified beneficiary (whose disability resulted in an extended COBRA coverage period), Social Security Administration has determined that you are no longer disabled.	You must provide notice within 30 days after the date of the Social Security Administration's determination.	Notice of Cessation of Disability* <i>Notice should also include:</i> <ul style="list-style-type: none"> • Name and address of the disabled qualified beneficiary, • Date of the Social Security Administration's determination that you are no longer disabled, and • Copy of the Social Security Administration's determination.

***Notice Procedures**

Your notice should contain the following information:

- The name of the Plan;
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies);
- The qualifying event that started your COBRA coverage;
- The date that the qualifying event happened; and
- The signature, name and contact information of the individual sending the notice.

General Notice Procedures Applicable to Notice of Disability, Notice of Second Qualifying Event, Notice of a Qualifying Event, and Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

You must mail or hand-deliver any of the above notices to the COBRA Administrator at the following address depending on the date you begin or receive notification of your COBRA rights.

The COBRA Administrator is Fidelity. Please note the address below for Fidelity COBRA Services.

**Textron Human Resources Service Center
P.O. Box 770001
Cincinnati, OH 45277-0020
Phone: 1-866-698-9847**

**Monday – Friday (excluding NY Stock Exchange holidays)
between 8:30 a.m. and 8:30 p.m., Eastern Time**

If your notice does not contain all of the above required information, the incomplete notice may be rejected and COBRA or any COBRA extension will not be offered.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries:

- Who either lost coverage due to the qualifying event described in the notice,
- Who may be entitled to an extension of the maximum COBRA coverage period, or
- With respect to other coverage, Medicare entitlement or cessation of disability reported in the notice.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- The date coverage ends for failure to make the first required premium (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Cost of COBRA Continuation Coverage

As allowed by federal law, you have to pay 102% of the applicable premium for your COBRA continuation coverage. This includes the full cost of coverage plus a 2% administration fee. However, the cost of the 11-month disability extension will be 150% of the applicable premium if the disabled qualified beneficiary is covered, or 102% of the applicable premiums if only non-disabled qualified beneficiaries are covered.

At the end of the COBRA continuation period, you may be eligible to enroll in an individual conversion health plan, subject to Textron health plan rules.

Reporting Address Changes

To protect your rights and your family's rights, you should keep the appropriate parties informed of any changes in address, as follows:

- **Employee address:** If your address changes, you should notify the Textron Benefits Service Center.*
- **Dependent address:** If your spouse's or dependent's address changes (to an address other than your address), contact the Textron Human Resources Service Center as shown below.*

*If you are a qualified beneficiary receiving COBRA benefits, you must report any address changes directly to the COBRA Administrator, Fidelity, at 1-866-MY-TXT-HR (1-866-698-9847). In addition, if you have a vested pension benefit or a savings plan account, then you must also report any changes directly to Fidelity.

You should also keep a copy for your records of any notices you send to the Textron Human Resources Service Center or to the Plan and/or COBRA Administrator.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Whom to Contact With Questions About the Plan or Your COBRA Coverage Rights

If you are an active employee (including an employee on a leave of absence) or a retiree under the Plan, please contact the Textron Human Resources Service Center at:

**Textron Human Resources Service Center
P.O. Box 770001
Cincinnati, OH 45277-0020
Phone: 1-866-698-9847**

**Monday – Friday (excluding NY Stock Exchange holidays)
between 8:30 a.m. and 8:30 p.m., Eastern Time**

The contact information for the Plan may change from time to time. Generally, the most recent information will be included in the Plan's most recent SPD. (If you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Plan Administrator.)

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Health Coverage Tax Credit

The Trade Act of 2002 created a tax credit that expired in 2013 but was extended and modified by the Trade Preferences Extension Act of 2015. Under the current law, which applies through 2020, certain individuals who become eligible for trade adjustment assistance or are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals) are eligible for a tax credit to help defray the cost of COBRA coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/ and [Health Coverage Tax Credit, https://www.irs.gov/credits-deductions/individuals/hctc](https://www.irs.gov/credits-deductions/individuals/hctc).

Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Continuation Coverage

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the COBRA Administrator using the Plan contact information provided above. Contact the COBRA Administrator promptly after qualifying for TAA or ATAA or you may lose the right to elect COBRA during a special second election period.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. References to “you” or “your” in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the 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; and

- 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 for expenses you incur for an illness, injury, or condition 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:
 - o 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;
 - o providing any relevant information requested by the Plan;
 - o signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
 - o responding to requests for information about any accident or injuries;
 - o making court appearances;
 - o obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
 - o complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited

- to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
 - Benefits paid by the Plan may also be considered to be benefits advanced.
 - If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
 - By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
 - The Plan's rights to recovery will not be reduced due to your own negligence.
 - By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily..
 - The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits 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 a 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 participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan 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 Plan year (which is the calendar year).
- benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of 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; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Administrative Information

Textron Inc. provides the benefits described in this summary plan description and has discretionary authority to determine eligibility for Plan benefits, to construe the terms of the Plan(s) and to decide all questions arising in the administration of the Plan(s). The "Plan" refers to the Textron Non-Bargained Medical Plan and the Textron Bargained Medical Plan for certain employees, and the Textron Retiree Benefits Plan for certain retirees.

Plan Sponsor and Administrator

The Plan Administrator has discretionary authority to interpret Plan provisions, construe unclear terms, determine eligibility for benefits and otherwise make all decisions and determinations regarding Plan administration. By participating in the Plan, you (and your dependents or beneficiaries, if any) agree to accept the Plan Administrator's authority. You can contact the Plan Administrator (which is also the Plan Sponsor) as follows:

Textron Inc.
Benefits Strategy & Compliance Department
40 Westminster Street
Providence, RI 02903
(401) 421-2800

The Plan Administrator or any plan fiduciary may engage attorneys, accountants, actuaries, consultants, and others to advise it on issues related to the Plan. When it does so, the adviser's client is the Plan Administrator or plan fiduciary and not any participant or beneficiary under the Plan. Communications between an attorney and a client are "privileged," which means that they may not be disclosed to third parties unless the client waives the privilege. The Plan Administrator intends and expects to preserve this attorney-client privilege, and all other rights to maintain confidentiality, to the full extent permitted by law. No participant or beneficiary will be permitted to review any communication between the Plan Administrator or plan fiduciary (including any representative or agent of the Plan Administrator or plan fiduciary) and any of its attorneys or other advisers with respect to whom a privilege applies, unless mandated by a court order.

Claims Administrator

Textron has delegated authority to third party administrators to administer certain benefit claims. The Claims Administrator for your benefit is UnitedHealthcare. Subject to Textron's overall authority as Plan Administrator, the Claims Administrator has discretionary authority to interpret Plan provisions and determine benefit claims.

Employer Identification Number

Textron Inc.'s employer identification number, assigned by the IRS, is 05-0315468.

Type of Plan and Plan Number

The Textron Non-Bargained Medical Plan, the Textron Bargained Medical Plan, and the Textron Retiree Benefits Plan are ERISA group health plans that provide health and welfare benefits. The Textron Non-Bargained Medical Plan identification number is 525, the Textron Bargained Medical Plan identification number is 526, and the Textron Retiree Benefits Plan identification number is 528.

Plan Year

The Plan Year is the year by which the Plan's fiscal records are kept. The Plan Year is the calendar year.

Type of Administration

The type of administration associated with this Plan is as listed elsewhere in this document.

Agent for Legal Process

If you wish to file suit, legal papers may be served on your Claims Administrator at the address listed elsewhere in this document or on the Plan Administrator at the address above.

Amendments to the Plan and Termination of Coverage

Textron (including its divisions or subsidiaries) intends to continue this Plan, but it reserves to itself or its designee the right to change or terminate the Plan or any of the Plan benefits at any time to the extent permitted by law. This can occur without the consent of, and without prior notice to, any active or retired person, eligible dependent or beneficiary covered by these benefits. Any amendments or termination will be communicated in writing.

Collective Bargaining Agreements

This Plan is administered in consideration of the terms of multiple collective bargaining agreements. A copy of these agreements may be obtained upon written request to the Plan Administrator and is available for examination by participants and their beneficiaries. Notwithstanding anything contained herein to the contrary, Textron will comply with the requirements of a specific bargaining agreement or regulation, if applicable.

Overpayment and Underpayment of Benefits

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

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

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the benefits under the Plan.
- All or some of the payment was made in error.

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits for the Covered Person that are payable under the Plan; or (ii) future benefits that are payable to other Covered Persons under the Plan. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

The following Notice of Privacy Practices explains the federal HIPAA regulations regarding your personal healthcare information. We are required to provide this information to you and strongly recommend that you take a few minutes to review.

Review and Determination of Benefits in Accordance with the Claims Administrator's Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings the Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of the Claims Administrator's reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting the Claims Administrator at **myuhc.com** or the telephone number on your ID card.

The Claims Administrator may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

"We" refers to the Textron Non-Bargained Medical Plan, Textron Bargained Medical Plan, Textron Non-Bargained Welfare Benefits Plan, Textron Bargained Welfare Benefits Plan, the Textron Flexible Spending Account Plan, and the Textron Retiree Benefits Plan, which are referred to collectively and individually in this Notice of Privacy Practices as the "Plan." "You" or "yours" refers to the individual participants in the Plan. If you are covered by an insured health option under the Plan you will receive a separate notice from the insurer or Health Maintenance Organization (HMO.)

Use and Disclosure of Protected Health Information

We are required by federal law to protect the privacy of your personal health information (referred to in this notice as Protected Health Information or (PHI)). We are also required to provide you with this notice regarding our legal duties, privacy practices, policies, and procedures regarding your Protected Health Information (PHI), and to abide by the terms of this notice, as it may be updated from time to time.

Under applicable law, we are permitted to make certain types of uses and disclosures of your PHI, without your authorization, for treatment, payment, and healthcare operations purposes.

The Plan's Rights

For treatment purposes, such use and disclosure may take place in providing, coordinating or managing healthcare and its related services by one or more of your providers, such as when your primary care physician consults with a specialist regarding your condition.

For payment purposes, such use and disclosure may take place to determine responsibility for coverage and benefits, such as when we confer with other health plans to resolve a coordination of benefits issue. We also may use your PHI for other payment-related purposes, such as to assist in making Plan eligibility and coverage determinations, or for utilization review activities.

For healthcare operations purposes, such use and disclosure may take place in a number of ways involving Plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support us, or we may contact you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Plan.

We may disclose your PHI to the Plan Sponsor in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose PHI to

the Plan Sponsor in connection with payment, treatment, or healthcare operations.

In addition, we may use or disclose your PHI without your authorization under conditions specified in federal regulations, including:

- As required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
- For public health activities;
- Disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence;
- To a health oversight agency for oversight activities authorized by law;
- In connection with judicial and administrative proceedings;
- To a law enforcement official for law enforcement purposes;
- To a coroner or medical examiner;
- To cadaveric organ, eye or tissue donation programs;
- For research purposes, as long as certain privacy-related standards are satisfied;
- To avert a serious threat to health or safety;
- For specialized government functions (e.g., military and veteran activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations); and
- For Workers' Compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

We may disclose to one of your family members, to a relative, to a close personal friend or to any other person identified by you PHI that is directly relevant to the person's involvement with your care, or payment related to your care. In addition, we may use or disclose the PHI to notify a member of your family, your personal representative, another person responsible for your care or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, if there is an emergency, or if you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and we will disclose only the information that is directly relevant to the person's involvement with your healthcare.

Uses and Disclosures Requiring Your Authorization

Your authorization is required for (1) uses and disclosures of PHI for marketing purposes, (2) disclosures that constitute a sale of PHI, and (3) most uses and

disclosures of psychotherapy notes (which the Plan rarely, if ever, receives). You may revoke your authorization in writing for these uses and disclosures at any time, but the revocation will not affect any disclosure made prior to the receipt of the revocation.

Your Rights

Uses and disclosures for purposes other than those described above in the section entitled "The Plan's Rights" will be made only with your written authorization, and you may revoke your authorization in writing at any time, except to the extent that we have taken action in reliance on your authorization.

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment, or healthcare operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request. You may exercise this right by contacting the individual or office identified at the end of this notice. They will provide you with additional information.

You have the right to request the following with respect to your Protected Health Information:

- Inspection and copying;
- Amendment or correction;
- An accounting of certain disclosures of this information by us (you are not entitled to an accounting of disclosures made for payment, treatment or healthcare operations, or disclosures made pursuant to your written authorization);
- A paper copy of this notice upon request, even if you agreed to receive the notice electronically; and
- To receive your PHI by alternative means or at an alternative location if you indicate that disclosure by the regular means could pose a danger to you and you specify a reasonable alternative address or method of contact.

You have the right to receive notification following a breach of your unsecured PHI.

Prohibited Uses and Disclosures

We are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Right to Change Terms of the Notice

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI we maintain. If we change this notice you will be notified, and the updated notice will be posted on the Company intranet and

NetBenefits.com. You may also obtain a copy by calling the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847) and follow the prompts to reach the Service Center, Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 A.M. and 8:30 P.M. Eastern time.

Contacting the Plan

If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below or to:

**Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201**

You will not be retaliated against for filing a complaint.

You may exercise the rights described in this notice by contacting the office identified below. They will provide you with additional information. The contact is:

**Textron Inc.
Benefits Strategy & Compliance Department
40 Westminister Street
Providence, RI 02903
Attn: HIPAA Privacy Officer
(401) 421-2800**

Limitations on Disclosure to the Company of Protected Health Information

The Protected Health Information (PHI) created or received by a Group Health Plan in connection with your provided benefit coverage is protected by the HIPAA Privacy Regulations. However, there are instances where the Plan must disclose your health information. The following gives you information regarding the Plan's rights.

General Disclosures

1. **Summary Information.** Under the HIPAA Privacy Regulations, a group health plan (or a health insurance issuer or health maintenance organization providing coverage under a group health plan) may disclose summary health information to the Company if such information is requested by the Company in order to obtain premium bids from health plans for providing coverage under the group health plan or to modify, amend or terminate the group health plan.
2. **Enrollment Information.** A group health plan (or a health insurance issuer or health maintenance organization providing coverage under a group health plan) may also disclose to the Company information about whether an individual is participating in the group health plan or is enrolled or has disenrolled from a health insurance issuer or health maintenance organization

offered by the group health plan.

3. **Authorized Disclosures.** A group health plan (or a health insurance issuer or health maintenance organization providing coverage under a group health plan) may disclose PHI to the Company if the individual who is the subject of the information authorized the disclosure in writing. The individual generally may revoke his or her authorization at any time by providing a written notice to the Plan; but the revocation will not apply to any information that the group health plan has already disclosed.

Otherwise, pursuant to the HIPAA Privacy Regulations, a group health plan may disclose your PHI to the Company (or allow a health insurance issuer or health maintenance organization to disclose PHI to the Company) only under the circumstances described in the next section.

Restricted Disclosures

The Plan may disclose PHI to the Company, and the Company may use or further disclose the PHI it receives from the Plan, as necessary to permit the Company to perform plan administration functions on behalf of the group health plan. **For example:**

- The Company may receive and disclose PHI to arrange with a health maintenance organization or similar provider to provide services under the Plan;
- The Company may receive and disclose PHI to a reinsurer for purposes of obtaining a reinsurance contract or seeking reimbursement under such contract; and
- The Company (or its delegate) may receive and review PHI when deciding claims for benefits under the Plan in accordance with the Plan's claims procedures.

The Plan may also disclose PHI to the Company, and the Company may use or further disclose the PHI it receives from the Plan, as necessary to permit the Company to assist the Plan with payment functions, such as resolving an issue involving the coordination of benefits with another health plan.

When the Plan discloses PHI to the Company for plan administrative purposes or payment purposes, as described in this section, the Company's use and further disclosure of the PHI is subject to the following restrictions:

- The Company shall not use or disclose PHI except as permitted or required by this document or as required by law.
- The Company shall ensure that any agent or subcontractor to whom the Company provides PHI agrees to the same restrictions and conditions that apply to the Company with respect to such information.

- Without specific authorization from the individual who is the subject of the information, the Company shall not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan, except as required by law.
- The Company shall report to the relevant group health plan any use or disclosure of PHI that is inconsistent with the limitations mentioned here.
- With respect to the PHI about an individual contained in a designated record set, the Company shall:
 - Make the PHI available to the individual for access to inspect or shall provide a copy of such information, as provided in 45 C.F.R. § 164.524;
 - Incorporate any amendment to inaccurate or incomplete PHI, as provided in 45 C.F.R. § 164.526; and
 - Make available the information required to provide the individual an accounting of certain types of disclosures of such information (if any), as provided in 45 C.F.R. § 164.528.

Further information relating to the procedures for the activities set forth in this paragraph can be found in the Group Health Plan's Notice of Privacy Practices.

- The Company shall make its internal practices and records that relate to use and disclosure of PHI available to the US Department of Health and Human Services, for purposes of determining the group health plan's compliance with the HIPAA Privacy Regulations.
- The Company shall return or destroy all PHI and copies thereof when such information is no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Company shall not use or disclose the retained PHI unless such use or disclosure is necessary for the reason that makes the return or destruction of the information infeasible.
- The Company shall ensure that only the following classes of employees of the Company shall have access to PHI:
 - Medical professionals who are providing healthcare or treatment to the individual who is the subject of the PHI;
 - The employees who are directly involved in administering the Plan (including employees who receive PHI in order to make or approve payments on behalf of the Plan and employees who receive PHI in order to assist the Plan in carrying out its healthcare operations);
 - The person(s) who must administer Workers' Compensation benefits or comply with those laws; and
 - The person(s) who must comply with OSHA laws.
- The Company shall ensure that the employees listed above shall have access

to, and may use or disclose, PHI only for purposes of performing plan administration functions on behalf of the group health plan.

- The Company shall provide a process for resolving any issues of noncompliance with the foregoing restrictions and conditions. That process is as follows:
 - Any individual who believes that the Company has not complied with the restrictions and conditions above with respect to his or her PHI may file a claim using the same procedures that apply under the Plan to a post-service claim for benefits.
 - If the Company determines that an employee has violated the foregoing restrictions and conditions, the employee may be subject to disciplinary action including, but not limited to, required attendance at a HIPAA compliance training session and/or the imposition of any penalty that might apply for noncompliance with a Company policy.
- The Company shall certify to the group health plan that the Plan documents have been amended as provided in this SPD and that the Company agrees to the limitations set forth in this SPD.

Definitions Applicable to this Notice of Privacy Rights

The following definitions apply to the use of your PHI and to the Notice of Privacy Rights:

Company—Textron Inc. and any operation, plant, subsidiary or division of Textron Inc. or any predecessor or successor operation, plant, subsidiary or division.

Designated Record Set—The definition assigned to that term in 45 C.F.R. § 164.501. The term “Designated Record Set” includes the enrollment, payment, claims adjudication, and case or medical management record systems maintained by Group Health Plan or by Company on behalf of group health plan, or any group of records used (in whole or in part) by Group Health Plan or by the Company on behalf of Group Health Plan, to make decisions about an individual.

Group Health Plan—A benefit option that constitutes a “Group Health Plan” within the meaning of 45 C.F.R. § 160.103. A Group Health Plan includes a benefit option designated as a “Group Health Plan” for purposes of HIPAA by the Company in the ***Textron Medical Plans Detail*** chart, by the US Department of Health and Human Services in official guidance or a binding ruling, or by a court.

HIPAA Privacy Regulations—The Standards for Privacy of Individually Identifiable Health Information promulgated by the US Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, which are codified at 45 C.F.R. Parts 160, 164.

Notice of Privacy Practices—The notice, provided by the Group Health Plan pursuant to 45 C.F.R. § 164.520, describing, among other things, the Group Health Plan’s uses and disclosures of PHI, an individual’s rights under the HIPAA Privacy

Regulations, and the Group Health Plan's duties under the HIPAA Privacy Regulations.

Privacy Officer—The Privacy Officer is responsible for developing, implementing and maintaining the privacy policies and procedures regarding the privacy of PHI and making sure Textron Inc. is compliant with the HIPAA Privacy Rule.

Protected Health Information (PHI)—The definition assigned to that term at 45 C.F.R. § 164.501. "Protected Health Information" includes any health information about an individual (including demographic information) that:

- Identifies or can be used to identify the individual;
- Is created or received by a healthcare provider, health plan, or employer; and
- Relates to:
 - Past, present, or future physical or mental health or condition of an individual;
 - The provision of healthcare to the individual; or
 - The past, present or future payment for the provision of healthcare to the individual.

Summary Health Information—The definition assigned to that term at 45 C.F.R. § 164.504(a). "Summary Health Information" includes information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the Company has provided health benefits under the Group Health Plan, provided that all identifiers (except zip code) have been removed.

Your Rights Under ERISA

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

RECEIVE INFORMATION ABOUT PLAN 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the 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 plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. (See **Claims Procedures** for details.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the 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 up to \$110 a day until you receive the materials, unless the materials were not

sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part (and you have exhausted the administrative remedies available under the Plan), you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. (For questions regarding eligibility, enrollment or contribution rates for this Plan, please contact the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847).) 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 N.W., Washington, D.C. 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.

Terms to Know

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

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Enrollment Period—The period of time during which eligible persons who have not previously enrolled in the Plan may do so and currently enrolled persons may change their enrollment options. Those who enroll during an annual enrollment period are not considered to be late enrollees. The Plan does not accept late enrollees.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS)— A program administered by the Claims Administrator or its affiliates made available to you by Textron. The BRS program provides:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options;
and

Access to specialized Network facilities and Physicians for bariatric surgery services.

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

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

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Cardinal Health, Inc. The CRS program provides:

- Specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Claims Administrator – is UnitedHealthcare.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA—Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Administrator— is Fidelity; Administers the COBRA rights of each employee to receive coverage under certain conditions.

Coinsurance—Coinsurance is the amount that you must pay after you have met your deductible but before you reach your out-of-pocket maximum. The amount of coinsurance will depend on the benefit level option that you select.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures—procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective—the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services—those health services, including services, supplies or

Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD Covered Health Benefits.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility.
- Not otherwise excluded in this SPD under What is Not Covered, Exclusions.

Consumer Directed Health Plan (CDHP) - refers to a health insurance plan that allows members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay routine health care expenses directly, while a high-deductible health insurance policy protects them from catastrophic medical expenses.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible—The amount of covered expenses that each covered person must incur out-of-pocket in a Plan Year before the Plan begins to pay benefits. In the case of family coverage, it means the amount of covered expenses that two or more family members together must incur out-of-pocket in a Plan Year before the Plan begins to pay. For the Textron Low Deductible/High/Maximum Deductible-HSA Option, the deductible includes Textron's annual contribution plus the amount that you as the covered person pay.

Deductible Corridor—The amount of the deductible that you pay after Textron has made its annual contribution. See also the definition for "Member Responsibility" below.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under the *Dependent Eligibility* Section. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

Durable Medical Equipment (DME)—medical equipment that is all of the following:

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

Effective Treatment (for Psychiatric Conditions, Alcohol or Drug Abuse)— Therapy that is prescribed and supervised by a physician, is appropriate to the condition being treated, and is either:

- Delivered on an inpatient basis,
- Delivered on an outpatient basis individually or in group sessions, or
- Part of a follow-up program.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in the health coverage benefit section.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in this SPD. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or

more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency Health Services - with respect to an Emergency, both of the following:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Enrollment Date—The first date of coverage or, if there is a waiting period, the first day of the waiting period. For individuals who enroll when first eligible, the enrollment date is often the first day of employment.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator and the Company make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital

Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials*.
- If you are not a participant in a qualifying Clinical Trial and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and the Company may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and the Company must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Gender Dysphoria— A disorder characterized by the following diagnostic criteria classified in the 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.
- 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 one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

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

Health Maintenance Organization (HMO) - is a type of managed care organization that provides a form of health care coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract.

High Deductible Health Plan (HDHP)—is a plan with a deductible that is at or above the threshold to qualify to make HSA contributions. In general, this type of plan will have lower premiums and higher deductibles than a traditional health plan. It is a form of catastrophic coverage.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.

- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Maintenance or Long-Term Medication—This type of prescribed medication is intended to treat and keep a condition at the current status or level. Examples of such products are heart and blood pressure medication, long-term pain medication, arthritis treatment, and medication for treating diabetes.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com, www.mymedica.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by the Company who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories listed in the

current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Member Responsibility—The healthcare expenses for which you must pay, after your HRA balance has been used, until you meet your annual deductible for the Textron HRA Plan. Your Member Responsibility can be less if you roll over HRA Benefit Dollars from the previous Plan Year(s), thus increasing the HRA amount available to you. However, the Member Responsibility could also increase, up to the full amount of your deductible, if you choose to spend your HRA Benefit Dollars on HRA-only covered expenses.

Neonatal Resource Services (NRS)—a program administered by UnitedHealthcare or its affiliates made available to you by Textron. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network Provider—when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Qualified IRS Expenses—Medical services, such as acupuncture, that are not covered by the Health Coverage component of the Plan, but that may be reimbursable through your HRA or HSA. See the **Health Reimbursement Account (HRA)** or **Health Savings Account (HSA) SPD** (whichever is applicable) for covered qualified IRS expenses that are not Covered Health Services under the

Health Coverage component of the Plan.

Out-of-Network Provider or non-Network Provider—A provider not under contract with the network Administrator.

Out-of-Pocket Maximum—*For the Textron HRA Plan*, this means the limit on the total in-network healthcare cost you could pay in a calendar year. Once you have paid the maximum (which includes your deductible, but not your HRA) for the benefit option level that you select, the Plan will cover remaining eligible expenses at 100% for the remainder of the year, subject to any limits under the Textron HRA Plan.

For the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Option, this means the maximum amount of money you must pay in coinsurance and deductible(s) before the Textron Low Deductible/High Deductible/Maximum Deductible-HSA Option begins to pay your covered expenses at 100% for a network provider, subject to any limits under the HDHP. There is no out-of-pocket maximum for out-of-network services.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Partial Hospitalization Program (PHP)—PHP is designed as an alternative to hospitalization. PHP offers all of the program intensity of acute inpatient care without having to stay in the hospital overnight. Treatment consists of multiple treatment modalities (e.g., individual therapy, group therapy, education groups, family therapy and physician oversight) provided in a coordinated manner to achieve short-term stabilization of immediate crises. Partial Hospitalization is time-limited and concludes when the patient's immediate presenting problem is stabilized or resolved.

Personal Health Support—programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care, designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse—the primary nurse that the Claims Administrator may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician.

Pharmaceutical Product List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject, from time to time, to UnitedHealthcare's periodic review and change. You may find out which tier a particular Pharmaceutical Product has been placed through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Physician—This term means:

- A person legally licensed to practice medicine and surgery and practicing within the scope of that license, or
- Any other legally-licensed practitioner of the healing arts who renders services within the scope of his or her license.

This term does not include a resident physician, an intern or a person in training.

Plan Administrator/Plan Sponsor—Textron Inc.

Preferred Provider Organization (PPO)—is a managed care organization of medical doctors, hospitals, and other health care providers who have covenanted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Provider—A healthcare professional or facility that is licensed, certified or otherwise qualified under state law to provide healthcare services.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day,

structured milieu:

- Room and board.
- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD 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.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Special Enrollment Period—A period of 30 calendar days (i.e., not necessarily one month) during which an eligible employee is allowed to enroll himself or herself and/or any eligible dependents when any of certain qualified changes in status occur. The day after the qualified change in status is the first day of the 30-day special enrollment period. Changes in Dependent's Medicaid or Children's Health Insurance Program coverage results in a 60 calendar day special enrollment period. Those who are eligible to enroll during a special enrollment period are not considered to be late enrollees. The Plan does not accept late enrollees.

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

Spouse - an individual to whom you are legally married.

Substance-Related and Addictive Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Summary Plan Description (SPD)—is a document describing the features of an employer sponsored benefit plan. The Employee Retirement Income Security Act (ERISA) requires that SPDs address several different aspects of the plan, such as participant rights.

Surgical Procedure—The incision or excision of any part of the body, the electro cauterization of any part of the body, the manipulative reduction of a fracture or dislocation, the suturing of a wound, treatment of burns, tapping (paracentesis), application of plaster casts, pneumothorax injection of sclerosing solution or endoscopy.

Transitional Living - Mental health services and substance-related and addictive disorder services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

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

Unproven Services—health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received).
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues

medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and Textron may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and Textron must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and Textron may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and Textron do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and Textron to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's and Textron's discretion. Other apparently similar promising but unproven services or prescription drugs may not qualify.

Urgent Care - Care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Waiting Period for Eligibility—The time between the first day of employment and the effective date of coverage under the Plan. For this Plan, there is no waiting period; the effective date of coverage is the date of hire.

Nondiscrimination and Accessibility Requirements

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

- Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
- Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Getting Help in Other Languages or Formats

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

EXHIBIT 19

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

IN THE CIRCUIT COURT OF THE
17TH JUDICIAL CIRCUIT IN AND
FOR BROWARD COUNTY, FLORIDA

CASE NO: CACE 20-3898 (07)

INPHYNET CONTRACTING
SERVICES LLC, ET AL.,

Plaintiffs,

VS

UNITED HEALTHCARE OF FLORIDA,
INC., ET AL.,

Defendants,

Broward County Courthouse
Fort Lauderdale, Florida
Monday, August 12, 2024
8:39 a.m. - 1:26 p.m.

VOLUME II
Page 244 - 452

The above-styled cause came on for Jury
Trial held before the Honorable JACK TUTER,
Presiding Judge, Pursuant to notice, at the
Broward County Courthouse, on the 12th day of
August, 2024 at 8:00 a.m.

1 APPEARANCES:
2 On behalf of Plaintiff:
3 LASH & GOLDBERG
2500 Weston Road
4 Suite 220, Weston Corporate Centre
Fort Lauderdale, Florida 33331
5 BY: JUSTIN C. FINEBERG, ESQ.
jfineberg@lashgoldberg.com
6 BY: MICHAEL E. STRAUCH, ESQ.
mstrauch@lashgoldberg.com
7 BY: JOHN W. BLACK, ESQ.
jblack@lashgoldberg.com
8 BY: ANNETTE M. TUCKER ESQ.,
atucker@lashgoldberg.com
9 BY: VIRGINIA BOIES, ESQ.
vboies@lashgoldberg.com
10 BY: KEISHA JONES, Paralegal
kjones@lashgoldberg.com

11
12 On behalf of Defendant:
13 GIBSON DUNN & CRUTCHER LLP
333 South Grand Avenue
14 Los Angeles, California 90071-3197
BY: RICHARD J. DOREN, ESQ.
15 rdoren@gibsondunn.com
BY: HEATHER RICHARDSON, ESQ.
16 hrichardson@gibsondunn.com
17 GIBSON DUNN & CRUTCHER LLP
2001 Ross Avenue, Suite 2100
18 Dallas, TX 75201
BY: BETTY X. YANG, ESQ.
19 byang@gibsondunn.com
BY: HEATHER RICHARDSON, ESQ.
20 hrichardson@gibsondunn.com

21
22 AKERMAN LLP
401 East Jackson Street
23 Suite 1700
Tampa, Florida 33602
24 BY: IRENE BASSSEL FRICK, ESQ.
irene@basselfrick@akerman.com
25

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

APPEARANCES CONTINUED:

AKERMAN LLP

Three Brickell City Centre

98 Southeast Seventh Street

Suite 1100

Miami, Florida 33131

BY: MICHAEL CHAVIES, ESQ.

michael.chavies@akerman.com

ALSO PRESENT:

Cassie Johnson (Defendant's Corporate rep.)

Dr. Randy Katz

REPORTED BY:

MARIA E. FERNANDEZ, RPR, FPR-C

VERITEXT DEPOSITION & LITIGATION SERVICES

305.376.8800

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I N D E X

Preliminary Instructions	247
Opening by Mr. Fineberg	260-289
Opening by Mr. Doren	289-323

DR. RANDY KATZ	
Examination	Page
Direct By Mr. Black	326
Cross By Ms. Richardson	367
Redirect By Mr. Black	399

KEN BRISTOW

Direct By Mr. Fineberg	404
------------------------	-----

EXHIBITS ADMITTED INTO EVIDENCE

Exhibit 325	356
Exhibit 324	406

1 have in place with that insured. But, again, we
2 expect -- because if we set our provider's charges at
3 reasonable levels, we would expect to receive our
4 billed charges that we billed for the service because
5 we believe those are at a reasonable level or a
6 reasonable discount off of those charges because we --
7 we allow for some different network agreements that we
8 have called "billed network agreements." And I may be
9 getting too technical, but can allow for a discount
10 off of those billed charges when an insurer is not
11 directly contracted with a provider.

12 Q And I just want the jury to be very clear
13 about our demands and medical group's demands in this
14 case, Mr. Bristow.

15 Is it your understanding that the medical
16 groups are asking for their billed charges as damages
17 in this case?

18 A No, we are not.

19 Q And what is your understanding of what the
20 medical groups are requesting in this case?

21 A My understanding is that we rely upon our
22 expert's evaluation to determine what is the fair
23 market value for the services that we provided and
24 taking the difference between what his expert opinion
25 is, evaluating the market, and comparing it against

1 what United Healthcare actually allowed and saying the
2 difference is what should be the damages against all
3 the volume services that were provided.

4 Q And we're going to talk about that in some
5 detail once we get further into our discussion.

6 Let me just set up with a little more
7 background with you. The jury has already heard about
8 EMTALA and what it means.

9 But, generally, just to get real high level
10 of review, your understanding of the EMTALA mandate
11 and what that means for the medical groups.

12 A So the essence is that emergency department
13 and its providers effectively have to see, treat, and
14 care for each and every patient that shows up in the
15 emergency room.

16 And that is regardless of what insurance
17 they have, the kind of insurance they may have, or if
18 they have insurance, or if they have any ability to
19 pay. That cannot be a part of the equation. You will
20 see, treat, and take care of everyone equally who
21 shows up in the emergency department.

22 Q So earlier today the jury looked at a pie
23 chart about different payor classes in the emergency
24 department. They saw Medicare, Medicaid, self-pay,
25 and commercial.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

COURT CERTIFICATE

STATE OF FLORIDA)
COUNTY OF BROWARD)

I, MARIA E. FERNANDEZ, RPR and FCRA-C,
certify that I was authorized to and did
stenographically report the foregoing proceedings
and that the transcript is a true and complete
record of my stenographic notes.

Dated this 13th day of August, 2024.



MARIA E. FERNANDEZ, RPR, FCR-C

EXHIBIT 18

FILED UNDER SEAL

EXHIBIT 17



For Providers For Brokers

Search

Search

Español

Already a member?

Sign In

Home Individuals & Families Employers Medicare Find a Doctor

Legal

Information on Payment of Out-of-Network Benefits

Information on Payment of Out-of-Network Benefits

Certain health care benefit plans administered or insured by affiliates of UnitedHealth Group Incorporated provide "out-of-network" medical and surgical benefits for members. With out-of-network benefits, members may be entitled to payment for covered expenses if they use doctors and other health care professionals outside of the UnitedHealthcare network. The member or health care professional, depending on whether or not the member has assigned his or her claim, may send a claim for such out-of-network professional services to be paid by a UnitedHealth Group affiliate. The UnitedHealth Group affiliate will pay based on the terms of the member's health care benefit plan that in many cases provides for payment for amounts that are the lower of either:

- the out-of-network provider's actual charge billed to the member, or
- "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

What Do These Terms Mean?

The terms "the reasonable and customary amount," "the usual, customary, and reasonable amount," and "the prevailing rate" are among the standards that various health care benefit plans may use to pay out-of-network benefits. Such plans determine the amounts payable under these standards by reference to various available resources. These resources contain information on the charges or costs for professional services or supplies. The resource used for payment of professional services is based on what other health care professionals in the relevant geographic areas or regions charge for their services.

These standards do not apply to plans where reimbursement is determined using Medicare rates. Further, UnitedHealth affiliates use different resources in applying these standards with respect to services provided by facilities such as general hospitals or ambulatory surgical centers or in determining the reimbursement for pharmaceutical products (as further discussed below). Also, a member's health care benefit plan may define these standards differently or contain additional standards, and it is the language of the member's health care benefit plan or the plan's interpretation of such language that is controlling. Therefore, a member should always consult his or her health care benefit plan when assessing how much he or she may be reimbursed for out-of-network benefits.

How Does This Affect Members?

If a health care benefit plan requires payment using the term "reasonable and customary" or similar language mentioned above with respect to medical and surgical procedures performed and billed by

health care professionals or health care professional group practices, then the affiliates of UnitedHealth Group most commonly refer to a schedule of charges created by FAIR Health, Inc. ("FAIR Health") to determine the amount of the payment.

What is FAIR Health?

FAIR Health is a not-for-profit company, independent of UnitedHealth Group affiliates, established following the New York Attorney General's ("NYAG") investigation into alleged conflicts of interest related to the ownership and use of Ingenix, Inc.'s Prevailing Healthcare Charges System database ("PHCS Database") and Medical Data Research database ("MDR database") and the fairness of their rates. Ingenix, Inc. ("Ingenix"), now known as Optum Insight, Inc. ("Optum Insight"), is a wholly-owned subsidiary of UnitedHealth Group Incorporated. Under a January 2009 settlement agreement between UnitedHealth Group Incorporated and the NYAG, Ingenix's PHCS and MDR Databases closed following the establishment of the new database to be owned and operated by FAIR Health.

FAIR Health provides health care consumers with an estimate of how much out-of-network services will cost them. Health care consumers can access [FAIR Health's Consumer Price Lookup](#).

Additionally, FAIR Health publishes two Benchmark data products called the FH Benchmark Database and the FH RV Benchmark Database. The information in these FAIR Health Benchmark databases is updated and published by FAIR Health at scheduled times each year. UnitedHealth Group affiliates which administer health care plans based on the term "reasonable and customary" or similar standards use the medical/surgical module of one of these FAIR Health Benchmark Databases to determine the maximum amount they will pay for reimbursement of professional fees for medical and surgical services. By using the schedule of charges in the medical/surgical module of these FAIR Health Benchmark databases, the maximum amount a UnitedHealth Group affiliate will pay to members will, at times, be less than the amount billed for particular professional services. Use of this maximum amount then affects the members' "out-of-pocket" cost they must pay to out-of-network health care professionals, under the terms of many health care benefit plans, members are responsible for the difference between the professionals' charges and what the UnitedHealth Group affiliate pays.

How are the FAIR Health Databases Used For Out-of-Network Payments?

Various health insurers and plan administrators periodically send FAIR Health data about claims for services of health care professionals. The claims include the date and the place of the service, the procedure code, and the provider's charge. FAIR Health combines this information into databases that show how much health care professionals have charged for nearly all services in defined geographic areas in the United States. FAIR Health creates and publishes two Benchmark Databases named the FH Benchmark Database and the FH RV Benchmark Database. Depending on the applicable health care plan, UnitedHealth Group affiliates may use one of these databases as a resource for determination of reimbursement amounts for out-of-network services of health care professionals.

The following example illustrates the information gathered by FAIR Health in the FH Benchmark Database: FAIR Health receives charge information of health care professionals who perform colonoscopies in a particular geographic area for a particular time period. The charges of these health care professionals for colonoscopies are arranged from low to high and then percentiles are identified from that arrangement. Here is a simplified illustration of a percentile chart for a colonoscopy for one geographic area:

CPT Code	Description	50th	60th	70th	75th	80th	85th	90th	95th
45378	COLONOSCOPY	\$764	\$783	\$859	\$887	\$907	\$939	\$1008	\$1105

Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals, but plan designers and administrators of particular health care benefit plans may choose different percentiles for use with applicable health care benefit plans. Members may contact the customer service line of the applicable UnitedHealth Group affiliate shown on the back of the member's health identification card to learn of the percentile applicable to the member's health plan.

Health care benefit plans managed by UnitedHealth Group affiliates began to use FAIR Health's Benchmarking Databases to determine payment for out-of-network professional services within 60 days of first receiving the applicable FAIR Health Benchmark Database Modules at various times in 2011. Prior to receiving the FAIR Health Benchmarking Database Modules, UnitedHealth Group affiliates used Ingenix's PHCS database schedules and MDR database schedules to determine payment for out-of-network professional services when reimbursed under standards such as "reasonable and customary" and other similar standards.

For additional information regarding the FAIR Health Benchmark Databases, please visit [FAIR Health's website](#).

How were the Ingenix Schedules Prepared and Used for Payments?

The PHCS Database was designed to use actual, fee-for-service health care professional charges for private sector health care services, or as explained below, when not enough information was available, it reported values based on a methodology using derived charges and relative values. Ingenix collected information from insurers and other health plan administrators nationwide, including information from Puerto Rico and the Virgin Islands. Ingenix asked these contributors to submit only actual fee-for-service charges that professionals billed. Data contributors received a discount on their license fees for the PHCS or MDR Databases based on how much of their charges information was accepted and used by Ingenix.

After Ingenix collected billed charge information from data contributors, Ingenix reviewed the information before using it to create the PHCS and MDR Databases. Specifically, Ingenix excluded information that (i) was out of date, (ii) was incomplete (missing data fields such as a procedure code, zip code, or billed charge), (iii) contained invalid zip codes or procedure codes, or (iv) had billed amounts that fell outside of certain high and low charge parameters set by Ingenix to identify what it deemed to be "outlier" charges.

The PHCS Database set forth amounts determined by the Ingenix process, organized by medical procedure codes, known as CPT codes, and geographic area (geozips). For CPT code/geozip combinations with 9 or more actual charges used by Ingenix in creating the PHCS product, the Database reported those charges at the 50th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th "percentiles." By way of example, the 90th percentile was the amount equal to or greater than 90% of the charges used by Ingenix in creating the PHCS Database for that CPT code/geozip combination. Affiliates of UnitedHealth Group frequently used the 80th percentile of the PHCS Database as their benchmark, but plan sponsors may have chosen different percentiles for use with their plans. For CPT code/geozip

combinations with fewer than 9 actual charges in the repository of data collected from contributors for use in the PHCS Database, the Database reported "derived charges" in the percentile tables. To calculate derived charges, Ingenix pooled billed charges for similar services from the relevant geographic area. The charge data was standardized using "relative values," which were numbers that were assigned to procedure codes based on an assessment of the difficulty and expense of the procedures. More complex and more expensive procedures received higher relative values, while less complex and less expensive procedures received lower relative values. For the PHCS Database, Ingenix licensed its relative values from a company not affiliated with UnitedHealth or Ingenix called **Relative Value Studies Incorporated**.

The MDR Database consisted entirely of derived charges. Ingenix used its own proprietary relative values in creating the MDR Database, and the derived charges methodology used for the MDR Database was different from, though similar to, that used for the PHCS Database.

The medical and surgical modules of the PHCS and MDR Databases contained tables covering over 8,000 different codes across over 400 different Geozips. Each release of the Databases used the data contributed with dates of service during a 12-month moving window between 3 and 15 months prior to the date each module is released.

The service and product codes employed in the Databases were based on either the Current Procedural Terminology ("CPT") coding system developed and maintained by the American Medical Association ("AMA") or the Healthcare Common Procedure Coding System ("HCPCS") developed and maintained by the Centers for Medicare and Medicaid Services ("CMS"). The Databases were divided into "modules," which were compilations of the various tables for different codes that were generally related to one another (e.g., there is a PHCS medical services module and a PHCS surgical services module). There were eight different modules for the PHCS Database and nine modules for the MDR Database. UnitedHealth affiliates used only the medical and surgical modules of the PHCS Database when they reimbursed claims under "reasonable and customary" or other similar standards as described above for professional services delivered and billed by health care professionals or health care provider groups. Geozips were used to group the charges for a particular CPT code by similar geographical area for summarization and presentation in the database tables. Geozips were based on the first three digits of United States zip codes and were either a single three-digit zip code area or a combination of two or more three-digit zip code areas. Whether a Geozip covered only one or more than one three-digit zip code area was based upon: (i) an analysis of submitted charge data for each PHCS release; (ii) the volume of available data; and (iii) geographical similarities involved with the zip code areas underlying each Geozip. The zip code areas that are combined in particular Geozips could vary from year-to-year.

A sample PHCS percentile table is provided below.

CPT Code	Description	50th	60th	70th	75th	80th	85th	90th	95th
71050	RADIOLOGICAL EXAMINATION (2 VIEWS)	\$102	\$103	\$106	\$107	\$107	\$107	\$113	\$122
99211	OFFICE VISIT; EVALUATION AND MANAGEMENT; MINIMAL PRESENTING PROBLEM	\$62	\$70	\$75	\$80	\$85	\$85	\$100	\$100

Important Exclusions

UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases to determine out-of-network benefits for professional services if a member's health care benefits plan does not require payment under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate" or similar terms. For example, if a member's plan provides for payment based upon Medicare rates, UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases as a resource for determining payment amounts.

Reimbursement Policies

UnitedHealth affiliates may apply certain payment policies that can affect both the amount they pay for such benefits and a member's out-of-pocket costs. For example, the Multiple Procedure Policy applies when multiple procedures are performed on the same day by the same healthcare professional. Under this policy, coverage for the primary/major procedure is 100% of the allowable amount, and 50% of the allowable amount for the secondary procedure. Coverage for all subsequent procedures is 25 or 50% of the allowable amount, depending on a member's health plan. This accounts for the fact that many medical and surgical services include pre-procedure and post-procedure work, as well as generic services integral to the standard medical/surgical service (like recording preoperative, intraoperative, and postoperative documentation) that would be performed for the primary procedure and not duplicated for additional procedures. See descriptions of the [Multiple Procedure Policy and other payment policies](#).

Physician Administered Pharmaceuticals

UnitedHealth Group affiliates consider pharmaceutical products administered and billed by health care professionals or health care provider groups to be professional services or supplies for purposes of claims reimbursement when such drugs are covered under a member's health plan. UnitedHealth Group affiliates generally deem the Average Wholesale Price ("AWP") for such pharmaceutical products to be an amount which satisfies plan standards such as "reasonable and customary" or similar standards mentioned above, and thus use AWP to determine out-of-network reimbursement for such products.

The AWP values considered by UnitedHealth Group affiliates are provided by a comprehensive database covering virtually every drug product approved by the Food and Drug Administration for manufacture and distribution. This database is developed and maintained by an independent vendor, Thomson Reuters, and is collected from over 1,200 pharmaceutical manufacturers and distributors.

UnitedHealth Group affiliates reimburse for pharmaceutical products administered and billed by health care professionals or health care provider groups by reference to AWP for a number of reasons. AWP is an industry standard of reimbursement and is widely accepted by health care professionals, governments, and managed care companies as appropriate payment for such products. In addition, government studies demonstrate that reimbursement at AWP typically is significantly higher than actual prices paid by health care professionals for pharmaceutical products. Finally, the prices paid by health care professionals for these products do not vary across geographic regions to the degree that charges for professional services vary across geographic regions, which makes a national standard on reimbursement for these products more appropriate and more consistent with the plan standards mentioned above.

Glossary

Allowable amount – as used in circumstances covered by this notice, the dollar amount eligible for reimbursement with respect to a claim for out-of-network benefits. The standard for determining the allowed amount can vary by health plan, and may be based (depending upon the language of a member's health plan) upon the lower of either the provider's charge or the "reasonable and customary amount," as explained in the beginning of this notice. This dollar amount may not be the amount ultimately paid to the member or provider as it may be reduced by any co-insurance or deductible that is owed by the member.

AWP (Average Wholesale Price) – the Average Wholesale Price for pharmaceutical products which UnitedHealth Group affiliates determine based on a comprehensive database developed and maintained by Thomson Reuters.

CPT codes – a set of codes and descriptions of services and procedures performed by physicians and other health care professionals. Each service and procedure is identified by its own five-digit code. Physicians and other health care professionals use CPT codes in making claims for payment. CPT codes are maintained by the American Medical Association.

FAIR Health – a not-for-profit organization selected by the Attorney General of the State of New York ("NYAG") to provide the health care consumer with data associated with out-of network services.

FH Benchmarking Database – one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out-of-network professional services when reimbursed under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

FH RV Benchmarking Database – one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out-of-network professional services when reimbursed under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

Ingenix – a wholly-owned subsidiary of UnitedHealth Group (NYSE: UNH). Ingenix is now known as Optum Insight, Inc.

MDR database – one of two compilations of information on health care professional charges created by Ingenix, Inc., now known as Optum Insight, Inc., a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group affiliates no longer use the MDR database for determining reimbursement.

Optum Insight, Inc. – a wholly-owned subsidiary of UnitedHealth Group (NYSE: UNH). Optum Insight, Inc. was formerly known as Ingenix.

Out-of-network benefits – benefits provided under a health care benefits plan for services or supplies provided by doctors and other health care professionals who are not parties to a contract with a UnitedHealth Group affiliate.

Out-of-pocket cost – portion of the cost of health services that the plan member must pay, including the difference between the amount charged by an out-of-network provider and what a UnitedHealth Group affiliate pays for such services.

Prevailing Healthcare Charges System database ("PHCS Database") – one of two compilations of information on health care professional charges created by Ingenix, Inc., now known as Optum Insight, Inc., a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group affiliates no longer use the PHCS database for determining reimbursement.

Professional Services – Health care services provided, and billed for, by professionals such as physicians, psychologists, behavioral and health therapists and other practitioners. It does not include health care services for which facilities, such as hospitals or other health care centers, seek reimbursement.

Provider network – doctors and other health care professionals who agree to provide medical care to our members under the terms of a contract.

UnitedHealth Group – UnitedHealth Group (NYSE: UNH) is a diversified health and well-being company dedicated to making health care work better. Headquartered in Minneapolis, Minn., UnitedHealth Group offers a broad spectrum of products and services through UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, OptumHealth, Optum Insight and Prescription Solutions. Through this family of businesses, UnitedHealth Group affiliates serve more than 70 million individuals nationwide.

[Newsroom](#) [Contact Us](#) [Careers](#) [Health Care Fraud](#) [Legal](#) [Privacy](#) [Terms of Use](#) [Accessibility](#)

Follow us



© 2019 United HealthCare Services, Inc.

How is your visit? ✕

EXHIBIT 16

**DISTRICT COURT OF APPEAL
SECOND DISTRICT OF FLORIDA**

**CASE NO. 2D-20-3717
LT CASE NO. 2017-CA-011207**

**UNITED HEALTHCARE OF FLORIDA, INC.
and UNITED HEALTHCARE INSURANCE CO.,**

Petitioners,

v.

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Respondent.

**RESPONDENT GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES,
LLC's RESPONSE TO PETITION FOR CERTIORARI**

ALAN D. LASH

Florida Bar No. 510904

JUSTIN C. FINEBERG

Florida Bar No. 53716

RACHEL H. LEBLANC

Florida Bar No. 0021815

JONATHAN E. SIEGELAUB

Florida Bar No. 1019121

LASH & GOLDBERG LLP

Miami Tower, Suite 1200

100 Southeast 2nd Street

Miami, Florida 33131

Telephone: (305) 347-4040

Facsimile: (305) 347-4050

Attorneys for Respondent

CASE NO. 2D-20-3717

TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

PRELIMINARY STATEMENT 1

STATEMENT OF THE CASE 4

STANDARD OF REVIEW 17

SUMMARY OF THE ARGUMENT 18

ARGUMENT 20

 I. GTB’S COST DATA IS IRRELEVANT..... 21

 II. GOVERNMENT CLAIMS DATA IS IRRELEVANT 29

 III. THE TRIAL COURT’S RELEVANCY DETERMINATIONS,
 EVEN IF INCORRECT, WILL NOT CAUSE IRREPARABLE
 INJURY 37

CONCLUSION..... 39

CERTIFICATE OF COMPLIANCE..... 43

CASE NO. 2D-20-3717

TABLE OF AUTHORITIES

Cases

2-Bal Bay Props., LLC v. Asset Mgmt. Holdings, LLC,
291 So. 3d 617 (Fla. 2d DCA 2020)..... 23

Allstate Ins. Co. v. Langston,
655 So. 2d 91 (Fla. 1995) 18, 37

Am. Med. Ass’n v. United Healthcare Corp.,
2009 WL 1437819 (S.D.N.Y. May 19, 2009)..... 10

Baker Cty. Med. Servs., Inc. v. Aetna Health Mgmt., LLC,
31 So. 3d 842 (Fla. 1st DCA 2010)passim

Colomar v. Mercy Hosp., Inc.,
461 F. Supp. 2d 1265 (S.D. Fla. 2006) 26

English v. McCrary,
348 So. 2d 293 (Fla. 1977) 17

Giacalone v. Helen Ellis Memorial Hospital Foundation, Inc.,
8 So. 3d 1232 (Fla. 2d DCA 2009)passim

Hall v. Reynolds,
268 So. 3d 829 (Fla. 2d DCA 2019) 17

Harborside Healthcare, LLC v. Jacobson,
222 So. 3d 612 (Fla. 2d DCA 2017) 18

Kane v. Stewart Tilghman Fox & Bianchi, P.A.,
85 So. 3d 1112 (Fla. 4th DCA 2012) 8, 23

Merkle v. Health Options, Inc.,
940 So. 2d 1190 (Fla. 4th DCA 2006) 6, 33

CASE NO. 2D-20-3717

Merle Wood & Assocs., Inc. v. Trinity Yachts, LLC,
714 F.3d 1234 (11th Cir. 2013)..... 8

Point Conversions, LLC v. Pfeffer & Marin Holdings, LLC,
305 So. 3d 609 (Fla. 3d DCA 2020)..... 17

Power Plant Entm’t, LLC v. Trump Hotels & Casino Resorts Dev. Co., LLC,
958 So. 2d 565 (Fla. 4th DCA 2007)..... 37

Tenet Healthsystem GB, Inc. v. Care Improvement Plus S. Cent. Ins. Co.,
875 F.3d 584 (11th Cir. 2017)..... 30, 31

Tumelaire v. Naples Estates Homeowners Ass’n, Inc.,
137 So. 3d 596 (Fla. 2d DCA 2014)..... 18

Wal-Mart Stores, Inc. v. Weeks,
696 So. 2d 855 (Fla. 2d DCA 1997)..... 18

White v. Fort Myers Beach Fire Control Dist.,
302 So. 3d 1064 (Fla. 2d DCA 2020)..... 15

Zirkelbach Constr., Inc. v. Rajan,
93 So. 3d 1124 (Fla. 2d DCA 2012)..... 18

Statutes

42 U.S.C. § 1395w-21..... 12, 35

42 U.S.C. § 1395w—22(k)(1)..... 31

Fla. Stat. § 627.64194..... 7

Fla. Stat. § 627.64194(4) 6

Fla. Stat. § 641.513 6, 7, 26

Fla. Stat. § 641.513(5) passim

CASE NO. 2D-20-3717

Fla. Stat. § 641.513(5)(a)-(c).....21
Fla. Stat. § 641.513(6)31
Fla. Stat. § 90.40120

Rules

Florida Rules of Appellate Procedure 9.045.....2
Florida Rules of Appellate Procedure 9.110(1)17
Florida Rules of Appellate Procedure 9.130(a)(3)17
Florida Rules of Appellate Procedure 9.210(a)(2)2

Regulations

42 C.F.R. § 422.214(a)(1).....31
Florida Administrative Code Rule 69O-191.0496

CASE NO. 2D-20-3717

PRELIMINARY STATEMENT

This action involves Respondent Gulf-to-Bay Anesthesiology Associates, LLC's ("GTB") claims for damages based upon the rates of payment remitted by Petitioners United Healthcare of Florida, Inc. and United Healthcare Insurance Co. (together, "United") for covered medical services rendered to United's insureds holding **commercial** insurance plans. Florida law requires United to reimburse out-of-network medical providers like GTB at rates equaling the fair market value of the services provided. United has deliberately violated the law by systematically reimbursing GTB at rates below fair market value. In other words, the crux of this case is a dispute over the fair market value of medical services rendered.

In accordance with well-established authority providing that fair market value is defined as the rate that a willing buyer would pay and a willing seller would accept in an arm's length transaction, the parties have already exchanged voluminous data from comparable past market transactions. This is precisely the type of data that both parties' experts agree is necessary and sufficient to calculate fair market value. In fact, United retained two experts on this point. One of its experts determined the methodologies for computing fair market value, and the other expert calculated the amounts

CASE NO. 2D-20-3717

that United would owe based on those methodologies. In total, United's experts calculated GTB's damages as ranging from nearly \$10 million to over \$15 million. Apparently discontented with the results of its experts' analyses, United has, at the eleventh hour, requested additional categories of data. It now seeks disclosure of data regarding GTB's cost structure and GTB's payments received from Medicare Advantage Organizations and Managed Medicaid Plans.

As explained in detail below, the trial court properly denied United's motions to compel production of these data sets because both are entirely irrelevant and are not discoverable. As shown in Point I, United asserts entitlement to the cost data because it would cast light on the "reasonableness" of GTB's billed charges. But the reasonableness of GTB's billed charges is not at issue in this dispute, as GTB expressly is not seeking recovery of its billed charges. Rather, the claims at issue focus on the statutory methodology for determining the appropriate rate of reimbursement, which is "fair market value." Importantly, operative the statutes **do not** include costs as a factor for consideration. And, in its common law claims, GTB similarly seeks recovery of fair market value.

CASE NO. 2D-20-3717

As shown in Point II, Medicare Advantage and Managed Medicaid claims data is irrelevant because it simply is not comparable. This lawsuit is focused only on commercial claims, and no governmental claims are at issue. This is critical because, as opposed to commercial claims where the rates are established by participants operating at arm's length in a free market, the government sets the Medicare and Medicaid fee schedules and the government sets the reimbursement rates for out-of-network claims for both Medicare Advantage and Managed Medicaid. Thus, this data has no bearing on the issues in dispute, which are solely focused on appropriate reimbursement rates for services rendered to commercially insured patients.

As shown in Point III, even if the trial court's relevancy determinations were incorrect (they were not), this Court should still deny the Petition because certiorari review is unavailable under the circumstances. This Petition presents a run-of-the-mill discovery dispute. Despite United's protestations to the contrary, the discovery rulings do not even come close to meeting the high standard for setting aside on certiorari review an order denying discovery, which requires that such order "eviscerate" the requesting party's claim or defense. That United can calculate fair market value and mount a defense to GTB's claims based upon the data already

CASE NO. 2D-20-3717

produced is apparent from the fact that United unilaterally determined the reimbursement amounts in the first instance, without the benefit of any of this belatedly requested discovery.

At bottom, United requested discovery, the trial court denied the discovery on relevance grounds, and United is unhappy with that outcome. But a party's displeasure alone does not render certiorari review appropriate. The law is clear that trial courts have broad discretion to resolve discovery disputes, and discovery orders are not to be set aside in extraordinary writ proceedings absent irreparable harm, which plainly does not exist here.

Accordingly, the Court should deny the Petition.

STATEMENT OF THE CASE

GTB is a Tampa-based anesthesiology practice. (App.¹ 22 ¶ 2.) United is a health insurance company and claims administrator. (App. 24 ¶ 10.) United provides health insurance for its members, which includes

¹ Citations to "App." refer to the appendix prepared by Petitioners and submitted simultaneously with the Original Petition. Citations to "Supp. App." refer to the Supplemental Appendix prepared by Petitioners and submitted simultaneously with the Amended Petition. Citations to "Resp. App." refer to the appendix prepared by Respondent and submitted herewith.

CASE NO. 2D-20-3717

coverage for anesthesiology services.² Between May 20, 2003 and May 20, 2017, United and GTB were parties to an agreement (“Participation Agreement”). (App. 24 ¶ 11.) The Participation Agreement governed, *inter alia*, the reimbursement rates which United would pay for anesthesiology services rendered by GTB to United’s members. *Id.* Under the Participation Agreement, GTB agreed to accept discounted rates of reimbursement in exchange for certain contractual benefits. *Id.*

Effective May 21, 2017, United terminated the Participation Agreement. Since then, GTB has continued providing care to United’s members as an out-of-network provider. (App. 30 ¶ 44.) In other words, no express agreement between United and GTB exists to govern reimbursement, or any other aspect, of the medically necessary and covered services provided to United’s members. (App. 31 ¶ 51.) Nonetheless, Florida law regulates the rates that United must pay for out-of-network anesthesia services. For instance, Florida Statutes § 641.513(5) requires health maintenance organizations (“HMOs”) to reimburse out-of-network

² United’s “members” are individuals holding commercial health insurance underwritten and/or administered by United.

CASE NO. 2D-20-3717

providers of emergent care³ at the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services were provided," or an agreed upon rate.⁴ (App. 30 ¶¶ 45.) Florida Statutes § 627.64194(4) imposes the same requirement upon preferred provider organizations ("PPOs") for emergent and non-emergent services. (App. 28-29 ¶¶ 35-36.) And, GTB alleges that Florida's common law similarly obligates United to pay GTB fair value for these services.

³ While § 641.513 expressly applies to emergency services, Florida Administrative Code Rule 690-191.049 extends the obligation of an HMO to pay hospital-based providers, including anesthesiologists, for "medically necessary and approved physician care rendered to a non-Medicare subscriber at a contracted hospital." Moreover, § 641.3154 obligates HMOs to pay providers, such as GTB, for authorized services without regard to the location where the medical services were rendered. There is no dispute that the claims at issue in this case were all medically necessary, approved, and paid (albeit at unlawfully low rates).

⁴ Contrary to United's assertion (Am. Pet. at 10), § 641.513 was not enacted to protect insurance companies. Rather, the statute was enacted to protect non-participating providers, ensuring that they are adequately paid for a service they are required by law to perform. See, e.g., *Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1196 (Fla. 4th DCA 2006) ("Section 641.513(5) clearly imposes a duty on HMOs to reimburse non-participating providers according to the statute's dictates, not based on Medicare reimbursement rates. The intent of the section is to ensure that the non-participating providers are adequately paid for a service they are required by law to perform").

CASE NO. 2D-20-3717

A “usual and customary provider charge” equals the “fair market value of the services provided.” *Baker Cty. Med. Servs., Inc. v. Aetna Health Mgmt., LLC*, 31 So. 3d 842, 845 (Fla. 1st DCA 2010). And fair market value is “the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.” *Id.* The central disputed issue in this litigation is whether United has met its obligation to pay fair market value. GTB alleges that, since termination of the Participating Provider Agreement, United systematically has reimbursed claims at amounts well below the fair market value of the services rendered. (App. 29 ¶ 39, 30 ¶ 48, 32 ¶ 61, 34 ¶ 69, 36 ¶ 82.) In so doing, United has violated Florida law.

GTB has asserted five substantive claims in this action. In Counts I and II of the Amended Complaint, GTB alleges violations of §§ 627.64194 and 641.513 (the “Statutory Claims”). (App. 28-31 ¶¶ 31-49.) Because these statutes obligate United to pay usual and customary charges, *i.e.*, fair market value, in the Statutory Claims GTB seeks to recover the difference between the amounts actually paid and fair market value. (*Id.*) In Counts III, IV, and V, GTB seeks recovery under common law theories for injuries resulting from United’s underpayments (the “Common Law Claims”). (App. 31-38 ¶¶ 50-89.)

CASE NO. 2D-20-3717

Count III asserts breach of implied-in-fact contract. GTB alleges that the parties, by continuing to transact with each other in an environment in which United was legally obligated to pay fair market value for anesthesia services rendered, formed an enforceable agreement requiring United to pay fair market value. By paying less than fair market value, United has breached the agreement. (App. 31-33 ¶¶ 50-63.) Counts IV and V are for *quantum meruit* and unjust enrichment.⁵ GTB alleges that, in rendering valuable services to United's insureds, it has conferred a benefit upon United for which United is equitably obligated to pay fair value. (App. 33-38 ¶¶ 64-89.) Florida law provides that the measure of damages for unjust enrichment is the value of the benefit from the standpoint of the recipient. *Kane v. Stewart Tilghman Fox & Bianchi, P.A.*, 85 So. 3d 1112, 1115 (Fla. 4th DCA 2012). In other words, in Counts IV and V, like the other counts, GTB seeks recovery of the difference between the amounts already paid by United and the fair market value of the anesthesia services rendered to United's members.

⁵ Unjust enrichment and *quantum meruit* are nearly identical causes of action. See *Merle Wood & Assocs., Inc. v. Trinity Yachts, LLC*, 714 F.3d 1234, 1237 (11th Cir. 2013).

CASE NO. 2D-20-3717

Given the above, this action revolves entirely around the proper calculation of fair market value for the anesthesia services rendered by GTB. Such calculation will determine whether United faces liability, and, if so, the *quantum* of damages. And, in determining fair market value, it is critical to understand the distinction in the healthcare market between “billed charges” and the reimbursement amounts customarily paid by insurance companies and accepted by providers. United explains this distinction in its Amended Petition:

Florida medical providers are effectively unrestricted in the prices they “bill” for their services. However, in reality, medical providers actually expect payors to pay vastly different—and lower—prices than their “billed charges.” The prices providers ask insurers and HMOs to pay pursuant to contract may be far, far less than the provider’s billed charges—but providers still “bill” all payors their maximum prices. This practice is similar to the “sticker price” posted on the back of hotel room doors or on the window of a new car. Those prices generally reflect a price much higher than the price customers are actually asked to pay for the room or the car [S]ignificant incentives exist for providers to keep their billed prices as high as possible—even though they usually accept far less in payment for their services.

(Am. Pet. at 12-13.)

As noted, Florida law provides that “[f]air market value is the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.” *Baker County*, 31 So. 3d at 845. And, in light of the distinction

CASE NO. 2D-20-3717

in the statute, which sets forth a “lesser of” methodology between billed charges and usual and customary charges (i.e., the amounts customarily paid and accepted in the market as payment in full for services rendered), discovery in this case has been properly geared towards determining those latter values. GTB has produced extensive amounts of data to United, all of which are relevant to the one critical disputed issue: the prices to which a willing buyer and willing seller would agree in an arm’s length transaction for the anesthesia services rendered. Data produced, includes, *inter alia*:

- The amounts GTB received and accepted on its contracted commercial claims in the Florida market for the period in dispute;
- The amounts GTB received and accepted on its out-of-network commercial claims in the Florida market for the period in dispute;
- The amounts GTB successfully negotiated with United for out-of-network anesthesia claims (these negotiated rates are not the subject of damages, but clearly inform how the parties determine fair market value for out-of-network anesthesia claims);
- Market data from FAIR Health,⁶ an independent, industry benchmark database, and the amounts United paid to GTB when referencing this database;

⁶ United is intimately familiar with FAIR Health. The genesis of FAIR Health was a scam that United perpetrated in the 2000s to unlawfully drive down out-of-network reimbursement rates by manipulating the data populating a wholly-owned subsidiary database called Ingenix. This misbehavior came to light in 2009. In addition to settling the resulting class actions for \$350 million, see *Am. Med. Ass’n v. United Healthcare Corp.*, 2009 WL 1437819,

CASE NO. 2D-20-3717

Not contented with this voluminous discovery,⁷ United sought numerous additional categories of information. At issue in this Petition, United demanded information regarding GTB's internal cost structure. (App. 239-40, 243-44.) Citing this Court's decision in *Giacalone v. Helen Ellis*

at *4 (S.D.N.Y. May 19, 2009), United paid \$50 million to resolve an enforcement action brought by the New York Attorney General's Office.

See State of New York, Office of the Attorney General, Assurance of Discontinuation, Investigation No. 2008-161, p. 10, Jan. 13, 2009, https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/United%20Health.pdf (last accessed March 13, 2021).

Under the terms of its settlement with the NYAG, the \$50 million was used to fund the creation of FAIR Health, which would serve as an industry standard, independent, transparent, benchmark repository of reimbursement data.

See State of New York, Office of the New York Attorney General, Press Release, Attorney General Cuomo Announces Historic Nationwide Reform of Consumer Reimbursement System for Out-of-Network Health Care Charges, Oct. 27, 2009, <https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-reform-consumer> (last accessed March 31, 2021).

⁷ After GTB moved to compel production of this relevant data from United and the trial court entered an agreed order compelling such production, United also produced the amounts United paid to providers of similar anesthesia services in Florida, including, without limitation, payments made to the provider group most comparable to GTB in size, scope and volume, for the period in dispute. (Resp. App. 24-25.)

CASE NO. 2D-20-3717

Memorial Hospital Foundation, Inc., 8 So. 3d 1232 (Fla. 2d DCA 2009), United maintained that cost data is discoverable because it is relevant in assessing the reasonableness of GTB’s billed charges. (App. 243-44.) GTB objected to the discovery request, contending that the reasonableness of the charges is not at issue in a dispute over fair market value. (App. 907:1-909:6.)

In addition, United demanded GTB’s reimbursement data for patients insured under Medicare Advantage and Managed Medicaid plans (“Government Claims Data”). (App. 445-446.) GTB objected to the request, contending that claims reimbursed by government insurance plans are not at issue in this dispute and are not comparable to the commercial claims at issue. (App. 516-520.) GTB noted United’s apparent agreement on this point. Although GTB never requested Government Claims Data from United, in its initial response to GTB’s discovery request—which sought other, relevant information—United asserted a preemptive, general objection to producing its own Government Claims Data. (App. 518-19 (“United objects to any requests concerning claims for benefits submitted by Plaintiff for reimbursement of anesthesia services rendered to any individuals who are enrolled in a Medicare Advantage Plan governed by Medicare Part C, 42

CASE NO. 2D-20-3717

U.S.C. § 1395w-21, et seq, and its regulations, or any Medicaid managed care plan within the meaning of Chapter 409, Part IV, Florida Statutes.”.)

Ultimately, United moved to compel production of GTB’s cost data and Government Claims Data. (App. 235, 432.) GTB submitted an Omnibus Response. (Resp. App. 0051.) The trial court then conducted oral argument on the motions.⁸ After oral argument, the trial court issued an order on several of the outstanding discovery issues. (Resp. App. 239.)⁹ The

⁸ In its Petition, United takes an unnecessary potshot at the trial judge who ruled on the relevant discovery motions, the Honorable Christopher Sabella. (Am. Pet. at 18-19, 35-36.) United suggests that Judge Sabella denied those motions in part because he is new to the case and usually assigned to the criminal division. But the transcript makes clear that Judge Sabella carefully considered the issues, held a lengthy hearing where he asked thoughtful questions, and invited both parties to submit proposed orders before rendering his decisions. (App. 855-924.)

Moreover, Judge Sabella was assigned to Division C for several months in 2020, has been a circuit court judge since 2006, and previously served in the General Civil Division. United’s effort to discount the discovery orders by implying that Judge Sabella is inexperienced, or that the issues at stake were too complex for him to resolve correctly, inappropriate and, in any event, belied by the record.

⁹ In this Omnibus Order, the Court made several important rulings on the scope of discovery, including: (1) denying United’s motion to compel and granting a protective order against discovery of information and documents regarding the ownership/acquisition of GTB; (2) limiting the timeframe of discovery to 2017 forward; (3) limiting discovery to anesthesia services only; (4) limiting discovery to the state of Florida; and (5) limiting discovery to exclude Medicare or Medicaid claims. Despite these clear rulings,

CASE NO. 2D-20-3717

Omnibus Order did not address the questions of whether discovery would include (1) Government Claims Data; and (2) Plaintiff's cost information. Rather, the trial court reserved ruling "on the questions of (1) whether discovery will include Medicare Advantage and Managed Medicaid; and (2) Plaintiff's cost information" and ordered the parties to "submit supplemental filings regarding these two questions for the Court's consideration and determination." (Resp. App. 239.) The Omnibus Order reflected the trial court's verbal pronouncement at the conclusion of the hearing, requesting both parties to submit competing proposed orders containing argument and authority on those two issues. (Resp. App. 209-210.)¹⁰ And, the trial court

throughout the Petition, United continues to assert irrelevant and immaterial arguments regarding GTB's ownership and acquisition. United's continued focus on issues that the Court has already found outside the permissible boundaries of discovery, instead of focusing on those issues that are relevant, is telling.

¹⁰ During the oral argument, GTB's counsel specifically argued that cost discovery should be precluded because the Florida standard jury instructions for *quantum meruit* or unjust enrichment do not contemplate costs. (App. 907.) Thus, while United now contends that it was unaware that GTB would rely on the standard jury instructions as the basis for its position, United's contentions are again belied by the record.

CASE NO. 2D-20-3717

informed the parties that a staff attorney would further review and research the issues. (Resp. App. 209-210.)

In response to the trial court's request, both sides submitted competing proposed orders on the issues regarding Government Claims Data and cost data. (Resp. App. 259-278.) The proposed orders were provided simultaneously to the trial court in Microsoft Word format, so the court had all of the parties' submissions and arguments when making its decisions. Each of United's proposed orders consisted of several pages, with detailed reasoning and citation to authorities.¹¹ After consideration of all of the submissions, the trial court entered its orders.¹²

¹¹ Throughout the Petition, United tacitly criticizes the trial court for entering GTB's proposed orders virtually verbatim. (*E.g.*, Am. Pet. at 18-19.) However, the trial court properly requested proposed orders from both sides, which apprised it of the parties' positions and disagreements with the opposing party's proposed orders. The court then considered the issues for several weeks before rendering a decision. Under the circumstances, the court clearly exercised its independent judgment. *See, e.g., White v. Fort Myers Beach Fire Control Dist.*, 302 So. 3d 1064, 1075-76 (Fla. 2d DCA 2020).

¹² The trial court conducted a status conference on the same day that it issued the Orders. While the contents of the conference were not transcribed, the court alerted the parties to the rulings and announced that it had carefully considered the issues.

CASE NO. 2D-20-3717

The trial court found that cost data was irrelevant. (App. 814-20.) Citing *Baker County*, it held that “the relevant inquiry was in the ‘fair market value’ of the services provided,” and that “the analysis focuses solely on the price of the services, rather than the costs of the services.” (App. 818 ¶ 9.) The court found *Giacalone* inapposite because “Defendants have not raised any unreasonable pricing claims here, either by affirmative defense or counterclaim. Instead, the pleadings here focus on a statutory analysis that addresses the fair market value of the services provided, determined by the price a willing buyer would pay and willing seller would accept.” (App. 819 ¶ 13.)

The court also held that Government Claims Data is irrelevant. (App. 806-13.) It found significant that:

One, there are no claims in this dispute involving Government Claims. Two, Florida statutes and case law clearly distinguish between commercial claims and Government Claims, making discovery of Government Claims irrelevant and improper. Three, in their responses to Plaintiff’s discovery requests, Defendants acknowledged the impropriety of discovery regarding Government Claims by objecting to producing *their own documents* regarding Government Claims.

(App. 809 (emphasis in original).)

Upon the trial court’s denial of its motions to compel, United moved for reconsideration and contemporaneously filed its original Petition in this writ

CASE NO. 2D-20-3717

proceeding. (Supp. App. 22.) Upon denial of the motion for reconsideration, United filed its Amended Petition.

STANDARD OF REVIEW

Certiorari review¹³ of a discovery order is permitted where the order departs from the essential requirements of law, causing material injury to a petitioner throughout the remainder of the proceedings and effectively

¹³ Incredibly, this is United's **third** meritless writ petition. The first was summarily denied. See Case No. 2D-19-3258, Order dated Dec. 11, 2019. United voluntarily withdrew the second only after GTB had expended considerable resources responding. See Case No. 2D-20-1780, Order dated Sept. 15, 2020. Now, this Court is presented with the third. United's behavior is abusive and must stop. The law is clear that extraordinary writs may issue only in extraordinary circumstances, and that writ proceedings are not a substitute for ordinary appellate review of trial court orders. See, e.g., *Point Conversions, LLC v. Pfeffer & Marin Holdings, LLC*, 305 So. 3d 609, 611 (Fla. 3d DCA 2020) ("Since mandamus is an extraordinary writ, the adequate remedy requirement has long been recognized as essential to ensure that the writ only be invoked in extraordinary circumstances."); *Hall v. Reynolds*, 268 So. 3d 829, 829 (Fla. 2d DCA 2019) (per curiam) ("[C]ertiorari should not be used to circumvent the appellate rule which limits interlocutory review of non-final orders."); *English v. McCrary*, 348 So. 2d 293, 296 (Fla. 1977) (Writ of prohibition "is meant to be very narrow in scope, to be employed with great caution and utilized only in emergencies.").

In running to this Court on a writ petition every time it finds itself on the losing end of a trial court's interlocutory order, United transparently seeks to evade the final order requirement imposed by Florida's appellate rules. See Fla. R. App. P. 9.110(1); 9.130(a)(3). This behavior is unfair to this Court and to GTB, both of whom must expend significant time and resources addressing the meritless petitions.

CASE NO. 2D-20-3717

leaving no adequate remedy on appeal. *Allstate Ins. Co. v. Langston*, 655 So. 2d 91, 94 (Fla. 1995). “Only if the challenged order causes irreparable harm to the petitioner, conferring jurisdiction to [the district court], [can the district court] consider whether the trial court departed from the essential requirements of the law in entering it.” *Harborside Healthcare, LLC v. Jacobson*, 222 So. 3d 612, 615 (Fla. 2d DCA 2017).

“In the case of an order regarding discovery, the trial court has **broad discretion.**” *Wal-Mart Stores, Inc. v. Weeks*, 696 So. 2d 855, 856 (Fla. 2d DCA 1997) (emphasis added). A trial court’s discovery order should be set aside on certiorari review only where it “constitutes an **abuse of discretion** which would cause irreparable damage which cannot be remedied on appeal[.]” *Id.* (emphasis added). *See also Tumelaire v. Naples Estates Homeowners Ass’n, Inc.*, 137 So. 3d 596, 598 (Fla. 2d DCA 2014) (certiorari reversal of discovery order appropriate only where trial court abuses discretion resulting in irreparable injury); *Zirkelbach Constr., Inc. v. Rajan*, 93 So. 3d 1124, 1127 (Fla. 2d DCA 2012) (same).

SUMMARY OF THE ARGUMENT

As explained in Point I below, the trial court correctly rejected United’s attempt to compel disclosure of GTB’s cost data. Relying upon this Court’s

CASE NO. 2D-20-3717

decision in *Giacalone*, United contends that cost data is discoverable because it goes to the reasonableness of GTB's billed charges. But that argument fails because the reasonableness of GTB's billed charges is not at issue. Under both the statutory and common law theories asserted in the Amended Complaint, GTB is entitled to the difference between the amounts actually paid and fair market value. Fair market value is the price to which a willing buyer and willing seller would agree in an arm's length transaction. As such, it can be measured only by review of the rates actually paid by comparable commercial insurers and accepted by physicians in the relevant geography for comparable anesthesia services in the relevant time period. As United itself acknowledges, physicians' billed charges often differ substantially from the rates actually paid in the market by insurers and accepted by physicians as payment in full. As such, the amounts billed and the reasonableness thereof are irrelevant to the claims in this case.

As explained in Point II, the trial court correctly rejected United's attempt to compel disclosure of GTB's Government Claims Data. As noted, fair market value is the price to which a willing buyer and willing seller would agree in an arm's length transaction. In other words, it is the price that would arise in a free market. The Government Claims Data is irrelevant because it

CASE NO. 2D-20-3717

does not result from arm's length transactions in a free market. Quite the opposite. Medicare and Medicaid rates are set by the government, based upon budgetary considerations. And while United contends that Medicare Advantage and Managed Medicaid plans differ from traditional Medicare and Medicaid insofar as private insurers administer the plans and have a limited ability to negotiate rates with medical providers, those rates are still ultimately tethered to the government fee schedules and the government-determined monthly capitation payments that the insurers receive as compensation. As such, even "negotiated" rates fall substantially below the rates insurers pay to providers for services rendered to commercially insured patients and simply are not comparable to such commercial claims.

Finally, as explained in Point III, even if the requested materials were arguably relevant, this Court should not disturb the trial court's orders. Certiorari review is available to correct an erroneous discovery order only in exceptional circumstances, where the order would result in irreparable harm to the losing party. Such circumstances plainly do not exist here.

ARGUMENT

United contends that GTB's cost data and Government Claims Data are relevant and hence discoverable. Florida Statutes § 90.401 defines

CASE NO. 2D-20-3717

relevant evidence as “evidence tending to prove or disprove a material fact.” United maintains that the cost data is relevant because it would tend to prove or disprove the reasonableness of GTB’s billed charges. (Am. Pet. at 30 (“United has requested discovery on GTB’s internal cost structure for purposes of challenging the reasonableness of GTB’s charges.”).) And it maintains that the Government Claims Data is relevant to a determination of fair market value for the anesthesia services rendered. (Am. Pet. at 43-44 (“[D]iscovery of negotiated charges and discounts accorded to private Medicare Advantage and Managed Medicaid plans is not only relevant, but central to United’s defense against GTB’s common law and statutory claims.”).) As explained below, both positions are meritless.

I. GTB’S COST DATA IS IRRELEVANT

The cost data is irrelevant because the reasonableness of GTB’s billed charges is not at issue. The relevant statutes entitle GTB to the lesser of: (a) the provider’s charges; (b) usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to. Fla. Stat. §§ 641.513(5)(a)-(c); 627.64194(4) (incorporating § 641.513(5)). For the disputed claims at issue, the parties did not agree to a rate. Therefore, determining whether United has violated

CASE NO. 2D-20-3717

the statutes and, if so, the amount of damages, requires a calculation of the lesser of the “usual and customary provider charges” and GTB’s billed charges. In this case, both United’s and GTB’s experts agree that the usual and customary charges are less than GTB’s full billed charges. (Resp. App. 138-140, 133-134, 235-236.) Accordingly, the only analysis required here is a determination of what constitutes usual and customary provider charges for out-of-network anesthesia services in the relevant communities where the services were provided. See Fla. Stat. §§ 641.513(5); 627.64194(4). The statutes do not address costs.

The leading case on the proper methodology for determining usual and customary provider charges is the First District’s decision in *Baker County*. Recognizing that the term is undefined in the statute, the *Baker County* Court performed a careful analysis of the statutory text to derive a meaning. 31 So. 3d at 845. It concluded that: “[i]n the context of the statute, it is clear what is called for is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.” *Id.* In other words, under its Statutory Claims, GTB is entitled to recover the fair market value of the anesthesia services rendered (less the amounts already paid by United).

CASE NO. 2D-20-3717

The Common Law claims are similar. In Count III, GTB alleges that the parties have formed an implied-in-fact contract requiring United to pay fair market value for the medical services rendered. (App. 31-33 ¶¶ 50-63.) And Counts IV and V are for unjust enrichment and *quantum meruit*. (App. 33-38 ¶¶ 64-89.) Florida law is clear that the measure of damages for unjust enrichment is the value of the benefit conferred from the perspective of the recipient. *Kane*, 85 So. 3d at 1115; *2-Bal Bay Props., LLC v. Asset Mgmt. Holdings, LLC*, 291 So. 3d 617, 619 (Fla. 2d DCA 2020) (“[T]he measure of damages in an unjust enrichment case is the enhanced value of the property from the perspective of the owner, and not the cost of the improvements.”) In other words, GTB’s common law theories, like its statutory theories, provide that United is obligated to pay fair market value for the anesthesia services rendered, not its billed charges.

Fair market value can be calculated only through a review of comparable market data. It is undisputed that the way to determine the price to which a hypothetical willing buyer and willing seller would agree in an arm’s length transaction is to ascertain the payments to which actual buyers and sellers have actually agreed in comparable arm’s length transactions. Indeed, United’s own damages expert, healthcare economist Dr. Adam

CASE NO. 2D-20-3717

Block, has testified that, for purposes of determining fair market value, a provider's charges do not matter.

Q: As you say, the charges do not matter for the purpose of fair market value analysis, correct?

A: That is correct.

(Resp. App. 243:1-8.)

In recognition of such, the parties have exchanged extensive historical market data from their own transactions, as well as from public databases. GTB has disclosed its in-network contracted rates with other commercial payors, the reimbursement amounts it has been paid and has accepted from other commercial payors on out-of-network claims, rates it negotiated with United for out-of-network anesthesia services, and market data from the FAIR Health database. (Resp. App. 47-50, 135-137, 238.)

Similarly, United has produced de-identified claims data, which reflects the reimbursement amounts it paid to in-network and out-of-network anesthesia providers in Florida for the dispute period. As such, both GTB and United have already produced the relevant claims data regarding amounts paid and accepted for similar services in the community for patients with commercial health insurance, *i.e.*, evidence of what actual willing buyers and willing sellers have agreed upon in arm's length transactions. This is

CASE NO. 2D-20-3717

the precise evidence that is relevant and sufficient to determine fair market value of the anesthesia services rendered to commercially insured patients in Florida.

United's position that cost data is discoverable is based almost entirely upon *Giacalone*, where this Court found that a hospital's cost data was relevant to a determination of the reasonableness of its billed charges. (Am. Pet. at 27-34.) United contends that "[t]he trial court's orders directly conflict with" *Giacalone*. (Am. Pet. at 4.) United's contention is erroneous. The trial court carefully considered United's arguments, carefully reviewed *Giacalone*, and rejected United's position. United's argument fares no better in this Petition, because *Giacalone* is easily distinguishable.

Giacalone involved an uninsured patient who had been admitted to a hospital and undergone surgery to implant a pacemaker. 8 So. 3d at 1234. Upon admission, the patient signed a form in which he agreed "to pay the account at the hospital in accordance with the regular rates and terms of the hospital." *Id.* The hospital billed the patient for the full billed charges, which the patient refused to pay. The hospital sued, alleging that the "reasonable value" of [its] unpaid services totaled \$52,280.70, the amount of its billed charges. *Id.* at 1235. The patient asserted a number of affirmative defenses

CASE NO. 2D-20-3717

and counterclaims, and “[t]he central theme of [his] defenses and counterclaims was that the Hospital’s charges for its services were unreasonable and unconscionable.” *Id.* Importantly, *Giacalone* did not involve any claims under §§ 641.513 or 627.64194.

During the litigation, the plaintiff sought discovery of the hospital’s cost data. *Id.* at 1234. The trial court sustained the Hospital’s objections to the discovery in a form order. *Id.* On certiorari review, this Court quashed the trial court’s blanket discovery order, directing the trial court to reconsider the individual requests. *Id.* at 1236. The Court reasoned that, under Florida law, “[a] patient may not be bound by unreasonable charges **in an agreement to pay charges** in accordance with standard and current rates.” *Id.* at 1235 (quotation marks omitted and emphasis added). As such, the Court recognized that “**the reasonableness of the Hospital’s charges was the primary issue to be determined**” *Id.* at 1235 (emphasis added).

In assessing the relevance of the requested discovery materials, the *Giacalone* Court, relying upon a federal decision called *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265 (S.D. Fla. 2006), recognized that there are “three nonexclusive kinds of evidence relevant to the **determination of a claim of unreasonable pricing** by a hospital.” 8 So. 3d at 1235 (emphasis

CASE NO. 2D-20-3717

added). One of the three is data demonstrating the hospital's internal cost structure. *Id.* Accordingly, the *Giacalone* Court vacated the discovery order and instructed the trial court to reconsider the issues. *Id.* at 1236.

In this case, as contrasted with *Giacalone*, GTB did not sue United to recover its full billed charges and expressly does not contend that its full billed charges are the reasonable value of the services rendered. Under both the Statutory Claims and the Common Law Claims, GTB seeks only the fair market value of the services rendered. Unlike *Giacalone*, the defendant here is an insurance company rather than an uninsured patient, GTB is not contending that there is an agreement requiring the defendant to pay the provider's billed charges, there is no "claim of unreasonable pricing," and the provider is expressly proceeding under theories requiring payment of fair market value, not billed charges.¹⁴ Even if United could demonstrate that GTB's charges are in fact unreasonable, that would have no impact upon the dispute. Neither *Giacalone* nor any other authority directs that a provider's

¹⁴ United itself contends that the rates insurers actually pay and medical providers actually accept in the market are often substantially below the providers' full billed charges. (Am. Pet. at 12-13.)

CASE NO. 2D-20-3717

cost structure is somehow relevant in determining the fair market value of the services rendered by the provider.

Moreover, the nature of the trial court's detailed order in this case is vastly different from that of the cursory form order at issue in *Giacalone*. The trial court here carefully reviewed the factual allegations and legal claims asserted, as well as the discovery requests. The court considered *Giacalone* and found the factual and legal circumstances of that case to be readily distinguishable. The trial court further noted that the applicable statutes and legal theories at issue here do not include any consideration of costs, and it reasonably refused to expand discovery into issues unrelated to the actual claims asserted.

Finally, there is no argument that the trial court's order would "eviscerate" United's defense, because United has never raised an unreasonable pricing defense. As the trial court aptly noted: "[United has] not raised any unreasonable pricing claims here, either by affirmative defense or counterclaim. Instead, the pleadings here focus on a statutory analysis that addresses the fair market value of the services provided, determined by the price a willing buyer would pay and willing seller would

CASE NO. 2D-20-3717

accept. *Baker County*, 31 So. 3d at 845-846. The focus of that analysis is on market pricing.” (App. 819 ¶ 13.)

In sum, the trial court properly exercised its discretion in ruling on the discovery issues, finding that costs are irrelevant to the claims and defenses in this action. The trial court properly denied United’s motion to compel disclosure of GTB’s cost data, and this Court should not disturb that ruling.¹⁵

II. GOVERNMENT CLAIMS DATA IS IRRELEVANT

Likewise, the trial court properly exercised its discretion in denying discovery into the Government Claims Data, because that data is irrelevant to the issues in dispute. As GTB’s Amended Complaint makes clear, this

¹⁵ United may contend that GTB has put the reasonableness of its billed charges at issue because its expert witness, Patrick Pilch, has opined that the fair market value of the claims at issue in this case is approximately 80-90% of GTB’s billed charges. (Resp. App. 45-46.) But the Court should disregard any such argument. Mr. Pilch simply expressed his opinion in relationship to GTB’s charges. But, his opinion was not that the charges, in and of themselves, was the measure of damages. Instead, he reviewed comparable market data for the relevant geography in the relevant time period, including the data which Mr. Pilch concluded best represented fair-market value transactions for out-of-network anesthesia services. Mr. Pilch then liquidated GTB’s damages in a range of up to approximately \$30 million. (Resp. App. 46.) In fact, United’s expert similarly expressed damages by calculating a dollar amount per service, and then correlated that amount to GTB’s billed charges. In either case, GTB’s billed charges are simply a metric for expressing the damages calculations, but the damages calculations themselves are not based on those charges.

CASE NO. 2D-20-3717

action seeks recovery only on underpaid commercial claims, not government claims. (App. 24 ¶ 10 n.3.) Considering government claims in a valuation of commercial claims affords an apples-to-oranges comparison. With government claims, there are no free market, arm's length transactions; the rates are simply set by regulation. In fact, the *Baker County* Court explicitly recognized that “[t]he reimbursement rates for Medicare and Medicaid are set by government agencies and cannot be said to be ‘arm’s-length.’” 31 So. 3d at 845-46. Accordingly, the trial court properly denied United’s motion to compel disclosure of the Government Claims Data.

United contends that Medicare Advantage and Managed Medicaid plans function like commercial insurance, insofar as the Medicare Advantage Organizations and Medicaid Managed Care Plans which administer them are able to negotiate contracted rates with medical providers. (Am. Pet. at 36-43.) But United overlooks that this contracting occurs against the backdrop of a regulatory scheme in which the government establishes the baseline rates by decree. Those baseline rates—which are often substantially below the amounts to which a provider would be entitled from a commercial insurer—anchor any negotiations. This reality is amply illustrated by *Tenet Healthsystem GB, Inc. v. Care Improvement Plus S. Cent. Ins. Co.*, 875 F.3d

CASE NO. 2D-20-3717

584, 591 (11th Cir. 2017), a case upon which United itself relies. (Am. Pet. at 37-38.) In *Tenet*, the federal Eleventh Circuit explained that, while Medicare Advantage Organizations may negotiate contracted rates with medical providers, in the absence of such a contract, federal regulations require that a provider who renders care to a patient enrolled in a Medicare Advantage plan “must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.” *Id.* at 590 (quoting 42 C.F.R. § 422.214(a)(1).); see also 42 U.S.C. § 1395w—22(k)(1) (non-contracted providers shall accept as payment in full the amount the physician could collect “if the individual were not so enrolled”).

Managed Medicaid operates in a similar fashion. As noted above, Florida Statutes § 641.513(5) governs out-of-network reimbursements for care rendered to patients insured under commercial HMO plans. It provides that the reimbursement shall be the lesser of: (1) billed charges; (2) an agreed rate; or (3) usual and customary provider charges. A separate statutory scheme, Florida Statutes § 641.513(6), governs reimbursement for patients insured under Managed Medicaid HMO plans. It provides that the reimbursement methodology is dictated by Chapter 409. While §

CASE NO. 2D-20-3717

409.967(1)(b), in turn, adopts § 641.513(5)'s "lesser of" methodology, it adds a fourth prong for the base Medicaid rate.¹⁶

In other words, as a matter of federal law, out-of-network physicians who render care to patients holding Medicare Advantage insurance are reimbursed at the base Medicare rates. Likewise, as a matter of state law, out-of-network physicians who render care to patients holding Managed Medicaid insurance are reimbursed at the base Medicaid rates. In these circumstances, negotiated rates will naturally tend to converge around the base Medicare and Medicaid rates, as insurers have little incentive to agree to contracted rates significantly above the out-of-network default. This is evidenced by the fact that, under the Participation Agreement, there were **separate** fee schedules for commercial insurance and Medicare Advantage plans. (Resp. App. 67-69.)

This set of circumstances differs markedly from those surrounding commercial claims, where the out-of-network default is fair market value, as measured by the prices that would be agreed upon by willing parties acting

¹⁶ Section 641.513(7) addresses insurance under the Florida Healthy Kids Corporation Act. It similarly adds a fourth prong for the base Medicaid rate to § 641.513(5)'s "lesser of" methodology.

CASE NO. 2D-20-3717

at arm's length. *Baker County*, 31 So. 3d at 845. With commercial claims, negotiated rates will tend to converge around fair market value. As such, Medicare Advantage and Managed Medicaid contracted rates are not valid comparators for commercial rates. See, e.g., *Merkle*, 940 So. 2d at 1196 (“Section 641.513(5) clearly imposes a duty on HMOs to reimburse non-participating providers according to the statute’s dictates, not based on Medicare reimbursement rates. The intent of the section is to ensure that the non-participating providers are adequately paid for a service they are required by law to perform”).

United offers several additional arguments, none of which has merit. First, United again relies on *Giacalone*, noting that “[a]mong the information that Mr. Giacalone had requested in discovery . . . were ‘the Hospital’s charges and discounts granted to the various categories of patients that it serves (e.g., self-pay patients, **Medicare patients**, **Medicaid patients**, charity care patients, and privately insured patients[.]’” (Am. Pet. at 38-39 (quoting *Giacalone*, 8 So. 3d at 1235) (emphasis in original).) But *Giacalone* is inapposite for the reasons already discussed. Unlike here, the primary disputed issue in *Giacalone* was the reasonableness of the hospital’s billed charges (which the hospital had demanded that the patient pay in full). 8 So.

CASE NO. 2D-20-3717

3d at 1235. This Court sensibly concluded that data showing that the hospital routinely granted discounts to all classes of patients could be relevant in showing that it was unreasonable to demand payment of full billed charges from Mr. Giacalone. But that conclusion has no bearing on the question at issue in this dispute: the fair market value of the medical services GTB rendered to commercially insured patients under the relevant statutes and claims. In fact, *Giacalone* implies quite the opposite: that the discounts afforded to commercially insured patients in fact differ from those afforded to patients with government insurance.

Second, United makes passing reference to testimony from its expert witness, Dr. Block, that “fair market value of the disputed benefit claims is best determined by including **all** claims,” including Medicare Advantage and Managed Medicaid. (Am. Pet. at 22 (emphasis in original).) But, that opinion is not based on Florida law and ignores the economic reality surrounding Medicare Advantage and Managed Medicaid.

Finally, United attempts to downplay a critical, revealing fact: that United itself has objected to production of its own Government Claims Data. (Am. Pet. at 43.) The chronology here is significant. GTB served its first request for production of documents on December 15, 2017. (Resp. App. 6-

CASE NO. 2D-20-3717

14.) Given various procedural delays, United did not serve responses and objections until March 8, 2019. (Resp. App. 15-23.) Although GTB had not requested production of United's Government Claims Data, United affirmatively included the following general objection in its responses and objections to GTB's requests:

United objects to any requests concerning claims for benefits submitted by Plaintiff for reimbursement of anesthesia services rendered to any individuals who are enrolled in a Medicare Advantage Plan governed by Medicare Part C, 42 U.S.C. § 1395w-21, *et seq.*, and its regulations or any Medicaid managed care plan within the meaning of Chapter 409, Part IV, Florida Statutes.

(Resp. App. 16 ¶ 4.)

In other words, United itself recognized that Government Claims Data is not discoverable in this case.

On April 13, 2020, United served its first request for production of documents. In that request, despite its standing objection to production of its own Government Claims Data, United demanded production of GTB's Government Claims Data. (Resp. App. 39 ¶ 59.) Following an objection from GTB, United moved to compel production of GTB's Government Claims Data on August 21, 2020. (App. 248.) In its September 14, 2020 response to that motion, GTB pointed out the absurdity of United objecting to

CASE NO. 2D-20-3717

production of its own Government Claims Data while simultaneously moving to compel production of that same data from GTB. (App. 518-19.) GTB further noted that:

Consistent with [United's] relevance objection, during the three-year course of this litigation, neither [United] nor [GTB] has produced any information regarding Government Claims. Thus, this case has always proceeded without any discovery into Government Claims. At this juncture, [GTB] already produced an expert report on damages, which analyzed [United's] discovery materials as part of that analysis. It would be prejudicial to allow [United] to do an about-face now.

(App. 519.)

Confronted with this untenable position, on September 30, 2020 United produced its Government Claims Data (without formally notifying GTB that it had withdrawn its standing objection and without GTB ever requesting production of that data). (Resp. App. 234). United now contends that, in light of this belated, unilateral flip-flop, the trial court and this Court should simply ignore the position it took for the prior eighteen months. (Am. Pet. at 43.) But United's gamesmanship should not be rewarded. As GTB explained to the trial court, not only is United's longstanding objection an admission that Government Claims Data is irrelevant to this dispute over commercial reimbursement rates, but it would be highly prejudicial to GTB if

CASE NO. 2D-20-3717

United were able to substantially alter the nature and scope of the case at this late stage.

Accordingly, the trial court properly denied United's motion to compel disclosure of the Government Claims Data.

III. THE TRIAL COURT'S RELEVANCY DETERMINATIONS, EVEN IF INCORRECT, WILL NOT CAUSE IRREPARABLE INJURY

Putting aside the question of the relevancy of cost and Government Claims Data, this Court should deny the Petition because irrelevance alone is no basis for certiorari review of a discovery order. In *Allstate*, the Florida Supreme Court made clear that "not every erroneous discovery order creates certiorari jurisdiction" 655 So. 2d at 94. Rather, the touchstone for certiorari is whether an erroneous discovery order would cause irreparable harm to a party. *Id.* at 94-95. As this Court recognized in *Giacalone*, "[c]ertiorari is rarely available to review orders denying discovery because in most cases the harm can be corrected on appeal." 8 So. 3d at 1234; see also *Power Plant Entm't, LLC v. Trump Hotels & Casino Resorts Dev. Co., LLC*, 958 So. 2d 565, 567 (Fla. 4th DCA 2007) (en banc) ("[F]ew orders denying discovery will involve information so relevant and crucial to the position of the party seeking discovery, that it will amount to a departure from the essential requirements of law so as to warrant certiorari review.").

CASE NO. 2D-20-3717

Irreparable injury exists only where “the order denying that discovery effectively eviscerates a party’s claim, defense, or counterclaim” *Giacalone*, 8 So. 3d at 1234.

Here, even if the cost data and Government Claims Data were relevant (as explained above, they are not), it cannot credibly be argued that deprivation of that data would “eviscerate” United’s defense to GTB’s claims. As noted, the parties have already exchanged voluminous amounts of relevant market data. And, significantly, United’s experts have already rendered detailed opinions regarding the fair market value of the out-of-network anesthesia services, and they did so without any of the discovery United is now pursuing. Their methodology has already been disclosed, and they have provided substantial deposition testimony regarding their analyses. Simply put, United has already mounted a defense to the claims alleged in GTB’s Amended Complaint.

Ultimately, in denying United’s motions to compel, the trial court acted well within its broad discretion. Right or wrong, the court’s decisions have not resulted in irreparable harm; United’s defense remains safely intact. In fact, United itself unilaterally decided how much it would pay GTB for the anesthesia claims, and, therefore, must have believed it had sufficient

CASE NO. 2D-20-3717

information to support its decision. It is certainly telling that United is fighting so vigorously to inquire about information it never had when making the unreasonably low payments. United is aware of the market forces that dictate fair market rates, and its experts have already concluded that United grossly underpaid GTB for the medically necessary anesthesia services based upon that information. This case should be decided by the jury on the relevant and material evidence regarding fair market value, all of which has already been exchanged in discovery.

At bottom, United simply cannot demonstrate irreparable harm or that its defense is “eviscerated” in the absence of this discovery. Rather, were this Court to set aside the trial court’s rulings in such unremarkable circumstances, what would be eviscerated in this proceeding is any limitation upon the availability of interlocutory appellate review of discovery orders. Accordingly, the Court should deny the Petition.

CONCLUSION

For the reasons set forth above, this Court should deny the Petition.

CASE NO. 2D-20-3717

Respectfully submitted:

LASH & GOLDBERG LLP

Suite 1200, Miami Tower
100 Southeast Second Street
Miami, Florida 33131-2100
(305) 347-4040/(305) 347-4050 Fax

By: /s/ Justin C. Fineberg

ALAN D. LASH

Florida Bar No. 510904

JUSTIN C. FINEBERG

Florida Bar No. 53716

RACHEL H. LEBLANC

Florida Bar No. 0021815

JONATHAN E. SIEGELAUB

Florida Bar No. 1019121

Attorneys for Respondent

DATED: March 18, 2021

CASE NO. 2D-20-3717

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 18th day of March, 2021, a true and correct copy of the foregoing was served via the Court's efilings system and was furnished to all parties listed below:

KATHERINE E. GIDDINGS, BCS
katherine.giddings@akerman.com
elisa.miller@akerman.com
myndi.qualls@akerman.com
Akerman LLP
201 East Park Avenue, Suite 300
Tallahassee, Florida 32301
Telephone: (850) 224-9634
Telecopier: (850) 222-0103

CHRISTINE B. GARDNER
christine.gardner@akerman.com
lella.provoste@akerman.com
Akerman LLP
Phillips Point, Suite 1100 W
777 S. Flagler Drive
West Palm Beach, FL 33401
Telephone: (561) 652-5000

IRENE BASSEL FRICK
irene.bassel@akerman.com
nicole.emmett@akerman.com
Akerman LLP
401 East Jackson Street,
Suite 1700
Tampa, Florida 33602
Telephone: (813) 223-7333

GERA R. PEOPLES (450022)
gera.peoples@akerman.com
magda.cabra@akerman.com
Akerman LLP
Three Brickell City Centre
98 Southeast Seventh Street,
Suite 1100
Miami, Florida 33131
Telephone (305) 374-5600

SERVICE BY U.S. MAIL

The Honorable Christopher C. Sabella
Thirteenth Judicial Circuit Court
401 N. Jefferson St., Room 516
Tampa, Florida 33602

By: /s/ Justin C. Fineberg
Justin C. Fineberg

CASE NO. 2D-20-3717

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation and font requirement set forth in Rule 9.045, Florida Rules of Appellate Procedure. This brief contains 8,487 words. It has been prepared in a proportionally spaced typeface using Microsoft Word in Arial 14 point font, in compliance with the font requirements of Rule 9.210(a)(2), of the Florida Rules of Appellate Procedure.

By: /s/ Justin C. Fineberg
Justin C. Fineberg

EXHIBIT 15

FILED UNDER SEAL

EXHIBIT 15

FILED UNDER SEAL

EXHIBIT 19

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

IN THE CIRCUIT COURT OF THE
17TH JUDICIAL CIRCUIT IN AND
FOR BROWARD COUNTY, FLORIDA

CASE NO: CACE 20-3898 (07)

INPHYNET CONTRACTING
SERVICES LLC, ET AL.,

Plaintiffs,

VS

UNITED HEALTHCARE OF FLORIDA,
INC., ET AL.,

Defendants,

Broward County Courthouse
Fort Lauderdale, Florida
Monday, August 12, 2024
8:39 a.m. - 1:26 p.m.

VOLUME II
Page 244 - 452

The above-styled cause came on for Jury
Trial held before the Honorable JACK TUTER,
Presiding Judge, Pursuant to notice, at the
Broward County Courthouse, on the 12th day of
August, 2024 at 8:00 a.m.

1 APPEARANCES:
2 On behalf of Plaintiff:
3 LASH & GOLDBERG
2500 Weston Road
4 Suite 220, Weston Corporate Centre
Fort Lauderdale, Florida 33331
5 BY: JUSTIN C. FINEBERG, ESQ.
jfineberg@lashgoldberg.com
6 BY: MICHAEL E. STRAUCH, ESQ.
mstrauch@lashgoldberg.com
7 BY: JOHN W. BLACK, ESQ.
jblack@lashgoldberg.com
8 BY: ANNETTE M. TUCKER ESQ.,
atucker@lashgoldberg.com
9 BY: VIRGINIA BOIES, ESQ.
vboies@lashgoldberg.com
10 BY: KEISHA JONES, Paralegal
kjones@lashgoldberg.com

11
12 On behalf of Defendant:
13 GIBSON DUNN & CRUTCHER LLP
333 South Grand Avenue
14 Los Angeles, California 90071-3197
BY: RICHARD J. DOREN, ESQ.
15 rdoren@gibsondunn.com
BY: HEATHER RICHARDSON, ESQ.
16 hrichardson@gibsondunn.com
17 GIBSON DUNN & CRUTCHER LLP
2001 Ross Avenue, Suite 2100
18 Dallas, TX 75201
BY: BETTY X. YANG, ESQ.
19 byang@gibsondunn.com
BY: HEATHER RICHARDSON, ESQ.
20 hrichardson@gibsondunn.com

21
22 AKERMAN LLP
401 East Jackson Street
23 Suite 1700
Tampa, Florida 33602
24 BY: IRENE BASSSEL FRICK, ESQ.
irene@basselfrick@akerman.com
25

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

APPEARANCES CONTINUED:

AKERMAN LLP

Three Brickell City Centre

98 Southeast Seventh Street

Suite 1100

Miami, Florida 33131

BY: MICHAEL CHAVIES, ESQ.

michael.chavies@akerman.com

ALSO PRESENT:

Cassie Johnson (Defendant's Corporate rep.)

Dr. Randy Katz

REPORTED BY:

MARIA E. FERNANDEZ, RPR, FPR-C

VERITEXT DEPOSITION & LITIGATION SERVICES

305.376.8800

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I N D E X

Preliminary Instructions	247
Opening by Mr. Fineberg	260-289
Opening by Mr. Doren	289-323

DR. RANDY KATZ	
Examination	Page
Direct By Mr. Black	326
Cross By Ms. Richardson	367
Redirect By Mr. Black	399

KEN BRISTOW

Direct By Mr. Fineberg	404
------------------------	-----

EXHIBITS ADMITTED INTO EVIDENCE

Exhibit 325	356
Exhibit 324	406

1 have in place with that insured. But, again, we
2 expect -- because if we set our provider's charges at
3 reasonable levels, we would expect to receive our
4 billed charges that we billed for the service because
5 we believe those are at a reasonable level or a
6 reasonable discount off of those charges because we --
7 we allow for some different network agreements that we
8 have called "billed network agreements." And I may be
9 getting too technical, but can allow for a discount
10 off of those billed charges when an insurer is not
11 directly contracted with a provider.

12 Q And I just want the jury to be very clear
13 about our demands and medical group's demands in this
14 case, Mr. Bristow.

15 Is it your understanding that the medical
16 groups are asking for their billed charges as damages
17 in this case?

18 A No, we are not.

19 Q And what is your understanding of what the
20 medical groups are requesting in this case?

21 A My understanding is that we rely upon our
22 expert's evaluation to determine what is the fair
23 market value for the services that we provided and
24 taking the difference between what his expert opinion
25 is, evaluating the market, and comparing it against

1 what United Healthcare actually allowed and saying the
2 difference is what should be the damages against all
3 the volume services that were provided.

4 Q And we're going to talk about that in some
5 detail once we get further into our discussion.

6 Let me just set up with a little more
7 background with you. The jury has already heard about
8 EMTALA and what it means.

9 But, generally, just to get real high level
10 of review, your understanding of the EMTALA mandate
11 and what that means for the medical groups.

12 A So the essence is that emergency department
13 and its providers effectively have to see, treat, and
14 care for each and every patient that shows up in the
15 emergency room.

16 And that is regardless of what insurance
17 they have, the kind of insurance they may have, or if
18 they have insurance, or if they have any ability to
19 pay. That cannot be a part of the equation. You will
20 see, treat, and take care of everyone equally who
21 shows up in the emergency department.

22 Q So earlier today the jury looked at a pie
23 chart about different payor classes in the emergency
24 department. They saw Medicare, Medicaid, self-pay,
25 and commercial.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

COURT CERTIFICATE

STATE OF FLORIDA)
COUNTY OF BROWARD)

I, MARIA E. FERNANDEZ, RPR and FCRA-C,
certify that I was authorized to and did
stenographically report the foregoing proceedings
and that the transcript is a true and complete
record of my stenographic notes.

Dated this 13th day of August, 2024.



MARIA E. FERNANDEZ, RPR, FCR-C

EXHIBIT 18

FILED UNDER SEAL

EXHIBIT 17



For Providers For Brokers

Search Search

Español

Already a member? Sign In

Home Individuals & Families Employers Medicare Find a Doctor

Legal

Information on Payment of Out-of-Network Benefits

Information on Payment of Out-of-Network Benefits

Certain health care benefit plans administered or insured by affiliates of UnitedHealth Group Incorporated provide "out-of-network" medical and surgical benefits for members. With out-of-network benefits, members may be entitled to payment for covered expenses if they use doctors and other health care professionals outside of the UnitedHealthcare network. The member or health care professional, depending on whether or not the member has assigned his or her claim, may send a claim for such out-of-network professional services to be paid by a UnitedHealth Group affiliate. The UnitedHealth Group affiliate will pay based on the terms of the member's health care benefit plan that in many cases provides for payment for amounts that are the lower of either:

- the out-of-network provider's actual charge billed to the member, or
- "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

What Do These Terms Mean?

The terms "the reasonable and customary amount," "the usual, customary, and reasonable amount," and "the prevailing rate" are among the standards that various health care benefit plans may use to pay out-of-network benefits. Such plans determine the amounts payable under these standards by reference to various available resources. These resources contain information on the charges or costs for professional services or supplies. The resource used for payment of professional services is based on what other health care professionals in the relevant geographic areas or regions charge for their services.

These standards do not apply to plans where reimbursement is determined using Medicare rates. Further, UnitedHealth affiliates use different resources in applying these standards with respect to services provided by facilities such as general hospitals or ambulatory surgical centers or in determining the reimbursement for pharmaceutical products (as further discussed below). Also, a member's health care benefit plan may define these standards differently or contain additional standards, and it is the language of the member's health care benefit plan or the plan's interpretation of such language that is controlling. Therefore, a member should always consult his or her health care benefit plan when assessing how much he or she may be reimbursed for out-of-network benefits.

How Does This Affect Members?

If a health care benefit plan requires payment using the term "reasonable and customary" or similar language mentioned above with respect to medical and surgical procedures performed and billed by

health care professionals or health care professional group practices, then the affiliates of UnitedHealth Group most commonly refer to a schedule of charges created by FAIR Health, Inc. ("FAIR Health") to determine the amount of the payment.

What is FAIR Health?

FAIR Health is a not-for-profit company, independent of UnitedHealth Group affiliates, established following the New York Attorney General's ("NYAG") investigation into alleged conflicts of interest related to the ownership and use of Ingenix, Inc.'s Prevailing Healthcare Charges System database ("PHCS Database") and Medical Data Research database ("MDR database") and the fairness of their rates. Ingenix, Inc. ("Ingenix"), now known as Optum Insight, Inc. ("Optum Insight"), is a wholly-owned subsidiary of UnitedHealth Group Incorporated. Under a January 2009 settlement agreement between UnitedHealth Group Incorporated and the NYAG, Ingenix's PHCS and MDR Databases closed following the establishment of the new database to be owned and operated by FAIR Health.

FAIR Health provides health care consumers with an estimate of how much out-of-network services will cost them. Health care consumers can access [FAIR Health's Consumer Price Lookup](#).

Additionally, FAIR Health publishes two Benchmark data products called the FH Benchmark Database and the FH RV Benchmark Database. The information in these FAIR Health Benchmark databases is updated and published by FAIR Health at scheduled times each year. UnitedHealth Group affiliates which administer health care plans based on the term "reasonable and customary" or similar standards use the medical/surgical module of one of these FAIR Health Benchmark Databases to determine the maximum amount they will pay for reimbursement of professional fees for medical and surgical services. By using the schedule of charges in the medical/surgical module of these FAIR Health Benchmark databases, the maximum amount a UnitedHealth Group affiliate will pay to members will, at times, be less than the amount billed for particular professional services. Use of this maximum amount then affects the members' "out-of-pocket" cost they must pay to out-of-network health care professionals, under the terms of many health care benefit plans, members are responsible for the difference between the professionals' charges and what the UnitedHealth Group affiliate pays.

How are the FAIR Health Databases Used For Out-of-Network Payments?

Various health insurers and plan administrators periodically send FAIR Health data about claims for services of health care professionals. The claims include the date and the place of the service, the procedure code, and the provider's charge. FAIR Health combines this information into databases that show how much health care professionals have charged for nearly all services in defined geographic areas in the United States. FAIR Health creates and publishes two Benchmark Databases named the FH Benchmark Database and the FH RV Benchmark Database. Depending on the applicable health care plan, UnitedHealth Group affiliates may use one of these databases as a resource for determination of reimbursement amounts for out-of-network services of health care professionals.

The following example illustrates the information gathered by FAIR Health in the FH Benchmark Database: FAIR Health receives charge information of health care professionals who perform colonoscopies in a particular geographic area for a particular time period. The charges of these health care professionals for colonoscopies are arranged from low to high and then percentiles are identified from that arrangement. Here is a simplified illustration of a percentile chart for a colonoscopy for one geographic area:

CPT Code	Description	50th	60th	70th	75th	80th	85th	90th	95th
45378	COLONOSCOPY	\$764	\$783	\$859	\$887	\$907	\$939	\$1008	\$1105

Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals, but plan designers and administrators of particular health care benefit plans may choose different percentiles for use with applicable health care benefit plans. Members may contact the customer service line of the applicable UnitedHealth Group affiliate shown on the back of the member's health identification card to learn of the percentile applicable to the member's health plan.

Health care benefit plans managed by UnitedHealth Group affiliates began to use FAIR Health's Benchmarking Databases to determine payment for out-of-network professional services within 60 days of first receiving the applicable FAIR Health Benchmark Database Modules at various times in 2011. Prior to receiving the FAIR Health Benchmarking Database Modules, UnitedHealth Group affiliates used Ingenix's PHCS database schedules and MDR database schedules to determine payment for out-of-network professional services when reimbursed under standards such as "reasonable and customary" and other similar standards.

For additional information regarding the FAIR Health Benchmark Databases, please visit [FAIR Health's website](#).

How were the Ingenix Schedules Prepared and Used for Payments?

The PHCS Database was designed to use actual, fee-for-service health care professional charges for private sector health care services, or as explained below, when not enough information was available, it reported values based on a methodology using derived charges and relative values. Ingenix collected information from insurers and other health plan administrators nationwide, including information from Puerto Rico and the Virgin Islands. Ingenix asked these contributors to submit only actual fee-for-service charges that professionals billed. Data contributors received a discount on their license fees for the PHCS or MDR Databases based on how much of their charges information was accepted and used by Ingenix.

After Ingenix collected billed charge information from data contributors, Ingenix reviewed the information before using it to create the PHCS and MDR Databases. Specifically, Ingenix excluded information that (i) was out of date, (ii) was incomplete (missing data fields such as a procedure code, zip code, or billed charge), (iii) contained invalid zip codes or procedure codes, or (iv) had billed amounts that fell outside of certain high and low charge parameters set by Ingenix to identify what it deemed to be "outlier" charges.

The PHCS Database set forth amounts determined by the Ingenix process, organized by medical procedure codes, known as CPT codes, and geographic area (geozips). For CPT code/geozip combinations with 9 or more actual charges used by Ingenix in creating the PHCS product, the Database reported those charges at the 50th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th "percentiles." By way of example, the 90th percentile was the amount equal to or greater than 90% of the charges used by Ingenix in creating the PHCS Database for that CPT code/geozip combination. Affiliates of UnitedHealth Group frequently used the 80th percentile of the PHCS Database as their benchmark, but plan sponsors may have chosen different percentiles for use with their plans. For CPT code/geozip

combinations with fewer than 9 actual charges in the repository of data collected from contributors for use in the PHCS Database, the Database reported "derived charges" in the percentile tables. To calculate derived charges, Ingenix pooled billed charges for similar services from the relevant geographic area. The charge data was standardized using "relative values," which were numbers that were assigned to procedure codes based on an assessment of the difficulty and expense of the procedures. More complex and more expensive procedures received higher relative values, while less complex and less expensive procedures received lower relative values. For the PHCS Database, Ingenix licensed its relative values from a company not affiliated with UnitedHealth or Ingenix called **Relative Value Studies Incorporated**.

The MDR Database consisted entirely of derived charges. Ingenix used its own proprietary relative values in creating the MDR Database, and the derived charges methodology used for the MDR Database was different from, though similar to, that used for the PHCS Database.

The medical and surgical modules of the PHCS and MDR Databases contained tables covering over 8,000 different codes across over 400 different Geozips. Each release of the Databases used the data contributed with dates of service during a 12-month moving window between 3 and 15 months prior to the date each module is released.

The service and product codes employed in the Databases were based on either the Current Procedural Terminology ("CPT") coding system developed and maintained by the American Medical Association ("AMA") or the Healthcare Common Procedure Coding System ("HCPCS") developed and maintained by the Centers for Medicare and Medicaid Services ("CMS"). The Databases were divided into "modules," which were compilations of the various tables for different codes that were generally related to one another (e.g., there is a PHCS medical services module and a PHCS surgical services module). There were eight different modules for the PHCS Database and nine modules for the MDR Database. UnitedHealth affiliates used only the medical and surgical modules of the PHCS Database when they reimbursed claims under "reasonable and customary" or other similar standards as described above for professional services delivered and billed by health care professionals or health care provider groups. Geozips were used to group the charges for a particular CPT code by similar geographical area for summarization and presentation in the database tables. Geozips were based on the first three digits of United States zip codes and were either a single three-digit zip code area or a combination of two or more three-digit zip code areas. Whether a Geozip covered only one or more than one three-digit zip code area was based upon: (i) an analysis of submitted charge data for each PHCS release; (ii) the volume of available data; and (iii) geographical similarities involved with the zip code areas underlying each Geozip. The zip code areas that are combined in particular Geozips could vary from year-to-year.

A sample PHCS percentile table is provided below.

CPT Code	Description	50th	60th	70th	75th	80th	85th	90th	95th
71050	RADIOLOGICAL EXAMINATION (2 VIEWS)	\$102	\$103	\$106	\$107	\$107	\$107	\$113	\$122
99211	OFFICE VISIT; EVALUATION AND MANAGEMENT; MINIMAL PRESENTING PROBLEM	\$62	\$70	\$75	\$80	\$85	\$85	\$100	\$100

Important Exclusions

UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases to determine out-of-network benefits for professional services if a member's health care benefits plan does not require payment under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate" or similar terms. For example, if a member's plan provides for payment based upon Medicare rates, UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases as a resource for determining payment amounts.

Reimbursement Policies

UnitedHealth affiliates may apply certain payment policies that can affect both the amount they pay for such benefits and a member's out-of-pocket costs. For example, the Multiple Procedure Policy applies when multiple procedures are performed on the same day by the same healthcare professional. Under this policy, coverage for the primary/major procedure is 100% of the allowable amount, and 50% of the allowable amount for the secondary procedure. Coverage for all subsequent procedures is 25 or 50% of the allowable amount, depending on a member's health plan. This accounts for the fact that many medical and surgical services include pre-procedure and post-procedure work, as well as generic services integral to the standard medical/surgical service (like recording preoperative, intraoperative, and postoperative documentation) that would be performed for the primary procedure and not duplicated for additional procedures. See descriptions of the [Multiple Procedure Policy and other payment policies](#).

Physician Administered Pharmaceuticals

UnitedHealth Group affiliates consider pharmaceutical products administered and billed by health care professionals or health care provider groups to be professional services or supplies for purposes of claims reimbursement when such drugs are covered under a member's health plan. UnitedHealth Group affiliates generally deem the Average Wholesale Price ("AWP") for such pharmaceutical products to be an amount which satisfies plan standards such as "reasonable and customary" or similar standards mentioned above, and thus use AWP to determine out-of-network reimbursement for such products.

The AWP values considered by UnitedHealth Group affiliates are provided by a comprehensive database covering virtually every drug product approved by the Food and Drug Administration for manufacture and distribution. This database is developed and maintained by an independent vendor, Thomson Reuters, and is collected from over 1,200 pharmaceutical manufacturers and distributors.

UnitedHealth Group affiliates reimburse for pharmaceutical products administered and billed by health care professionals or health care provider groups by reference to AWP for a number of reasons. AWP is an industry standard of reimbursement and is widely accepted by health care professionals, governments, and managed care companies as appropriate payment for such products. In addition, government studies demonstrate that reimbursement at AWP typically is significantly higher than actual prices paid by health care professionals for pharmaceutical products. Finally, the prices paid by health care professionals for these products do not vary across geographic regions to the degree that charges for professional services vary across geographic regions, which makes a national standard on reimbursement for these products more appropriate and more consistent with the plan standards mentioned above.

Glossary

Allowable amount – as used in circumstances covered by this notice, the dollar amount eligible for reimbursement with respect to a claim for out-of-network benefits. The standard for determining the allowed amount can vary by health plan, and may be based (depending upon the language of a member's health plan) upon the lower of either the provider's charge or the "reasonable and customary amount," as explained in the beginning of this notice. This dollar amount may not be the amount ultimately paid to the member or provider as it may be reduced by any co-insurance or deductible that is owed by the member.

AWP (Average Wholesale Price) – the Average Wholesale Price for pharmaceutical products which UnitedHealth Group affiliates determine based on a comprehensive database developed and maintained by Thomson Reuters.

CPT codes – a set of codes and descriptions of services and procedures performed by physicians and other health care professionals. Each service and procedure is identified by its own five-digit code. Physicians and other health care professionals use CPT codes in making claims for payment. CPT codes are maintained by the American Medical Association.

FAIR Health – a not-for-profit organization selected by the Attorney General of the State of New York ("NYAG") to provide the health care consumer with data associated with out-of network services.

FH Benchmarking Database – one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out-of-network professional services when reimbursed under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

FH RV Benchmarking Database – one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out-of-network professional services when reimbursed under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

Ingenix – a wholly-owned subsidiary of UnitedHealth Group (NYSE: UNH). Ingenix is now known as Optum Insight, Inc.

MDR database – one of two compilations of information on health care professional charges created by Ingenix, Inc., now known as Optum Insight, Inc., a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group affiliates no longer use the MDR database for determining reimbursement.

Optum Insight, Inc. – a wholly-owned subsidiary of UnitedHealth Group (NYSE: UNH). Optum Insight, Inc. was formerly known as Ingenix.

Out-of-network benefits – benefits provided under a health care benefits plan for services or supplies provided by doctors and other health care professionals who are not parties to a contract with a UnitedHealth Group affiliate.

Out-of-pocket cost – portion of the cost of health services that the plan member must pay, including the difference between the amount charged by an out-of-network provider and what a UnitedHealth Group affiliate pays for such services.

Prevailing Healthcare Charges System database ("PHCS Database") – one of two compilations of information on health care professional charges created by Ingenix, Inc., now known as Optum Insight, Inc., a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group affiliates no longer use the PHCS database for determining reimbursement.

Professional Services – Health care services provided, and billed for, by professionals such as physicians, psychologists, behavioral and health therapists and other practitioners. It does not include health care services for which facilities, such as hospitals or other health care centers, seek reimbursement.

Provider network – doctors and other health care professionals who agree to provide medical care to our members under the terms of a contract.

UnitedHealth Group – UnitedHealth Group (NYSE: UNH) is a diversified health and well-being company dedicated to making health care work better. Headquartered in Minneapolis, Minn., UnitedHealth Group offers a broad spectrum of products and services through UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, OptumHealth, Optum Insight and Prescription Solutions. Through this family of businesses, UnitedHealth Group affiliates serve more than 70 million individuals nationwide.

[Newsroom](#) [Contact Us](#) [Careers](#) [Health Care Fraud](#) [Legal](#) [Privacy](#) [Terms of Use](#) [Accessibility](#)

Follow us



© 2019 United HealthCare Services, Inc.

How is your visit? ✕

EXHIBIT 16

**DISTRICT COURT OF APPEAL
SECOND DISTRICT OF FLORIDA**

**CASE NO. 2D-20-3717
LT CASE NO. 2017-CA-011207**

**UNITED HEALTHCARE OF FLORIDA, INC.
and UNITED HEALTHCARE INSURANCE CO.,**

Petitioners,

v.

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Respondent.

**RESPONDENT GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES,
LLC's RESPONSE TO PETITION FOR CERTIORARI**

ALAN D. LASH

Florida Bar No. 510904

JUSTIN C. FINEBERG

Florida Bar No. 53716

RACHEL H. LEBLANC

Florida Bar No. 0021815

JONATHAN E. SIEGELAUB

Florida Bar No. 1019121

LASH & GOLDBERG LLP

Miami Tower, Suite 1200

100 Southeast 2nd Street

Miami, Florida 33131

Telephone: (305) 347-4040

Facsimile: (305) 347-4050

Attorneys for Respondent

CASE NO. 2D-20-3717

TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

PRELIMINARY STATEMENT 1

STATEMENT OF THE CASE 4

STANDARD OF REVIEW 17

SUMMARY OF THE ARGUMENT 18

ARGUMENT 20

 I. GTB’S COST DATA IS IRRELEVANT..... 21

 II. GOVERNMENT CLAIMS DATA IS IRRELEVANT 29

 III. THE TRIAL COURT’S RELEVANCY DETERMINATIONS,
 EVEN IF INCORRECT, WILL NOT CAUSE IRREPARABLE
 INJURY 37

CONCLUSION..... 39

CERTIFICATE OF COMPLIANCE..... 43

CASE NO. 2D-20-3717

TABLE OF AUTHORITIES

Cases

2-Bal Bay Props., LLC v. Asset Mgmt. Holdings, LLC,
291 So. 3d 617 (Fla. 2d DCA 2020)..... 23

Allstate Ins. Co. v. Langston,
655 So. 2d 91 (Fla. 1995) 18, 37

Am. Med. Ass’n v. United Healthcare Corp.,
2009 WL 1437819 (S.D.N.Y. May 19, 2009)..... 10

Baker Cty. Med. Servs., Inc. v. Aetna Health Mgmt., LLC,
31 So. 3d 842 (Fla. 1st DCA 2010).....passim

Colomar v. Mercy Hosp., Inc.,
461 F. Supp. 2d 1265 (S.D. Fla. 2006) 26

English v. McCrary,
348 So. 2d 293 (Fla. 1977) 17

Giacalone v. Helen Ellis Memorial Hospital Foundation, Inc.,
8 So. 3d 1232 (Fla. 2d DCA 2009).....passim

Hall v. Reynolds,
268 So. 3d 829 (Fla. 2d DCA 2019)..... 17

Harborside Healthcare, LLC v. Jacobson,
222 So. 3d 612 (Fla. 2d DCA 2017)..... 18

Kane v. Stewart Tilghman Fox & Bianchi, P.A.,
85 So. 3d 1112 (Fla. 4th DCA 2012)..... 8, 23

Merkle v. Health Options, Inc.,
940 So. 2d 1190 (Fla. 4th DCA 2006)..... 6, 33

CASE NO. 2D-20-3717

Merle Wood & Assocs., Inc. v. Trinity Yachts, LLC,
714 F.3d 1234 (11th Cir. 2013)..... 8

Point Conversions, LLC v. Pfeffer & Marin Holdings, LLC,
305 So. 3d 609 (Fla. 3d DCA 2020)..... 17

Power Plant Entm’t, LLC v. Trump Hotels & Casino Resorts Dev. Co., LLC,
958 So. 2d 565 (Fla. 4th DCA 2007)..... 37

Tenet Healthsystem GB, Inc. v. Care Improvement Plus S. Cent. Ins. Co.,
875 F.3d 584 (11th Cir. 2017)..... 30, 31

Tumelaire v. Naples Estates Homeowners Ass’n, Inc.,
137 So. 3d 596 (Fla. 2d DCA 2014)..... 18

Wal-Mart Stores, Inc. v. Weeks,
696 So. 2d 855 (Fla. 2d DCA 1997)..... 18

White v. Fort Myers Beach Fire Control Dist.,
302 So. 3d 1064 (Fla. 2d DCA 2020)..... 15

Zirkelbach Constr., Inc. v. Rajan,
93 So. 3d 1124 (Fla. 2d DCA 2012)..... 18

Statutes

42 U.S.C. § 1395w-21..... 12, 35

42 U.S.C. § 1395w—22(k)(1)..... 31

Fla. Stat. § 627.64194..... 7

Fla. Stat. § 627.64194(4) 6

Fla. Stat. § 641.513 6, 7, 26

Fla. Stat. § 641.513(5) passim

CASE NO. 2D-20-3717

Fla. Stat. § 641.513(5)(a)-(c).....21
Fla. Stat. § 641.513(6)31
Fla. Stat. § 90.40120

Rules

Florida Rules of Appellate Procedure 9.045.....2
Florida Rules of Appellate Procedure 9.110(1)17
Florida Rules of Appellate Procedure 9.130(a)(3)17
Florida Rules of Appellate Procedure 9.210(a)(2)2

Regulations

42 C.F.R. § 422.214(a)(1).....31
Florida Administrative Code Rule 69O-191.0496

CASE NO. 2D-20-3717

PRELIMINARY STATEMENT

This action involves Respondent Gulf-to-Bay Anesthesiology Associates, LLC's ("GTB") claims for damages based upon the rates of payment remitted by Petitioners United Healthcare of Florida, Inc. and United Healthcare Insurance Co. (together, "United") for covered medical services rendered to United's insureds holding **commercial** insurance plans. Florida law requires United to reimburse out-of-network medical providers like GTB at rates equaling the fair market value of the services provided. United has deliberately violated the law by systematically reimbursing GTB at rates below fair market value. In other words, the crux of this case is a dispute over the fair market value of medical services rendered.

In accordance with well-established authority providing that fair market value is defined as the rate that a willing buyer would pay and a willing seller would accept in an arm's length transaction, the parties have already exchanged voluminous data from comparable past market transactions. This is precisely the type of data that both parties' experts agree is necessary and sufficient to calculate fair market value. In fact, United retained two experts on this point. One of its experts determined the methodologies for computing fair market value, and the other expert calculated the amounts

CASE NO. 2D-20-3717

that United would owe based on those methodologies. In total, United's experts calculated GTB's damages as ranging from nearly \$10 million to over \$15 million. Apparently discontented with the results of its experts' analyses, United has, at the eleventh hour, requested additional categories of data. It now seeks disclosure of data regarding GTB's cost structure and GTB's payments received from Medicare Advantage Organizations and Managed Medicaid Plans.

As explained in detail below, the trial court properly denied United's motions to compel production of these data sets because both are entirely irrelevant and are not discoverable. As shown in Point I, United asserts entitlement to the cost data because it would cast light on the "reasonableness" of GTB's billed charges. But the reasonableness of GTB's billed charges is not at issue in this dispute, as GTB expressly is not seeking recovery of its billed charges. Rather, the claims at issue focus on the statutory methodology for determining the appropriate rate of reimbursement, which is "fair market value." Importantly, operative the statutes **do not** include costs as a factor for consideration. And, in its common law claims, GTB similarly seeks recovery of fair market value.

CASE NO. 2D-20-3717

As shown in Point II, Medicare Advantage and Managed Medicaid claims data is irrelevant because it simply is not comparable. This lawsuit is focused only on commercial claims, and no governmental claims are at issue. This is critical because, as opposed to commercial claims where the rates are established by participants operating at arm's length in a free market, the government sets the Medicare and Medicaid fee schedules and the government sets the reimbursement rates for out-of-network claims for both Medicare Advantage and Managed Medicaid. Thus, this data has no bearing on the issues in dispute, which are solely focused on appropriate reimbursement rates for services rendered to commercially insured patients.

As shown in Point III, even if the trial court's relevancy determinations were incorrect (they were not), this Court should still deny the Petition because certiorari review is unavailable under the circumstances. This Petition presents a run-of-the-mill discovery dispute. Despite United's protestations to the contrary, the discovery rulings do not even come close to meeting the high standard for setting aside on certiorari review an order denying discovery, which requires that such order "eviscerate" the requesting party's claim or defense. That United can calculate fair market value and mount a defense to GTB's claims based upon the data already

CASE NO. 2D-20-3717

produced is apparent from the fact that United unilaterally determined the reimbursement amounts in the first instance, without the benefit of any of this belatedly requested discovery.

At bottom, United requested discovery, the trial court denied the discovery on relevance grounds, and United is unhappy with that outcome. But a party's displeasure alone does not render certiorari review appropriate. The law is clear that trial courts have broad discretion to resolve discovery disputes, and discovery orders are not to be set aside in extraordinary writ proceedings absent irreparable harm, which plainly does not exist here.

Accordingly, the Court should deny the Petition.

STATEMENT OF THE CASE

GTB is a Tampa-based anesthesiology practice. (App.¹ 22 ¶ 2.) United is a health insurance company and claims administrator. (App. 24 ¶ 10.) United provides health insurance for its members, which includes

¹ Citations to "App." refer to the appendix prepared by Petitioners and submitted simultaneously with the Original Petition. Citations to "Supp. App." refer to the Supplemental Appendix prepared by Petitioners and submitted simultaneously with the Amended Petition. Citations to "Resp. App." refer to the appendix prepared by Respondent and submitted herewith.

CASE NO. 2D-20-3717

coverage for anesthesiology services.² Between May 20, 2003 and May 20, 2017, United and GTB were parties to an agreement (“Participation Agreement”). (App. 24 ¶ 11.) The Participation Agreement governed, *inter alia*, the reimbursement rates which United would pay for anesthesiology services rendered by GTB to United’s members. *Id.* Under the Participation Agreement, GTB agreed to accept discounted rates of reimbursement in exchange for certain contractual benefits. *Id.*

Effective May 21, 2017, United terminated the Participation Agreement. Since then, GTB has continued providing care to United’s members as an out-of-network provider. (App. 30 ¶ 44.) In other words, no express agreement between United and GTB exists to govern reimbursement, or any other aspect, of the medically necessary and covered services provided to United’s members. (App. 31 ¶ 51.) Nonetheless, Florida law regulates the rates that United must pay for out-of-network anesthesia services. For instance, Florida Statutes § 641.513(5) requires health maintenance organizations (“HMOs”) to reimburse out-of-network

² United’s “members” are individuals holding commercial health insurance underwritten and/or administered by United.

CASE NO. 2D-20-3717

providers of emergent care³ at the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services were provided," or an agreed upon rate.⁴ (App. 30 ¶¶ 45.) Florida Statutes § 627.64194(4) imposes the same requirement upon preferred provider organizations ("PPOs") for emergent and non-emergent services. (App. 28-29 ¶¶ 35-36.) And, GTB alleges that Florida's common law similarly obligates United to pay GTB fair value for these services.

³ While § 641.513 expressly applies to emergency services, Florida Administrative Code Rule 690-191.049 extends the obligation of an HMO to pay hospital-based providers, including anesthesiologists, for "medically necessary and approved physician care rendered to a non-Medicare subscriber at a contracted hospital." Moreover, § 641.3154 obligates HMOs to pay providers, such as GTB, for authorized services without regard to the location where the medical services were rendered. There is no dispute that the claims at issue in this case were all medically necessary, approved, and paid (albeit at unlawfully low rates).

⁴ Contrary to United's assertion (Am. Pet. at 10), § 641.513 was not enacted to protect insurance companies. Rather, the statute was enacted to protect non-participating providers, ensuring that they are adequately paid for a service they are required by law to perform. See, e.g., *Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1196 (Fla. 4th DCA 2006) ("Section 641.513(5) clearly imposes a duty on HMOs to reimburse non-participating providers according to the statute's dictates, not based on Medicare reimbursement rates. The intent of the section is to ensure that the non-participating providers are adequately paid for a service they are required by law to perform").

CASE NO. 2D-20-3717

A “usual and customary provider charge” equals the “fair market value of the services provided.” *Baker Cty. Med. Servs., Inc. v. Aetna Health Mgmt., LLC*, 31 So. 3d 842, 845 (Fla. 1st DCA 2010). And fair market value is “the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.” *Id.* The central disputed issue in this litigation is whether United has met its obligation to pay fair market value. GTB alleges that, since termination of the Participating Provider Agreement, United systematically has reimbursed claims at amounts well below the fair market value of the services rendered. (App. 29 ¶ 39, 30 ¶ 48, 32 ¶ 61, 34 ¶ 69, 36 ¶ 82.) In so doing, United has violated Florida law.

GTB has asserted five substantive claims in this action. In Counts I and II of the Amended Complaint, GTB alleges violations of §§ 627.64194 and 641.513 (the “Statutory Claims”). (App. 28-31 ¶¶ 31-49.) Because these statutes obligate United to pay usual and customary charges, *i.e.*, fair market value, in the Statutory Claims GTB seeks to recover the difference between the amounts actually paid and fair market value. (*Id.*) In Counts III, IV, and V, GTB seeks recovery under common law theories for injuries resulting from United’s underpayments (the “Common Law Claims”). (App. 31-38 ¶¶ 50-89.)

CASE NO. 2D-20-3717

Count III asserts breach of implied-in-fact contract. GTB alleges that the parties, by continuing to transact with each other in an environment in which United was legally obligated to pay fair market value for anesthesia services rendered, formed an enforceable agreement requiring United to pay fair market value. By paying less than fair market value, United has breached the agreement. (App. 31-33 ¶¶ 50-63.) Counts IV and V are for *quantum meruit* and unjust enrichment.⁵ GTB alleges that, in rendering valuable services to United's insureds, it has conferred a benefit upon United for which United is equitably obligated to pay fair value. (App. 33-38 ¶¶ 64-89.) Florida law provides that the measure of damages for unjust enrichment is the value of the benefit from the standpoint of the recipient. *Kane v. Stewart Tilghman Fox & Bianchi, P.A.*, 85 So. 3d 1112, 1115 (Fla. 4th DCA 2012). In other words, in Counts IV and V, like the other counts, GTB seeks recovery of the difference between the amounts already paid by United and the fair market value of the anesthesia services rendered to United's members.

⁵ Unjust enrichment and *quantum meruit* are nearly identical causes of action. See *Merle Wood & Assocs., Inc. v. Trinity Yachts, LLC*, 714 F.3d 1234, 1237 (11th Cir. 2013).

CASE NO. 2D-20-3717

Given the above, this action revolves entirely around the proper calculation of fair market value for the anesthesia services rendered by GTB. Such calculation will determine whether United faces liability, and, if so, the *quantum* of damages. And, in determining fair market value, it is critical to understand the distinction in the healthcare market between “billed charges” and the reimbursement amounts customarily paid by insurance companies and accepted by providers. United explains this distinction in its Amended Petition:

Florida medical providers are effectively unrestricted in the prices they “bill” for their services. However, in reality, medical providers actually expect payors to pay vastly different—and lower—prices than their “billed charges.” The prices providers ask insurers and HMOs to pay pursuant to contract may be far, far less than the provider’s billed charges—but providers still “bill” all payors their maximum prices. This practice is similar to the “sticker price” posted on the back of hotel room doors or on the window of a new car. Those prices generally reflect a price much higher than the price customers are actually asked to pay for the room or the car [S]ignificant incentives exist for providers to keep their billed prices as high as possible—even though they usually accept far less in payment for their services.

(Am. Pet. at 12-13.)

As noted, Florida law provides that “[f]air market value is the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.” *Baker County*, 31 So. 3d at 845. And, in light of the distinction

CASE NO. 2D-20-3717

in the statute, which sets forth a “lesser of” methodology between billed charges and usual and customary charges (i.e., the amounts customarily paid and accepted in the market as payment in full for services rendered), discovery in this case has been properly geared towards determining those latter values. GTB has produced extensive amounts of data to United, all of which are relevant to the one critical disputed issue: the prices to which a willing buyer and willing seller would agree in an arm’s length transaction for the anesthesia services rendered. Data produced, includes, *inter alia*:

- The amounts GTB received and accepted on its contracted commercial claims in the Florida market for the period in dispute;
- The amounts GTB received and accepted on its out-of-network commercial claims in the Florida market for the period in dispute;
- The amounts GTB successfully negotiated with United for out-of-network anesthesia claims (these negotiated rates are not the subject of damages, but clearly inform how the parties determine fair market value for out-of-network anesthesia claims);
- Market data from FAIR Health,⁶ an independent, industry benchmark database, and the amounts United paid to GTB when referencing this database;

⁶ United is intimately familiar with FAIR Health. The genesis of FAIR Health was a scam that United perpetrated in the 2000s to unlawfully drive down out-of-network reimbursement rates by manipulating the data populating a wholly-owned subsidiary database called Ingenix. This misbehavior came to light in 2009. In addition to settling the resulting class actions for \$350 million, see *Am. Med. Ass’n v. United Healthcare Corp.*, 2009 WL 1437819,

CASE NO. 2D-20-3717

Not contented with this voluminous discovery,⁷ United sought numerous additional categories of information. At issue in this Petition, United demanded information regarding GTB's internal cost structure. (App. 239-40, 243-44.) Citing this Court's decision in *Giacalone v. Helen Ellis*

at *4 (S.D.N.Y. May 19, 2009), United paid \$50 million to resolve an enforcement action brought by the New York Attorney General's Office.

See State of New York, Office of the Attorney General, Assurance of Discontinuation, Investigation No. 2008-161, p. 10, Jan. 13, 2009, https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/United%20Health.pdf (last accessed March 13, 2021).

Under the terms of its settlement with the NYAG, the \$50 million was used to fund the creation of FAIR Health, which would serve as an industry standard, independent, transparent, benchmark repository of reimbursement data.

See State of New York, Office of the New York Attorney General, Press Release, Attorney General Cuomo Announces Historic Nationwide Reform of Consumer Reimbursement System for Out-of-Network Health Care Charges, Oct. 27, 2009, <https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-reform-consumer> (last accessed March 31, 2021).

⁷ After GTB moved to compel production of this relevant data from United and the trial court entered an agreed order compelling such production, United also produced the amounts United paid to providers of similar anesthesia services in Florida, including, without limitation, payments made to the provider group most comparable to GTB in size, scope and volume, for the period in dispute. (Resp. App. 24-25.)

CASE NO. 2D-20-3717

Memorial Hospital Foundation, Inc., 8 So. 3d 1232 (Fla. 2d DCA 2009), United maintained that cost data is discoverable because it is relevant in assessing the reasonableness of GTB’s billed charges. (App. 243-44.) GTB objected to the discovery request, contending that the reasonableness of the charges is not at issue in a dispute over fair market value. (App. 907:1-909:6.)

In addition, United demanded GTB’s reimbursement data for patients insured under Medicare Advantage and Managed Medicaid plans (“Government Claims Data”). (App. 445-446.) GTB objected to the request, contending that claims reimbursed by government insurance plans are not at issue in this dispute and are not comparable to the commercial claims at issue. (App. 516-520.) GTB noted United’s apparent agreement on this point. Although GTB never requested Government Claims Data from United, in its initial response to GTB’s discovery request—which sought other, relevant information—United asserted a preemptive, general objection to producing its own Government Claims Data. (App. 518-19 (“United objects to any requests concerning claims for benefits submitted by Plaintiff for reimbursement of anesthesia services rendered to any individuals who are enrolled in a Medicare Advantage Plan governed by Medicare Part C, 42

CASE NO. 2D-20-3717

U.S.C. § 1395w-21, et seq, and its regulations, or any Medicaid managed care plan within the meaning of Chapter 409, Part IV, Florida Statutes.”.)

Ultimately, United moved to compel production of GTB’s cost data and Government Claims Data. (App. 235, 432.) GTB submitted an Omnibus Response. (Resp. App. 0051.) The trial court then conducted oral argument on the motions.⁸ After oral argument, the trial court issued an order on several of the outstanding discovery issues. (Resp. App. 239.)⁹ The

⁸ In its Petition, United takes an unnecessary potshot at the trial judge who ruled on the relevant discovery motions, the Honorable Christopher Sabella. (Am. Pet. at 18-19, 35-36.) United suggests that Judge Sabella denied those motions in part because he is new to the case and usually assigned to the criminal division. But the transcript makes clear that Judge Sabella carefully considered the issues, held a lengthy hearing where he asked thoughtful questions, and invited both parties to submit proposed orders before rendering his decisions. (App. 855-924.)

Moreover, Judge Sabella was assigned to Division C for several months in 2020, has been a circuit court judge since 2006, and previously served in the General Civil Division. United’s effort to discount the discovery orders by implying that Judge Sabella is inexperienced, or that the issues at stake were too complex for him to resolve correctly, inappropriate and, in any event, belied by the record.

⁹ In this Omnibus Order, the Court made several important rulings on the scope of discovery, including: (1) denying United’s motion to compel and granting a protective order against discovery of information and documents regarding the ownership/acquisition of GTB; (2) limiting the timeframe of discovery to 2017 forward; (3) limiting discovery to anesthesia services only; (4) limiting discovery to the state of Florida; and (5) limiting discovery to exclude Medicare or Medicaid claims. Despite these clear rulings,

CASE NO. 2D-20-3717

Omnibus Order did not address the questions of whether discovery would include (1) Government Claims Data; and (2) Plaintiff's cost information. Rather, the trial court reserved ruling "on the questions of (1) whether discovery will include Medicare Advantage and Managed Medicaid; and (2) Plaintiff's cost information" and ordered the parties to "submit supplemental filings regarding these two questions for the Court's consideration and determination." (Resp. App. 239.) The Omnibus Order reflected the trial court's verbal pronouncement at the conclusion of the hearing, requesting both parties to submit competing proposed orders containing argument and authority on those two issues. (Resp. App. 209-210.)¹⁰ And, the trial court

throughout the Petition, United continues to assert irrelevant and immaterial arguments regarding GTB's ownership and acquisition. United's continued focus on issues that the Court has already found outside the permissible boundaries of discovery, instead of focusing on those issues that are relevant, is telling.

¹⁰ During the oral argument, GTB's counsel specifically argued that cost discovery should be precluded because the Florida standard jury instructions for *quantum meruit* or unjust enrichment do not contemplate costs. (App. 907.) Thus, while United now contends that it was unaware that GTB would rely on the standard jury instructions as the basis for its position, United's contentions are again belied by the record.

CASE NO. 2D-20-3717

informed the parties that a staff attorney would further review and research the issues. (Resp. App. 209-210.)

In response to the trial court's request, both sides submitted competing proposed orders on the issues regarding Government Claims Data and cost data. (Resp. App. 259-278.) The proposed orders were provided simultaneously to the trial court in Microsoft Word format, so the court had all of the parties' submissions and arguments when making its decisions. Each of United's proposed orders consisted of several pages, with detailed reasoning and citation to authorities.¹¹ After consideration of all of the submissions, the trial court entered its orders.¹²

¹¹ Throughout the Petition, United tacitly criticizes the trial court for entering GTB's proposed orders virtually verbatim. (*E.g.*, Am. Pet. at 18-19.) However, the trial court properly requested proposed orders from both sides, which apprised it of the parties' positions and disagreements with the opposing party's proposed orders. The court then considered the issues for several weeks before rendering a decision. Under the circumstances, the court clearly exercised its independent judgment. *See, e.g., White v. Fort Myers Beach Fire Control Dist.*, 302 So. 3d 1064, 1075-76 (Fla. 2d DCA 2020).

¹² The trial court conducted a status conference on the same day that it issued the Orders. While the contents of the conference were not transcribed, the court alerted the parties to the rulings and announced that it had carefully considered the issues.

CASE NO. 2D-20-3717

The trial court found that cost data was irrelevant. (App. 814-20.) Citing *Baker County*, it held that “the relevant inquiry was in the ‘fair market value’ of the services provided,” and that “the analysis focuses solely on the price of the services, rather than the costs of the services.” (App. 818 ¶ 9.) The court found *Giacalone* inapposite because “Defendants have not raised any unreasonable pricing claims here, either by affirmative defense or counterclaim. Instead, the pleadings here focus on a statutory analysis that addresses the fair market value of the services provided, determined by the price a willing buyer would pay and willing seller would accept.” (App. 819 ¶ 13.)

The court also held that Government Claims Data is irrelevant. (App. 806-13.) It found significant that:

One, there are no claims in this dispute involving Government Claims. Two, Florida statutes and case law clearly distinguish between commercial claims and Government Claims, making discovery of Government Claims irrelevant and improper. Three, in their responses to Plaintiff’s discovery requests, Defendants acknowledged the impropriety of discovery regarding Government Claims by objecting to producing *their own documents* regarding Government Claims.

(App. 809 (emphasis in original).)

Upon the trial court’s denial of its motions to compel, United moved for reconsideration and contemporaneously filed its original Petition in this writ

CASE NO. 2D-20-3717

proceeding. (Supp. App. 22.) Upon denial of the motion for reconsideration, United filed its Amended Petition.

STANDARD OF REVIEW

Certiorari review¹³ of a discovery order is permitted where the order departs from the essential requirements of law, causing material injury to a petitioner throughout the remainder of the proceedings and effectively

¹³ Incredibly, this is United's **third** meritless writ petition. The first was summarily denied. See Case No. 2D-19-3258, Order dated Dec. 11, 2019. United voluntarily withdrew the second only after GTB had expended considerable resources responding. See Case No. 2D-20-1780, Order dated Sept. 15, 2020. Now, this Court is presented with the third. United's behavior is abusive and must stop. The law is clear that extraordinary writs may issue only in extraordinary circumstances, and that writ proceedings are not a substitute for ordinary appellate review of trial court orders. See, e.g., *Point Conversions, LLC v. Pfeffer & Marin Holdings, LLC*, 305 So. 3d 609, 611 (Fla. 3d DCA 2020) ("Since mandamus is an extraordinary writ, the adequate remedy requirement has long been recognized as essential to ensure that the writ only be invoked in extraordinary circumstances."); *Hall v. Reynolds*, 268 So. 3d 829, 829 (Fla. 2d DCA 2019) (per curiam) ("[C]ertiorari should not be used to circumvent the appellate rule which limits interlocutory review of non-final orders."); *English v. McCrary*, 348 So. 2d 293, 296 (Fla. 1977) (Writ of prohibition "is meant to be very narrow in scope, to be employed with great caution and utilized only in emergencies.").

In running to this Court on a writ petition every time it finds itself on the losing end of a trial court's interlocutory order, United transparently seeks to evade the final order requirement imposed by Florida's appellate rules. See Fla. R. App. P. 9.110(1); 9.130(a)(3). This behavior is unfair to this Court and to GTB, both of whom must expend significant time and resources addressing the meritless petitions.

CASE NO. 2D-20-3717

leaving no adequate remedy on appeal. *Allstate Ins. Co. v. Langston*, 655 So. 2d 91, 94 (Fla. 1995). “Only if the challenged order causes irreparable harm to the petitioner, conferring jurisdiction to [the district court], [can the district court] consider whether the trial court departed from the essential requirements of the law in entering it.” *Harborside Healthcare, LLC v. Jacobson*, 222 So. 3d 612, 615 (Fla. 2d DCA 2017).

“In the case of an order regarding discovery, the trial court has **broad discretion.**” *Wal-Mart Stores, Inc. v. Weeks*, 696 So. 2d 855, 856 (Fla. 2d DCA 1997) (emphasis added). A trial court’s discovery order should be set aside on certiorari review only where it “constitutes an **abuse of discretion** which would cause irreparable damage which cannot be remedied on appeal[.]” *Id.* (emphasis added). *See also Tumelaire v. Naples Estates Homeowners Ass’n, Inc.*, 137 So. 3d 596, 598 (Fla. 2d DCA 2014) (certiorari reversal of discovery order appropriate only where trial court abuses discretion resulting in irreparable injury); *Zirkelbach Constr., Inc. v. Rajan*, 93 So. 3d 1124, 1127 (Fla. 2d DCA 2012) (same).

SUMMARY OF THE ARGUMENT

As explained in Point I below, the trial court correctly rejected United’s attempt to compel disclosure of GTB’s cost data. Relying upon this Court’s

CASE NO. 2D-20-3717

decision in *Giacalone*, United contends that cost data is discoverable because it goes to the reasonableness of GTB's billed charges. But that argument fails because the reasonableness of GTB's billed charges is not at issue. Under both the statutory and common law theories asserted in the Amended Complaint, GTB is entitled to the difference between the amounts actually paid and fair market value. Fair market value is the price to which a willing buyer and willing seller would agree in an arm's length transaction. As such, it can be measured only by review of the rates actually paid by comparable commercial insurers and accepted by physicians in the relevant geography for comparable anesthesia services in the relevant time period. As United itself acknowledges, physicians' billed charges often differ substantially from the rates actually paid in the market by insurers and accepted by physicians as payment in full. As such, the amounts billed and the reasonableness thereof are irrelevant to the claims in this case.

As explained in Point II, the trial court correctly rejected United's attempt to compel disclosure of GTB's Government Claims Data. As noted, fair market value is the price to which a willing buyer and willing seller would agree in an arm's length transaction. In other words, it is the price that would arise in a free market. The Government Claims Data is irrelevant because it

CASE NO. 2D-20-3717

does not result from arm's length transactions in a free market. Quite the opposite. Medicare and Medicaid rates are set by the government, based upon budgetary considerations. And while United contends that Medicare Advantage and Managed Medicaid plans differ from traditional Medicare and Medicaid insofar as private insurers administer the plans and have a limited ability to negotiate rates with medical providers, those rates are still ultimately tethered to the government fee schedules and the government-determined monthly capitation payments that the insurers receive as compensation. As such, even "negotiated" rates fall substantially below the rates insurers pay to providers for services rendered to commercially insured patients and simply are not comparable to such commercial claims.

Finally, as explained in Point III, even if the requested materials were arguably relevant, this Court should not disturb the trial court's orders. Certiorari review is available to correct an erroneous discovery order only in exceptional circumstances, where the order would result in irreparable harm to the losing party. Such circumstances plainly do not exist here.

ARGUMENT

United contends that GTB's cost data and Government Claims Data are relevant and hence discoverable. Florida Statutes § 90.401 defines

CASE NO. 2D-20-3717

relevant evidence as “evidence tending to prove or disprove a material fact.” United maintains that the cost data is relevant because it would tend to prove or disprove the reasonableness of GTB’s billed charges. (Am. Pet. at 30 (“United has requested discovery on GTB’s internal cost structure for purposes of challenging the reasonableness of GTB’s charges.”).) And it maintains that the Government Claims Data is relevant to a determination of fair market value for the anesthesia services rendered. (Am. Pet. at 43-44 (“[D]iscovery of negotiated charges and discounts accorded to private Medicare Advantage and Managed Medicaid plans is not only relevant, but central to United’s defense against GTB’s common law and statutory claims.”).) As explained below, both positions are meritless.

I. GTB’S COST DATA IS IRRELEVANT

The cost data is irrelevant because the reasonableness of GTB’s billed charges is not at issue. The relevant statutes entitle GTB to the lesser of: (a) the provider’s charges; (b) usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to. Fla. Stat. §§ 641.513(5)(a)-(c); 627.64194(4) (incorporating § 641.513(5)). For the disputed claims at issue, the parties did not agree to a rate. Therefore, determining whether United has violated

CASE NO. 2D-20-3717

the statutes and, if so, the amount of damages, requires a calculation of the lesser of the “usual and customary provider charges” and GTB’s billed charges. In this case, both United’s and GTB’s experts agree that the usual and customary charges are less than GTB’s full billed charges. (Resp. App. 138-140, 133-134, 235-236.) Accordingly, the only analysis required here is a determination of what constitutes usual and customary provider charges for out-of-network anesthesia services in the relevant communities where the services were provided. See Fla. Stat. §§ 641.513(5); 627.64194(4). The statutes do not address costs.

The leading case on the proper methodology for determining usual and customary provider charges is the First District’s decision in *Baker County*. Recognizing that the term is undefined in the statute, the *Baker County* Court performed a careful analysis of the statutory text to derive a meaning. 31 So. 3d at 845. It concluded that: “[i]n the context of the statute, it is clear what is called for is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.” *Id.* In other words, under its Statutory Claims, GTB is entitled to recover the fair market value of the anesthesia services rendered (less the amounts already paid by United).

CASE NO. 2D-20-3717

The Common Law claims are similar. In Count III, GTB alleges that the parties have formed an implied-in-fact contract requiring United to pay fair market value for the medical services rendered. (App. 31-33 ¶¶ 50-63.) And Counts IV and V are for unjust enrichment and *quantum meruit*. (App. 33-38 ¶¶ 64-89.) Florida law is clear that the measure of damages for unjust enrichment is the value of the benefit conferred from the perspective of the recipient. *Kane*, 85 So. 3d at 1115; *2-Bal Bay Props., LLC v. Asset Mgmt. Holdings, LLC*, 291 So. 3d 617, 619 (Fla. 2d DCA 2020) (“[T]he measure of damages in an unjust enrichment case is the enhanced value of the property from the perspective of the owner, and not the cost of the improvements.”) In other words, GTB’s common law theories, like its statutory theories, provide that United is obligated to pay fair market value for the anesthesia services rendered, not its billed charges.

Fair market value can be calculated only through a review of comparable market data. It is undisputed that the way to determine the price to which a hypothetical willing buyer and willing seller would agree in an arm’s length transaction is to ascertain the payments to which actual buyers and sellers have actually agreed in comparable arm’s length transactions. Indeed, United’s own damages expert, healthcare economist Dr. Adam

CASE NO. 2D-20-3717

Block, has testified that, for purposes of determining fair market value, a provider's charges do not matter.

Q: As you say, the charges do not matter for the purpose of fair market value analysis, correct?

A: That is correct.

(Resp. App. 243:1-8.)

In recognition of such, the parties have exchanged extensive historical market data from their own transactions, as well as from public databases. GTB has disclosed its in-network contracted rates with other commercial payors, the reimbursement amounts it has been paid and has accepted from other commercial payors on out-of-network claims, rates it negotiated with United for out-of-network anesthesia services, and market data from the FAIR Health database. (Resp. App. 47-50, 135-137, 238.)

Similarly, United has produced de-identified claims data, which reflects the reimbursement amounts it paid to in-network and out-of-network anesthesia providers in Florida for the dispute period. As such, both GTB and United have already produced the relevant claims data regarding amounts paid and accepted for similar services in the community for patients with commercial health insurance, *i.e.*, evidence of what actual willing buyers and willing sellers have agreed upon in arm's length transactions. This is

CASE NO. 2D-20-3717

the precise evidence that is relevant and sufficient to determine fair market value of the anesthesia services rendered to commercially insured patients in Florida.

United's position that cost data is discoverable is based almost entirely upon *Giacalone*, where this Court found that a hospital's cost data was relevant to a determination of the reasonableness of its billed charges. (Am. Pet. at 27-34.) United contends that "[t]he trial court's orders directly conflict with" *Giacalone*. (Am. Pet. at 4.) United's contention is erroneous. The trial court carefully considered United's arguments, carefully reviewed *Giacalone*, and rejected United's position. United's argument fares no better in this Petition, because *Giacalone* is easily distinguishable.

Giacalone involved an uninsured patient who had been admitted to a hospital and undergone surgery to implant a pacemaker. 8 So. 3d at 1234. Upon admission, the patient signed a form in which he agreed "to pay the account at the hospital in accordance with the regular rates and terms of the hospital." *Id.* The hospital billed the patient for the full billed charges, which the patient refused to pay. The hospital sued, alleging that the "reasonable value" of [its] unpaid services totaled \$52,280.70, the amount of its billed charges. *Id.* at 1235. The patient asserted a number of affirmative defenses

CASE NO. 2D-20-3717

and counterclaims, and “[t]he central theme of [his] defenses and counterclaims was that the Hospital’s charges for its services were unreasonable and unconscionable.” *Id.* Importantly, *Giacalone* did not involve any claims under §§ 641.513 or 627.64194.

During the litigation, the plaintiff sought discovery of the hospital’s cost data. *Id.* at 1234. The trial court sustained the Hospital’s objections to the discovery in a form order. *Id.* On certiorari review, this Court quashed the trial court’s blanket discovery order, directing the trial court to reconsider the individual requests. *Id.* at 1236. The Court reasoned that, under Florida law, “[a] patient may not be bound by unreasonable charges **in an agreement to pay charges** in accordance with standard and current rates.” *Id.* at 1235 (quotation marks omitted and emphasis added). As such, the Court recognized that “**the reasonableness of the Hospital’s charges was the primary issue to be determined**” *Id.* at 1235 (emphasis added).

In assessing the relevance of the requested discovery materials, the *Giacalone* Court, relying upon a federal decision called *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265 (S.D. Fla. 2006), recognized that there are “three nonexclusive kinds of evidence relevant to the **determination of a claim of unreasonable pricing** by a hospital.” 8 So. 3d at 1235 (emphasis

CASE NO. 2D-20-3717

added). One of the three is data demonstrating the hospital's internal cost structure. *Id.* Accordingly, the *Giacalone* Court vacated the discovery order and instructed the trial court to reconsider the issues. *Id.* at 1236.

In this case, as contrasted with *Giacalone*, GTB did not sue United to recover its full billed charges and expressly does not contend that its full billed charges are the reasonable value of the services rendered. Under both the Statutory Claims and the Common Law Claims, GTB seeks only the fair market value of the services rendered. Unlike *Giacalone*, the defendant here is an insurance company rather than an uninsured patient, GTB is not contending that there is an agreement requiring the defendant to pay the provider's billed charges, there is no "claim of unreasonable pricing," and the provider is expressly proceeding under theories requiring payment of fair market value, not billed charges.¹⁴ Even if United could demonstrate that GTB's charges are in fact unreasonable, that would have no impact upon the dispute. Neither *Giacalone* nor any other authority directs that a provider's

¹⁴ United itself contends that the rates insurers actually pay and medical providers actually accept in the market are often substantially below the providers' full billed charges. (Am. Pet. at 12-13.)

CASE NO. 2D-20-3717

cost structure is somehow relevant in determining the fair market value of the services rendered by the provider.

Moreover, the nature of the trial court's detailed order in this case is vastly different from that of the cursory form order at issue in *Giacalone*. The trial court here carefully reviewed the factual allegations and legal claims asserted, as well as the discovery requests. The court considered *Giacalone* and found the factual and legal circumstances of that case to be readily distinguishable. The trial court further noted that the applicable statutes and legal theories at issue here do not include any consideration of costs, and it reasonably refused to expand discovery into issues unrelated to the actual claims asserted.

Finally, there is no argument that the trial court's order would "eviscerate" United's defense, because United has never raised an unreasonable pricing defense. As the trial court aptly noted: "[United has] not raised any unreasonable pricing claims here, either by affirmative defense or counterclaim. Instead, the pleadings here focus on a statutory analysis that addresses the fair market value of the services provided, determined by the price a willing buyer would pay and willing seller would

CASE NO. 2D-20-3717

accept. *Baker County*, 31 So. 3d at 845-846. The focus of that analysis is on market pricing.” (App. 819 ¶ 13.)

In sum, the trial court properly exercised its discretion in ruling on the discovery issues, finding that costs are irrelevant to the claims and defenses in this action. The trial court properly denied United’s motion to compel disclosure of GTB’s cost data, and this Court should not disturb that ruling.¹⁵

II. GOVERNMENT CLAIMS DATA IS IRRELEVANT

Likewise, the trial court properly exercised its discretion in denying discovery into the Government Claims Data, because that data is irrelevant to the issues in dispute. As GTB’s Amended Complaint makes clear, this

¹⁵ United may contend that GTB has put the reasonableness of its billed charges at issue because its expert witness, Patrick Pilch, has opined that the fair market value of the claims at issue in this case is approximately 80-90% of GTB’s billed charges. (Resp. App. 45-46.) But the Court should disregard any such argument. Mr. Pilch simply expressed his opinion in relationship to GTB’s charges. But, his opinion was not that the charges, in and of themselves, was the measure of damages. Instead, he reviewed comparable market data for the relevant geography in the relevant time period, including the data which Mr. Pilch concluded best represented fair-market value transactions for out-of-network anesthesia services. Mr. Pilch then liquidated GTB’s damages in a range of up to approximately \$30 million. (Resp. App. 46.) In fact, United’s expert similarly expressed damages by calculating a dollar amount per service, and then correlated that amount to GTB’s billed charges. In either case, GTB’s billed charges are simply a metric for expressing the damages calculations, but the damages calculations themselves are not based on those charges.

CASE NO. 2D-20-3717

action seeks recovery only on underpaid commercial claims, not government claims. (App. 24 ¶ 10 n.3.) Considering government claims in a valuation of commercial claims affords an apples-to-oranges comparison. With government claims, there are no free market, arm's length transactions; the rates are simply set by regulation. In fact, the *Baker County* Court explicitly recognized that “[t]he reimbursement rates for Medicare and Medicaid are set by government agencies and cannot be said to be ‘arm’s-length.’” 31 So. 3d at 845-46. Accordingly, the trial court properly denied United’s motion to compel disclosure of the Government Claims Data.

United contends that Medicare Advantage and Managed Medicaid plans function like commercial insurance, insofar as the Medicare Advantage Organizations and Medicaid Managed Care Plans which administer them are able to negotiate contracted rates with medical providers. (Am. Pet. at 36-43.) But United overlooks that this contracting occurs against the backdrop of a regulatory scheme in which the government establishes the baseline rates by decree. Those baseline rates—which are often substantially below the amounts to which a provider would be entitled from a commercial insurer—anchor any negotiations. This reality is amply illustrated by *Tenet Healthsystem GB, Inc. v. Care Improvement Plus S. Cent. Ins. Co.*, 875 F.3d

CASE NO. 2D-20-3717

584, 591 (11th Cir. 2017), a case upon which United itself relies. (Am. Pet. at 37-38.) In *Tenet*, the federal Eleventh Circuit explained that, while Medicare Advantage Organizations may negotiate contracted rates with medical providers, in the absence of such a contract, federal regulations require that a provider who renders care to a patient enrolled in a Medicare Advantage plan “must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.” *Id.* at 590 (quoting 42 C.F.R. § 422.214(a)(1).); see also 42 U.S.C. § 1395w—22(k)(1) (non-contracted providers shall accept as payment in full the amount the physician could collect “if the individual were not so enrolled”).

Managed Medicaid operates in a similar fashion. As noted above, Florida Statutes § 641.513(5) governs out-of-network reimbursements for care rendered to patients insured under commercial HMO plans. It provides that the reimbursement shall be the lesser of: (1) billed charges; (2) an agreed rate; or (3) usual and customary provider charges. A separate statutory scheme, Florida Statutes § 641.513(6), governs reimbursement for patients insured under Managed Medicaid HMO plans. It provides that the reimbursement methodology is dictated by Chapter 409. While §

CASE NO. 2D-20-3717

409.967(1)(b), in turn, adopts § 641.513(5)'s "lesser of" methodology, it adds a fourth prong for the base Medicaid rate.¹⁶

In other words, as a matter of federal law, out-of-network physicians who render care to patients holding Medicare Advantage insurance are reimbursed at the base Medicare rates. Likewise, as a matter of state law, out-of-network physicians who render care to patients holding Managed Medicaid insurance are reimbursed at the base Medicaid rates. In these circumstances, negotiated rates will naturally tend to converge around the base Medicare and Medicaid rates, as insurers have little incentive to agree to contracted rates significantly above the out-of-network default. This is evidenced by the fact that, under the Participation Agreement, there were **separate** fee schedules for commercial insurance and Medicare Advantage plans. (Resp. App. 67-69.)

This set of circumstances differs markedly from those surrounding commercial claims, where the out-of-network default is fair market value, as measured by the prices that would be agreed upon by willing parties acting

¹⁶ Section 641.513(7) addresses insurance under the Florida Healthy Kids Corporation Act. It similarly adds a fourth prong for the base Medicaid rate to § 641.513(5)'s "lesser of" methodology.

CASE NO. 2D-20-3717

at arm's length. *Baker County*, 31 So. 3d at 845. With commercial claims, negotiated rates will tend to converge around fair market value. As such, Medicare Advantage and Managed Medicaid contracted rates are not valid comparators for commercial rates. See, e.g., *Merkle*, 940 So. 2d at 1196 (“Section 641.513(5) clearly imposes a duty on HMOs to reimburse non-participating providers according to the statute’s dictates, not based on Medicare reimbursement rates. The intent of the section is to ensure that the non-participating providers are adequately paid for a service they are required by law to perform”).

United offers several additional arguments, none of which has merit. First, United again relies on *Giacalone*, noting that “[a]mong the information that Mr. Giacalone had requested in discovery . . . were ‘the Hospital’s charges and discounts granted to the various categories of patients that it serves (e.g., self-pay patients, **Medicare patients**, **Medicaid patients**, charity care patients, and privately insured patients[.]’” (Am. Pet. at 38-39 (quoting *Giacalone*, 8 So. 3d at 1235) (emphasis in original).) But *Giacalone* is inapposite for the reasons already discussed. Unlike here, the primary disputed issue in *Giacalone* was the reasonableness of the hospital’s billed charges (which the hospital had demanded that the patient pay in full). 8 So.

CASE NO. 2D-20-3717

3d at 1235. This Court sensibly concluded that data showing that the hospital routinely granted discounts to all classes of patients could be relevant in showing that it was unreasonable to demand payment of full billed charges from Mr. Giacalone. But that conclusion has no bearing on the question at issue in this dispute: the fair market value of the medical services GTB rendered to commercially insured patients under the relevant statutes and claims. In fact, *Giacalone* implies quite the opposite: that the discounts afforded to commercially insured patients in fact differ from those afforded to patients with government insurance.

Second, United makes passing reference to testimony from its expert witness, Dr. Block, that “fair market value of the disputed benefit claims is best determined by including **all** claims,” including Medicare Advantage and Managed Medicaid. (Am. Pet. at 22 (emphasis in original).) But, that opinion is not based on Florida law and ignores the economic reality surrounding Medicare Advantage and Managed Medicaid.

Finally, United attempts to downplay a critical, revealing fact: that United itself has objected to production of its own Government Claims Data. (Am. Pet. at 43.) The chronology here is significant. GTB served its first request for production of documents on December 15, 2017. (Resp. App. 6-

CASE NO. 2D-20-3717

14.) Given various procedural delays, United did not serve responses and objections until March 8, 2019. (Resp. App. 15-23.) Although GTB had not requested production of United's Government Claims Data, United affirmatively included the following general objection in its responses and objections to GTB's requests:

United objects to any requests concerning claims for benefits submitted by Plaintiff for reimbursement of anesthesia services rendered to any individuals who are enrolled in a Medicare Advantage Plan governed by Medicare Part C, 42 U.S.C. § 1395w-21, *et seq.*, and its regulations or any Medicaid managed care plan within the meaning of Chapter 409, Part IV, Florida Statutes.

(Resp. App. 16 ¶ 4.)

In other words, United itself recognized that Government Claims Data is not discoverable in this case.

On April 13, 2020, United served its first request for production of documents. In that request, despite its standing objection to production of its own Government Claims Data, United demanded production of GTB's Government Claims Data. (Resp. App. 39 ¶ 59.) Following an objection from GTB, United moved to compel production of GTB's Government Claims Data on August 21, 2020. (App. 248.) In its September 14, 2020 response to that motion, GTB pointed out the absurdity of United objecting to

CASE NO. 2D-20-3717

production of its own Government Claims Data while simultaneously moving to compel production of that same data from GTB. (App. 518-19.) GTB further noted that:

Consistent with [United's] relevance objection, during the three-year course of this litigation, neither [United] nor [GTB] has produced any information regarding Government Claims. Thus, this case has always proceeded without any discovery into Government Claims. At this juncture, [GTB] already produced an expert report on damages, which analyzed [United's] discovery materials as part of that analysis. It would be prejudicial to allow [United] to do an about-face now.

(App. 519.)

Confronted with this untenable position, on September 30, 2020 United produced its Government Claims Data (without formally notifying GTB that it had withdrawn its standing objection and without GTB ever requesting production of that data). (Resp. App. 234). United now contends that, in light of this belated, unilateral flip-flop, the trial court and this Court should simply ignore the position it took for the prior eighteen months. (Am. Pet. at 43.) But United's gamesmanship should not be rewarded. As GTB explained to the trial court, not only is United's longstanding objection an admission that Government Claims Data is irrelevant to this dispute over commercial reimbursement rates, but it would be highly prejudicial to GTB if

CASE NO. 2D-20-3717

United were able to substantially alter the nature and scope of the case at this late stage.

Accordingly, the trial court properly denied United's motion to compel disclosure of the Government Claims Data.

III. THE TRIAL COURT'S RELEVANCY DETERMINATIONS, EVEN IF INCORRECT, WILL NOT CAUSE IRREPARABLE INJURY

Putting aside the question of the relevancy of cost and Government Claims Data, this Court should deny the Petition because irrelevance alone is no basis for certiorari review of a discovery order. In *Allstate*, the Florida Supreme Court made clear that "not every erroneous discovery order creates certiorari jurisdiction" 655 So. 2d at 94. Rather, the touchstone for certiorari is whether an erroneous discovery order would cause irreparable harm to a party. *Id.* at 94-95. As this Court recognized in *Giacalone*, "[c]ertiorari is rarely available to review orders denying discovery because in most cases the harm can be corrected on appeal." 8 So. 3d at 1234; see also *Power Plant Entm't, LLC v. Trump Hotels & Casino Resorts Dev. Co., LLC*, 958 So. 2d 565, 567 (Fla. 4th DCA 2007) (en banc) ("[F]ew orders denying discovery will involve information so relevant and crucial to the position of the party seeking discovery, that it will amount to a departure from the essential requirements of law so as to warrant certiorari review.").

CASE NO. 2D-20-3717

Irreparable injury exists only where “the order denying that discovery effectively eviscerates a party’s claim, defense, or counterclaim” *Giacalone*, 8 So. 3d at 1234.

Here, even if the cost data and Government Claims Data were relevant (as explained above, they are not), it cannot credibly be argued that deprivation of that data would “eviscerate” United’s defense to GTB’s claims. As noted, the parties have already exchanged voluminous amounts of relevant market data. And, significantly, United’s experts have already rendered detailed opinions regarding the fair market value of the out-of-network anesthesia services, and they did so without any of the discovery United is now pursuing. Their methodology has already been disclosed, and they have provided substantial deposition testimony regarding their analyses. Simply put, United has already mounted a defense to the claims alleged in GTB’s Amended Complaint.

Ultimately, in denying United’s motions to compel, the trial court acted well within its broad discretion. Right or wrong, the court’s decisions have not resulted in irreparable harm; United’s defense remains safely intact. In fact, United itself unilaterally decided how much it would pay GTB for the anesthesia claims, and, therefore, must have believed it had sufficient

CASE NO. 2D-20-3717

information to support its decision. It is certainly telling that United is fighting so vigorously to inquire about information it never had when making the unreasonably low payments. United is aware of the market forces that dictate fair market rates, and its experts have already concluded that United grossly underpaid GTB for the medically necessary anesthesia services based upon that information. This case should be decided by the jury on the relevant and material evidence regarding fair market value, all of which has already been exchanged in discovery.

At bottom, United simply cannot demonstrate irreparable harm or that its defense is “eviscerated” in the absence of this discovery. Rather, were this Court to set aside the trial court’s rulings in such unremarkable circumstances, what would be eviscerated in this proceeding is any limitation upon the availability of interlocutory appellate review of discovery orders. Accordingly, the Court should deny the Petition.

CONCLUSION

For the reasons set forth above, this Court should deny the Petition.

CASE NO. 2D-20-3717

Respectfully submitted:

LASH & GOLDBERG LLP

Suite 1200, Miami Tower
100 Southeast Second Street
Miami, Florida 33131-2100
(305) 347-4040/(305) 347-4050 Fax

By: /s/ Justin C. Fineberg

ALAN D. LASH

Florida Bar No. 510904

JUSTIN C. FINEBERG

Florida Bar No. 53716

RACHEL H. LEBLANC

Florida Bar No. 0021815

JONATHAN E. SIEGELAUB

Florida Bar No. 1019121

Attorneys for Respondent

DATED: March 18, 2021

CASE NO. 2D-20-3717

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 18th day of March, 2021, a true and correct copy of the foregoing was served via the Court's efilings system and was furnished to all parties listed below:

KATHERINE E. GIDDINGS, BCS
katherine.giddings@akerman.com
elisa.miller@akerman.com
myndi.qualls@akerman.com
Akerman LLP
201 East Park Avenue, Suite 300
Tallahassee, Florida 32301
Telephone: (850) 224-9634
Telecopier: (850) 222-0103

CHRISTINE B. GARDNER
christine.gardner@akerman.com
lella.provoste@akerman.com
Akerman LLP
Phillips Point, Suite 1100 W
777 S. Flagler Drive
West Palm Beach, FL 33401
Telephone: (561) 652-5000

IRENE BASSEL FRICK
irene.bassel@akerman.com
nicole.emmett@akerman.com
Akerman LLP
401 East Jackson Street,
Suite 1700
Tampa, Florida 33602
Telephone: (813) 223-7333

GERA R. PEOPLES (450022)
gera.peoples@akerman.com
magda.cabra@akerman.com
Akerman LLP
Three Brickell City Centre
98 Southeast Seventh Street,
Suite 1100
Miami, Florida 33131
Telephone (305) 374-5600

SERVICE BY U.S. MAIL

The Honorable Christopher C. Sabella
Thirteenth Judicial Circuit Court
401 N. Jefferson St., Room 516
Tampa, Florida 33602

By: /s/ Justin C. Fineberg
Justin C. Fineberg

CASE NO. 2D-20-3717

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation and font requirement set forth in Rule 9.045, Florida Rules of Appellate Procedure. This brief contains 8,487 words. It has been prepared in a proportionally spaced typeface using Microsoft Word in Arial 14 point font, in compliance with the font requirements of Rule 9.210(a)(2), of the Florida Rules of Appellate Procedure.

By: /s/ Justin C. Fineberg
Justin C. Fineberg

EXHIBIT 14

FILED UNDER SEAL