FREEPORT-MCMORAN INC. MEDICAL PLAN

SUMMARY PLAN DESCRIPTION
AND PLAN DOCUMENT

JANUARY 2017

WHERE TO FIND INFORMATION

ABOUT YOUR MEDICAL PLAN

The Freeport-McMoRan Inc. Medical Plan (the “Medical Plan” or “Plan”) can help you pay for the cost of medical services for you and your family. The Plan is a component plan of the Freeport-McMoRan Inc. Health & Welfare Plan (“Health & Welfare Plan”). It is an employee welfare benefit plan that has been adopted by Freeport-McMoRan Inc. (the “Company”) for the purpose of providing benefits to employees and their eligible dependents who are eligible to participate under its terms and conditions.

This document, together with the Important Plan Information document, constitutes as the summary plan description and, together with the Health & Welfare Plan, constitutes as the written plan instrument for the Plan as required by section 402 of ERISA. The purpose of this document is to describe the major features of your medical coverage under the Plan in effect as of January 1, 2017**.**

The Plan is not an employment contract. Participating in the Plan does not give you a right to continued employment with the Company or otherwise affect your employment rights. Specifically, nothing contained in this document or in the Plan document will be understood or interpreted to be a contract of employment between the Company (or any of its subsidiaries or affiliates) and you, nor as a limitation of the right of the Company to discipline, discharge or take action with respect to any of its employees.

If you have questions about your Medical Plan benefits, please contact the Freeport-McMoRan HR Service Center or the appropriate Claims Administrator. Contact information for the HR Service Center and the Claims Administrators is listed at the end of this summary and in the Important Plan Information document.

Be sure to refer to the “Important Plan Information” document for additional information.

HIGHLIGHTS OF YOUR MEDICAL PLAN

The Medical Plan provides several optional plan designs. These include:

- *The Consumer Driven Health Plan (CDHP) option; and*
- *The Exclusive Provider Organization (EPO) option; and*
- *The Preferred Provider Organization (PPO) option;*

The Medical Plan options available to you will be identified in your enrollment materials. The CDHP, EPO and PPO options are administered by UnitedHealthcare (UHC).

All of the Medical Plan options include prescription drug coverage.

This summary describes the Medical Plan options, including provisions that apply to all of the options.

ELIGIBILITY AND ENROLLMENT

If you are an eligible employee, you can enroll yourself and your eligible dependents in the Medical Plan when you first become eligible, during annual enrollment or mid-year if you have a change in status. Eligible dependents include your spouse and your children. See the Important Plan Information document for more details about who is eligible to enroll in the Plan and when you can enroll.

Initial Enrollment

You can choose the medical option under which you want to be covered, and also choose whether you want to cover only yourself or if you also want to enroll a spouse or any dependents. You can also elect to waive medical coverage if you have other medical coverage.

If you don't enroll by the 60th day, you will receive the default medical election as explained below and your share of the cost of coverage, if any, will be deducted from your paycheck.

Generally, the medical election you make when you are first eligible to enroll in the Plan will stay in effect through December 31 of that year.

Annual Enrollment

Annual enrollment is held in the fall of each year, and lets you enroll for the first time if you previously waived coverage, or it allows you to make new elections to meet your changing needs. You can elect a different medical option and update your dependent information to report any changes or additions. The election you make during the annual enrollment period will become effective on January 1 that immediately follows that annual enrollment period and, generally, will stay in effect through December 31.

If you do not make a new election during the annual enrollment period, you'll be enrolled in the same medical option (or waive option) for the next year.

Eligibility Changes During the Year

If you lose your status as an eligible employee during the year (for example, because you change from full time to part time status so that you are regularly scheduled to work fewer than 30 hours a week, or because you transfer to a collectively bargained position or if your employment terminates), and you later become eligible during the same calendar year, but after 30 days of your loss of eligibility, you will be treated as new hire and you will need to make new elections. If you regain eligible status within 30 days of the loss of eligibility, prior elections at termination will be reinstated unless another event has occurred that allows a change.

Default Elections

If you don't enroll or waive coverage during your initial enrollment period or during annual enrollment, your default election for the calendar year period being considered will be:

- **For new hires or rehires**, the default election is the CDHP option, and you will be enrolled in "Employee Only" coverage.
- **For subsequent annual enrollment periods**, the default election is the medical option and coverage category for which you are currently enrolled.

If the default option goes into effect, it will apply for the remainder of the calendar year being considered or until such time as you have an eligible change in status.

The default coverage may change from time to time at the discretion of the Plan Administrator. If this happens, you will be notified of any specific enrollment action required on your part.

When Coverage Begins

The medical coverage that you choose for yourself and any dependents begins on the date you meet the Plan's eligibility rules, as explained in the Important Plan Information document. For changes made during annual enrollment, coverage begins on January 1 that immediately follows that annual enrollment period.

If you enroll ***your eligible dependents*** for medical coverage when you first meet the Plan's eligibility rules, their coverage begins when yours does. You will be asked to provide a copy of your marriage certificate or child's birth certificate (and, possibly, other appropriate supporting documentation) when enrolling dependents in the medical Plan. After that, you have to enroll a new dependent — such as a spouse — within 60 days starting on the day that person becomes your dependent. Coverage is effective as of the date of initial eligibility or status change. (However, see "Special Rules for Newly Acquired

Children" below.) Your new benefit deductions will begin in the pay period following the date you submit your election.

Making Mid-Year Changes

Once coverage begins (or you waive coverage), you can make changes during the year only if you have an eligible change in status. You have to submit your change in status request to the HR Service Center, along with supporting documentation for the change, such as a marriage certificate or birth certificate, within 60 days of an eligible change in status if you want to make a corresponding change to your coverage. If you miss the deadline, you may not make changes until the next annual enrollment period.

A change in status includes a change in family status, a change in employment status, or a change in the cost or coverage under the Plan. See the Important Plan Information document for more information about the events that may allow you to make changes in your benefit elections.

If you have an eligible change in status, you can change your coverage category, add or delete a dependent, commence or cancel coverage under the Plan, or make any other change otherwise allowed. However, any change you make has to be consistent with the type of status change you had. For example, if you had elected "employee only" medical coverage, and you marry, you can change your coverage to add your new spouse and your spouse's children.

Please keep in mind you will need to provide a copy of your marriage certificate or birth certificates when adding a new dependent. You will also need to provide your new dependent's name, date of birth and Social Security number as soon as possible so that your dependent can be enrolled. The Plan Administrator requires proof of your dependent's eligibility to participate in the Plan at any time.

Special rules for certain newly-acquired children

When you acquire a new child by birth, adoption or placement for adoption, the following rules apply:

- If the medical coverage category you previously elected covers children, your child's medical coverage will begin automatically at birth or the date you acquired the child, as long as you notify the HR Service Center within one year.
- If the medical coverage category you previously elected does not cover children, you have one year to notify the HR Service Center. The child can be covered retroactively to the date he or she became your dependent. If any retroactive payments are due, the payment amount will be calculated on an after-tax basis, and you will need to submit a check for that amount, payable to Freeport-McMoRan Inc., within 45 days after notification.

Qualified Medical Child Support Orders (QMCSOs)

You may be required by a Qualified Medical Child Support Order ("QMCSO") to cover or continue coverage for a child. A QMCSO, which is a judgment, decree or order made under state law, may be issued in a divorce or separation proceeding or settlement. A QMCSO must meet specific rules that are set forth in a separate document. If a QMCSO meets those rules, the child will be automatically enrolled in coverage as your dependent and the Plan will pay benefits according to the terms of the QMCSO. You will be required to pay any additional cost for the child's coverage.

Refer to the Important Plan Information document for more information about the Plan's QMCSO rules and procedures. You also may contact the HR Service Center to learn more.

Children's Health Insurance Program (CHIP)

Special enrollment rights are available under the Children's Health Insurance Program Reauthorization Act of 2009. Refer to the Important Plan Information document for information about how changes in eligibility for Medicaid or the Children's Health Insurance Program can affect your coverage options.

HIPAA special enrollment events

If you change your dependent coverage due to a special enrollment event as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you can change the medical plan option under which you and your dependents are covered.

For this purpose, a HIPAA special enrollment event means the occurrence of one of the following events:

- You previously declined coverage for one or more of your eligible dependents because the dependent was covered under another medical plan, and the dependent loses coverage under the other plan.
- You acquire a new eligible dependent through marriage, birth, adoption or placement in connection with adoption.
- Your eligible child loses coverage under a Medicaid or CHIP plan as described above.

For example, if you marry and add your spouse and new children, you could change from the EPO option to the PPO option.

How to make changes

If you have a change in status or have questions regarding the rules discussed above and in the Important Plan Information document, contact the HR Service Center for assistance.

YOUR MEDICAL PLAN ELECTION OPTIONS

Medical Plans

You can elect one of several options — or you can waive coverage. Your choices for medical coverage are:

- Consumer Driven Health Plan (CDHP)
- Exclusive Provider Organization (EPO)
- Preferred Provider Organization (PPO)
- Waive Medical Coverage.

The CDHP, EPO and PPO are administered by UnitedHealthcare. For more information about each of the medical coverage options, see below “How the Medical Plan Options Work”.

Coverage Categories

You can choose from four coverage categories when electing medical coverage.

- Employee only
- Employee plus one or more children
- Employee plus spouse
- Employee plus family (spouse and one or more children)

You do not have to elect the same coverage category for medical that you elect for dental or vision. For example, you may elect employee only coverage for medical and employee plus family coverage for dental.

If you choose a medical category that covers you and your dependents, you all must be enrolled in the same medical option.

If You and Your Spouse or Child Are Both Employees of the Company

If both you and your spouse or child are employed by the Company and are eligible to participate in the Plan, some special rules apply to the dependent coverage categories you can choose. Each employee must make a medical election (or will receive the applicable default coverage explained under “How the Medical Plan Options Work” if no election is made within 60 days.)

- Two employees who are married to each other:
    - You each can elect coverage for yourself only, or
    - One of you may elect to waive coverage while the other elects to cover you as a dependent.

- You can't be covered as both a dependent spouse and an employee.
- Either one of you can cover children as dependents, as long as no child is covered as a dependent of more than one employee.

♦ A parent and eligible child who are both employees:

- The parent may cover the child-employee as a dependent under age 26, in which case the child-employee can waive coverage, or
- The child may elect coverage for himself/herself as an employee.
- You can't have coverage both as an employee and as the child of an employee.

Paying for Your Coverage

When you are first eligible to enroll in the Plan, and each year after that during the annual enrollment period, you will be notified of the amount of your contribution for the various Medical Plan options. This amount is referred to as a salary reduction contribution, and is made on a pre-tax basis through the Flexible Benefits Plan, which may help to lower your taxes.

In addition to your contribution, the Company funds a substantial portion of the cost of providing health care to you.

I.D. Cards

After you enroll in a medical plan option, you will receive an I.D. card from UnitedHealthcare. Your I.D. card will give important information to you and your health providers about your medical coverage, including the group contract number and your member I.D. number.

HOW THE MEDICAL PLAN OPTIONS WORK

The CDHP, the EPO and the PPO are administered by UnitedHealthcare, the Claims Administrator for all medical plan benefits. Contact information for the Claims Administrator is located at the end of this summary. Appendix B includes a Summary of Benefits for each of the Medical Plan options.

For information about your prescription drug benefits see the separate "Prescription Drug Benefits" section.

Certain preventive medical services, including routine physicals, screenings and mammograms, are covered under all medical options at 100% with no deductible. The Plan limits benefits for some expenses and does not pay benefits for all expenses, and there are Plan rules that must be met before benefits will be paid.

Important Terms

The following terms are used to describe how each of the medical plan options work. Refer to the charts below to see how these terms apply to the CDHP, EPO, and PPO options.

- **Deductible**: The annual deductible is a fixed-dollar amount you must pay for Covered Health Services in a calendar year before the Plan will pay for benefits in that calendar year. Any amount you or your covered dependent has to pay because an expense is not an Eligible Expense will not count towards the individual or family deductible.
- **Out-of-pocket maximum**: The Plan keeps track of the coinsurance amounts that you pay. After your expenses equal a specified amount, you reach the annual out-of-pocket maximum and the Plan pays 100% of your eligible medical expenses for the rest of the calendar year. A separate out-of-pocket maximum applies to prescription drug expenses for the PPO and EPO medical plan options.
- **Copayment or copay**: A copayment is a fixed-dollar amount that you pay when you receive certain Covered Health Services under the EPO Medical Plan option. For example, you will pay a copayment for a Physician's office visit. Prescription drug copayments also apply under all of the medical plan options.
- **Coinsurance**: A percentage of the cost of Eligible Expenses that the Plan pays after you satisfy the deductible . You are responsible for the remainder of the cost and for paying any amounts that are in excess of the Eligible Expense.

If you change from one medical plan option to another in the middle of a calendar year due to a qualifying Change in Status, the amounts you have accumulated toward satisfying the deductible or out-of-pocket maximum will be transferred to your new medical plan option.

The Medical Plan Options

The CDHP

The CDHP offers care through UnitedHealthcare's network of Physicians, Hospitals and other health care providers. This option also provides coverage if you choose a provider outside the network. However, when you use a network provider, the Plan pays a greater percentage of covered expenses and your out-of-pocket costs are less.

CDHP	In Network	Out of Network
Annual Deductible		
Employee only coverage	$1,300	
Employee + 1 or more dependents	$2,600	
Annual Out-of-Pocket Maximum		
Employee only coverage	$3,000	$6,000
Employee + 1 or more dependents	$6,000	$12,000
Prescription Drug costs apply to the Out-of-Pocket Maximum only under the CDHP option.		
Coinsurance	80% for most services	60% for most services

The amounts shown above may change for future years to comply with IRS requirements.

If you cover any dependents, you have to meet the family deductible before the Plan pays benefits for any family member (except in the case of certain preventive services that are paid at 100% with no deductible if provided in-network). The family deductible can be met by one or more than one person.

You pay the full negotiated price for non-preventive prescription drugs until you meet the deductible. All of your Eligible Expenses for in-network and out-of-network providers, as well as your covered prescription expenses, apply to the deductible. There is no separate non-network deductible.

Once the annual out-of-pocket maximum is met, then all allowable medical and prescription drug expenses are covered at 100%.

> Example: If you have family coverage and you incur $1,300 of eligible medical and prescription expenses for yourself, you still must pay the full negotiated cost of services until you, combined with all of your covered dependents, have $2,600 of expenses. Once the annual deductible is satisfied, Plan benefits are paid at the coinsurance percentage for the rest of the year for all covered family members. If you reach the annual out-of-pocket maximum the Plan will pay for 100% of your Eligible Expenses incurred through December 31 of the same year. If you do not cover any dependents, you will need to incur $1,300 of Eligible Expenses before the Plan begins to pay benefits at the coinsurance level.

You can search for a network provider at www.uhc.com (select UnitedHealthcare Choice Plus) or by logging in to www.myuhc.com.

Refer to the charts in Appendix B for more information about how coinsurance applies to specific services under the CDHP option. **For this plan only, your prescription drug expenses apply toward the medical annual out-of-pocket maximum.**

If you elect the CDHP you will be eligible for a Health Savings Account (HSA) that allows you to pay for unreimbursed health care expenses (including eligible dental and vision expenses) with tax-free money. See the section titled “Health Savings Accounts” for more information.

The EPO

The EPO option, which offers care through UnitedHealthcare’s network of Physicians, Hospitals and other health care providers, is available in most areas. **You must use the EPO network of providers for all your care,** or request in advance approval for a “gap exception” by the Claims Administrator when there is no appropriate in-network provider within a 30-mile radius. Contact the Claims Administrator at the number shown on your I.D. card to request a gap exception. Exceptions may also apply if non-network services are arranged by your in-network provider when you have no control or choice.

You can search for a network provider by logging in to www.myuhc.com (select UnitedHealthcare Choice)..

EPO	
Deductible	**$250 Individual** **$500 Family**
Annual Medical Out-of-Pocket Maximum (includes copays and coinsurance but excludes prescriptions)	
Individual	$2,900
Family	$5,800
Annual Prescription Out-of-Pocket Maximum	
Individual	$4,250
Family	$8,500
Copays	
Primary care physician	$20
Specialist	$40
Emergency room	$100 (waived if admitted)
Coinsurance	85% for hospital and certain other services

For most services you pay a copayment. For certain services including hospitalization, outpatient lab and x-ray, and durable medical equipment, you will be required to pay a percentage of the Eligible Expenses, called “coinsurance” after you meet the deductible.

The coinsurance amounts that you pay for hospitalization, x-ray, lab and durable medical equipment charges apply to the out-of-pocket maximum.

Refer to Appendix B for more information about how copayments and coinsurance apply to specific services under the EPO option.

There is a separate out-of-pocket maximum for prescription drug expenses.

The PPO

The Preferred Provider Organization (PPO) works much like the CDHP option described above. It offers care through UnitedHealthcare's network of Physicians, Hospitals and other health care providers. This option also provides coverage if you choose a provider outside the network. However, when you use a network provider, the Plan pays a greater percentage of Eligible Expenses and your out-of-pocket costs are less.

PPO	In Network	Out of Network
Annual Deductible		
Individual	$500	$1,000
Family	$1,000	$2,000
Annual Medical Out-of-Pocket Maximum (excludes prescriptions)		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Annual Prescription Out-of-Pocket Maximum		There is no out-of-pocket maximum for these expenses
Individual	$4,150	
Family	$8,300	
Coinsurance	80% for most services	60% for most services

You can meet the family deductible with any combination of individual deductibles, from two or more family members. However, one covered family member cannot satisfy the family deductible for all family members.

All of your Eligible Expenses for in-network and out-of-network providers apply to the deductible..

Copayments and amounts that you pay for prescription drugs do not count toward the deductible.

> Example: During the first few months of the year, you incur $500 in Eligible Expenses, and you have satisfied the deductible for yourself only. After that your spouse has $150 in Eligible Expenses and your child has $350 in Eligible Expenses. In the aggregate, your family has had $1,000 in Eligible Expenses. Plan benefits will now be paid at the coinsurance percentage for every covered member

of your family until you meet the annual out-of-pocket maximum for the year, at which time the plan will then begin to pay at 100% for covered expenses.

You can search for a network provider at www.uhc.com (select UnitedHealthcare Choice Plus) or by logging in to www.myuhc.com.

Refer to the chart in Appendix B for more information about how coinsurance applies under the PPO option.

There is a separate out-of-pocket maximum for expenses of prescription drugs obtained at a network provider. There is no out-of-maximum limit for non-network prescription expenses.

HEALTH SAVINGS ACCOUNT

When you enroll in the CDHP, you authorize the Company to send your personal information to the Health Savings Account administrator, on your behalf, to open a tax-free account called a Health Savings Account ("HSA"). Establishment of an HSA is subject to federal banking rules.

You are an HSA-Eligible Individual if:

- You meet the eligibility requirements of Internal Revenue Code Section 223;
- You are enrolled in the CDHP medical option;
- You do not have any other disqualifying non-high deductible health plan coverage;
- You are not enrolled in Medicare Part A or Part B; and
- You have a mailing address that is not a P.O. Box.

You may be required to certify that you meet all of the eligibility requirements under Code Section 223. You should be aware that coverage under a spouse's plan could make you ineligible to have an HSA. To find out more about HSA eligibility requirements and the consequences of making your own contributions or receiving Company contributions to an HSA when you are not eligible, including possible excise taxes and other penalties, see IRS Publication 969, "Health Savings Accounts and Other Tax Favored Health Plans."

An overview

An HSA is a tax-advantaged personal bank account that can be used for health care services. Money is contributed on a pre-tax basis, earns interest tax-free, and is not taxed when withdrawn to pay for qualified health care expenses. With an HSA, you can accumulate money on a tax-advantaged basis for current or future health care expenses, including those that you incur after retirement. You control your HSA and choose how to

spend the funds in your account. If you don't use the money in one year, the balance rolls into the next year so that you can use it later.

The Company may make contributions to your HSA. However, the HSA is not an employer-sponsored employee benefit plan – it is an individual trust or custodial account that you open as a HSA trustee/custodian to be used for reimbursement of "eligible medical expenses" (including dental and vision expenses) as described in IRS Publication 969 and in Code Section 223.

The Company's role is limited to making an employer contribution if it decides to do so in any year, and allowing you to contribute to your own HSA on a pre-tax basis. The Company has no authority or control over the funds deposited in your HSA. The HSA is not subject to ERISA.

Contributions

As long as you are an HSA-Eligible Individual, money may be deposited into your HSA up to an annual maximum set by the IRS. In 2017, the maximum contribution for single coverage is $3,400, and $6,750 for family coverage.

Each year the Company will decide whether to contribute to the accounts of all HSA-Eligible Individuals, and the amount of such contributions. The Company may decide to make its full contribution on January 1 for employees who are enrolled in the CDHP on that date or pro-rate on a monthly basis. Contributions for those who enroll after January 1 may be pro-rated and made on a monthly basis.

You will be notified of the Company's contribution, if any, during annual enrollment prior to each year.

You can elect to contribute up to the remainder of the maximum amount set by the IRS; however, you are not required to contribute to your HSA in order to be eligible to receive any Company contribution. Your contribution can be deducted from your paycheck on a pre-tax basis or you may choose to make a personal deposit to your account and take a deduction on your tax return. Your contributions made through payroll deduction will be deposited into your HSA following each pay period.

If you enroll in the CDHP mid-year, or if you stop participating in the CDHP before the end of a calendar year, the Company contribution and your personal contribution limit will be prorated. Generally, if your employment terminates, Company contributions to your HSA will stop.

The IRS limits apply to all HSAs that you have. If you or your spouse has another HSA, you are responsible for making sure your combined contributions don't exceed the limit. The portion contributed over the annual limit is considered taxable income and an excise tax applies.

The Company cannot guarantee that specific tax consequences will result from your participation in the HSA. Ultimately, it is your responsibility to determine the tax treatment of your HSA. You may wish to consult a tax advisor.

"Catch-up" contributions

If you will be at least 55 years old by the end of the year, you can contribute an additional $1,000 to your account in 2017. This amount may be changed by the IRS in future years.

Changing your HSA contributions

You can start, request a lump sum contribution or make changes to your HSA payroll contributions one time in each calendar quarter. You can stop making future contributions at any time. If you want to make a change, contact the HR Service Center.

Your new contribution election must be an annual amount. For example, if you elected to contribute $500 to your HSA for the year, you could change your annual contribution to $1,000. Your future payroll deductions will increase so that by the end of the year your total HSA contributions will equal $1,000.

You may not decrease future contributions to your HSA below the amount you have already contributed during the year. No refunds will be issued. Any money in your HSA will stay in your account to be used for health related expenses. You can check your payroll statement to see how much you have contributed to-date during the year.

The HR Service Center must receive your election to make a change before the first day of a month in order to assure that the change will be effective within that month. Due to required processing time the change may not go into effect as of the first payroll after you submit the form.

Keep in mind that total contributions for the year cannot exceed the IRS limit, including Company contributions to your HSA.

Using your account

You can use the money in your HSA to pay for medical expenses not paid by the Plan or for any other IRS-eligible health care expenses. This includes expenses incurred by yourself and your eligible tax dependents, including your spouse and any eligible children. If you have questions about whether your child is an eligible tax dependent for this purpose, contact your tax advisor.

As long as you use the money for IRS-eligible health care expenses, the money remains tax-free. If you use your HSA to pay for non-eligible expenses, tax penalties will apply.

You may pay for services using a debit card associated with your HSA, if your provider accepts it, or you can pay the provider directly and then file for reimbursement. You cannot access more than what is in your account at the time of service. If you incur expenses

that exceed the amount that is in your account you can have your expenses reimbursed later in the year as more contributions are made.

You cannot use your HSA to pay for over-the-counter **medications** other than insulin. However, some other types of health-care supplies purchased over-the-counter may be reimbursed through an HSA.

- Examples of medicines that require a prescription in order to be paid from an HSA: Aspirin and other pain relievers, antibiotic creams, allergy and sinus medications, cough, cold and flu medicines, sleep aids, laxatives, acid controllers and digestive aids.
- Examples of health-care supplies that can be paid from an HSA without a prescription: Band-Aids, birth control supplies, contact lens supplies and solutions, denture adhesives, first aid supplies, reading glasses, walkers, canes and insulin.

Coordination with Limited Purpose Health Care Flexible Spending Account

If you enroll in the CDHP medical option you cannot enroll in a regular Health Care Flexible Spending Account ("FSA"), but you can have a Limited Purpose Health Care Flexible Spending Account ("Limited Purpose FSA"). See the Summary Plan Description for the Freeport-McMoRan Inc. Health Care Reimbursement Plan for more information about these accounts.

In the event that an expense is eligible for reimbursement under both your Limited Purpose FSA and the HSA, you may seek reimbursement from either the Limited Purpose FSA or the HSA, but not both.

No "use it or lose it" rule

You will never forfeit the money in your HSA (see below regarding administrative fees). If there is money in your account at the end of the year, the full balance will roll over to the new year. When you leave the Company or retire, you take your account with you.

Earnings, Investing and Administrative Fees

Currently the Company sets up your HSA at Optum Bank. Your HSA money will earn a flat interest rate. Once your account grows to a minimum of $2,000, you will be eligible to choose from a variety of mutual funds to meet your investment style. There are no investment transaction fees or loads. You may contact Optum Bank for more information at the number shown below.

Interest and investment gains grow tax-free and will remain tax-free when used to pay eligible medical expenses. The portion of your HSA that is invested in funds can be used at any time to pay health expenses; however, before you can use the invested funds, you will need to transfer the applicable amount back to your HSA. You will be

able to manage your account online, or contact Optum Bank to arrange for a funds transfer.

Optum Bank charges a monthly administrative fee to manage your HSA bank account, which the Company will pay on behalf of eligible and enrolled employees for 2017, and fees may apply to other services that are available. If you have more than $5,000 in your account, Optum Bank will waive the monthly administrative fee. You can get more information and view your account statement at www.OptumBank.com or by calling Optum Bank at 1-844-326-7967.

OBTAINING BENEFITS

Covered Health Services

Benefits are payable for **Covered Health Services**, which are health treatments, devices or procedures provided for the purpose of preventing, diagnosing or treating a sickness, injury, Mental Illness, Substance Abuse or their symptoms. The services must be considered **Medically Necessary**. These are services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, Mental Illness, substance use disorder, condition, disease or its symptoms. The Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the date that your Medical Plan coverage ends; and
- Only when the person who receives the services is a covered person and meets all the eligibility requirements specified in the Plan.

A Covered Health Service must be:

- Supported by national medical standards of practice;
- In accordance with generally accepted standards of medical practice,
- Clinically appropriate;
- Not mainly for the convenience of you or your medical provider;
- Not more costly than an alternative service, drug or supply that is at least as likely to produce equivalent therapeutic or diagnostic results;
- Consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes. The research must satisfy the following conditions:
    - It must be based on trials that were well-conducted randomized controlled trials under which two or more treatments, devices or procedures are compared to each other.

- Patients must not be allowed to choose which treatment, device or procedure is received.
- These must be well-conducted cohort studies under 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.
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a treatment, device or procedure described in the “What’s Covered” section and which is not otherwise excluded under the “What’s Not Covered” section.
- It must be incurred in connection with the prevention of, diagnosing or treating a sickness, injury, Mental Illness, Substance Abuse or their symptoms.

Decisions about whether to cover new technologies, treatments, devices or procedures will be consistent with conclusions of prevailing medical research, which satisfies the requirements set forth above.

Patient care is decided between the covered person and his or her Physician. The fact that a Physician has prescribed, ordered, recommended, or approved a service or supply does not make it a Covered Health Service or eligible for coverage. A facility charge will be covered only if the services rendered at that facility are allowed as Covered Health Service benefits.

Eligible Expenses

Generally, “Eligible Expenses” are the same under all Medical Plan options. They must be Covered Health Services. An “Eligible Expense” is defined as:

- For Covered Health Services that are received from network providers, the fees charged by the provider pursuant to its contract with the Claims Administrator; or
- For Covered Health Services received from non-network providers, the amount determined by the Claims Administrator by either (1) calculating the amount based upon available data resources of competitive fees in that geographic area; or (2)applying the negotiated rates agreed to by the non-network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

Maximum benefits

The Plan does not have an overall maximum dollar limit. However, some benefits are subject to annual limits on the number of visits or services performed, and there is a limit on the amount that the Plan will pay for certain benefits. These limits are specified in Appendix B at the end of this summary and in the “What’s Covered” section.

Using Network and Non-Network Providers

Network providers (in-network)

If you are enrolled in the CDHP or PPO Medical Plan option, you can choose to receive care from UnitedHealthcare UHC Choice Plus network providers or from non-network providers. The Plan will pay a greater percentage of Eligible Expenses, after the deductible has been met, when a PPO network provider is used. You are not required to use a network provider. You make that decision each time you or a covered dependent needs medical care.

If you are enrolled in the EPO option, you must receive care from a UnitedHealthcare UHC Choice network provider for benefits to be payable. Exceptions may apply in certain very limited circumstances, as explained below.

To find out if a Physician or Hospital is part of the provider network, contact UnitedHealthcare at 1-877-771-5348 or visit the Website online at www.myuhc.com.

Non-network providers (out-of-network)

If you are enrolled in the PPO or the CDHP medical plan option, and you live in an area with a UHC Choice Plus network, benefits will be paid at the “out-of-network” coverage level if you choose to see non-network providers. You may be required to pay in full when you receive treatment and then file your own medical claim form. Non-network providers may also charge you more than the “usual and customary” charge for similar services in the same geographic area. Amounts in excess of the usual and customary charge come out of your own pocket and do not count towards the out-of-pocket maximum.

Charges for an out-of-network provider referred by your Physician may be paid at the in-network benefit level if consultation is arranged by your Physician when you have no control or choice and is provided in a network facility. This does not apply to any services that require prior authorization from UnitedHealthcare.

If you live in an area with a UHC network and your covered dependents live or are attending school in an area without a UHC network and seek care in that area, benefits for your covered dependents will be paid at the “out-of-network” coverage level.

If you are enrolled in the EPO option, services of non-network providers are not covered. This also applies for your covered dependents who live or attend school in an area without a UHC network. However, limited exceptions may apply if services are arranged by your in-network provider when you have no control or choice. **Only emergency services are covered outside the U.S.**

If there are no in-network providers within a 30-mile radius of your home, **you may request in advance for approval, called a Gap Exception,** from the Claims Administrator. If the Gap Exception is approved in advance, in-network benefits may be available for services from a non-network provider. A Gap Exception would be required

even if your in-network physician referred you to an out-of-network provider. Contact UnitedHealthcare at 1-877-771-5348 for more information about how to request a Gap Exception.

Mental Health/Substance Abuse

The Plan also includes Mental Health/Substance Abuse benefits. Generally, the benefits covered are described in the Covered Health Services section of this Plan summary and are available under the same terms and conditions that apply to other Covered Health Services.

If you are covered under the CDHP, EPO or PPO medical option, see Appendix A for information about how UnitedHealthcare manages in-network Mental Health/Substance Abuse benefits.

Prior Authorization or Precertification Requirements

Prior authorization (also called precertification) is required 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.

To ensure that your services or procedures will be covered and that you will receive the best available care, contact the Claims Administrator at the customer service telephone number shown on your I.D. card prior to receiving any non-routine medical services. For precertification for many non-emergency admissions and other services, you or your Physician must notify the Claims Administrator at least 14 days in advance. Procedures and services requiring precertification include any of the following:

- Inpatient facility admissions, including mental health and Substance Abuse treatment facilities
- Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for partial hospitalization/day treatment at a residential treatment facility)
- Surgery – inpatient or outpatient
- Home Health Care services
- Durable medical equipment, including prosthetic devices (over $1,000, either in purchase price or cumulative rental of a single item) and insulin pumps
- Reconstructive procedures, including breast reduction and reconstruction, except after cancer surgery
- Pregnancy or maternity inpatient services (if stay exceeds 48 hours for vaginal delivery or 96 hours for a cesarean delivery)

- Dental services provided to treat injury or damage due to an accident
- Transplantation services
- Emergency health services if you are admitted to a non-network Hospital
- Hospice care
- Skilled nursing facility and inpatient rehabilitation
- Vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty (not covered if cosmetic in nature)
- Clinical trials
- Intensive outpatient treatment for mental health and Substance Abuse
- Genetic testing
- Outpatient dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound
- Services related to congenital heart disease
- BRCA testing (breast cancer susceptibility)
- Compound drugs that cost more than $250

Notification timeframes

You or your network provider must notify the Claims Administrator with respect to the above listed procedures, services, supplies or confinements within the specified timeframes below. You are responsible for making sure that the Claims Administrator is notified to make sure services will be covered.

- **Emergency Procedures, Services or Supplies.** You must notify the Claims Administrator by telephone within two days after the procedure is performed or the services and supplies are provided. Once the Emergency no longer exists, the Claims Administrator must be notified before any additional procedures, services or supplies which are subject to prior authorization are provided.
- **Emergency Confinement.** The Claims Administrator must be notified within one business day of the date the confinement begins or as soon as reasonably possible if it is not reasonably possible to provide notice within one business day. Once the Emergency no longer exists, the Claims Administrator must be notified before any additional days of confinement which are subject to prior authorization are incurred.
- **Non-Emergency Procedures, Services, Supplies or Confinements.** The Claims Administrator must be notified at least five business days before the planned admission date, the date on which the procedure or service is scheduled to be performed or the date the supply is scheduled to be provided.

- **Pregnancy:** The Claims Administrator must be notified prior to the expected date of delivery only if the period of confinement is anticipated to exceed forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for cesarean delivery. After delivery, the Claims Administrator must be notified prior to the end of forty-eight (48) hours of confinement for a vaginal delivery and ninety-six (96) hours of confinement for cesarean delivery if the covered person's period of confinement is expected to exceed those periods. A non-Emergency confinement during pregnancy for reasons other than delivery is subject to the prior authorization requirements set forth above for a scheduled confinement.
- **Prenatal Programs.** The Claims Administrator must be notified during the covered person's first trimester of pregnancy, in order for her to participate in the prenatal program.
- **Organ/Tissue Transplants.** The Claims Administrator must be notified at least seven business days or as soon as reasonably possible before the scheduled date of each of the following: the evaluation, the donor search, the organ procurement/tissue harvest, and the transplant.
- **Outpatient Services.** The Claims Administrator must be notified at least five business days before the services are provided.
- **Reconstructive Procedures.** The Claims Administrator must be notified at least five business days before such procedures are performed.
- For **Mental Health/Substance Abuse** services, the Claims Administrator must be notified before you seek treatment.

The Claims Administrator will review the information provided with respect to the confinement, procedure, service or supply covered by the notice and make a determination as to whether that confinement, procedure, service or supply is covered by the Plan. Your provider will be notified of the decision.

Benefits will be payable with respect to such confinements, procedures, services or supplies only if they otherwise satisfy the requirements of the Plan.

Failure to comply with notification requirements

Benefits may be reduced or denied if you or your provider do not notify the Claims Administrator and comply with its decision.

I.D. Cards

Following your enrollment in one of the Medical Plan options, you will receive an identification card from the Claims Administrator for you and your family. More cards are available upon request by calling the telephone number on the back of your I.D. card.

Your I.D. card will give important information to your medical care and pharmacy providers about your Plan coverage.

Contact a Nurse

UnitedHealthcare provides a service that allows you to speak with a nurse 24 hours a day to help you decide when to seek medical care and learn more about your health care options. More information and contact information for these services is found in Appendix A to this summary.

WHAT'S COVERED

Benefits under the Plan are payable for Covered Services as defined under "Obtaining Benefits." See the section entitled "Some Important Terms" for definitions of some of the other terms that are used in the discussion of what medical services are covered or excluded.

The following Covered Health Services are subject to the applicable deductibles, copayment and coinsurance amounts described in the "How the Medical Plan Options Work" section. Covered Health Services also are subject to any general limitations or exclusions on Plan benefits otherwise described in this Summary Plan Description.

Refer to the charts in Appendix B at the end of this Summary Plan Description for more details about the copayments or coinsurance under each Medical Plan option and for limits that apply to some of the benefits.

- **Abortion.** Elective or therapeutic and including complications from an abortion. (Partial birth abortions are not covered.)
- **Acupuncture Services** when needle services are performed by a provider in the provider's office for pain therapy or the treatment of nausea.
- **Ambulance Services – Emergency.** Emergency ambulance transportation (ground or air) by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. If there is no Hospital within a 35-mile radius, transportation to the nearest urgent care or medical facility capable of attending to the patient is covered. Ambulance transfer from one Hospital to another because services are not available at the first Hospital is covered under the Hospital Inpatient benefit.
- **Ambulance Services – Non-Emergency.** Transportation by professional ambulance, other than air ambulance, to and from the nearest emergency room, urgent care or medical facility capable of attending to the patient; and by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. Non-emergency transportation by professional air ambulance is covered only to a medical facility in connection with receiving a transplant covered under the Plan.

- **Asthma Treatment**. UnitedHealthcare offers an asthma disease management program to help reduce unnecessary hospitalizations and health care costs for those with asthma. Call the number shown on your I.D. card to learn more.
- **Cochlear Implants**. Charges for a surgically implanted electronic device that provides a sense of sound to a person who is profoundly deaf or severely hard of hearing, including surgery to place a cochlear implant and follow-up visits with an audiologist.
- **Dental Services – Accident Only.** Dental services if treatment is necessary because of accidental damage, services are received from a Doctor of Dental Surgery (D.D.S) or Doctor of Medical Dentistry (D.M.D) *and* the medical damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. In addition,
    - the tooth being treated must be a sound, natural tooth;
    - the Physician must certify that the injured tooth was a virgin or unrestored tooth or a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a medical implant and functions normally in chewing and speech; and
    - the dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident.
- **Diabetic Supplies**, including glucose control solutions, lancets and glucose testing supplies, monitors and insulin pumps. These items are covered when obtained through the medical plan in the same manner as for Durable Medical Equipment. They also may be obtained through the prescription drug benefit.
- **Diapers** for handicapped children age 4 and older.
- **Durable Medical Equipment,** which is medical equipment that can stand repeated use; is not disposable; is used to serve a medical purpose with respect to the treatment of a sickness, injury or their symptoms; is generally not useful to a person in the absence of a sickness, injury or their symptoms; and is appropriate for use in the home**.** It must be ordered or provided by a Physician for outpatient use, used for medical purposes, and not consumable or disposable.

    If more than one piece of Durable Medical Equipment can meet your functional needs, only the most cost-effective piece of equipment will be covered. Generally, a single unit of Durable Medical Equipment and repair of that unit will be covered; however, a replacement unit will be provided once every three calendar years if necessary.
- **Emergency Health Services.** Emergency health services that are required to stabilize or initiate treatment in an Emergency and are received on an outpatient basis at a Hospital or Alternate Facility.

- **Enteral Feedings** when such feedings are the sole source of nutrition (providing more than 50% of the person's nutritional requirement).
- **Family Planning.** Services for abortion, tubal ligation, vasectomy and fertility testing. Physician's charges for injecting, inserting, implanting or removing contraceptives are covered. (Also see "Abortions," "Physician's Office Services" and "Infertility Services.") Contraceptive drugs or devices, including diaphragms and oral or injectable contraceptives, are covered.
- **Foot Care.** Services for severe systemic disease or preventive foot care for diabetes. Shoe orthotics are excluded.
- **Hearing Aids.** Charges for services and supplies up to $5,000 per ear, every three calendar years, including testing, fitting, replacement and repair, are covered.
- **Home Health Care.** Home Health Care received from a Home Health Agency that is ordered by a Physician and provided by or supervised by a registered nurse in the covered person's home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when Home Health Care is required. See Appendix B for limits.

  A **Home Health Agency** means an agency whose main function is to provide Home Health Care, and which is federally certified as a home health care agency and licensed by the state in which the services are to be provided, if licensing is required.
- **Hospice Care.** Hospice Care that is recommended by a Physician, and is an integrated program that provides comfort and support services for the terminally ill. "Hospice Care" includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members.
- **Hospital – Inpatient Stay.** Inpatient Stay in a Hospital, including
  - services and supplies received during the Inpatient Stay;
  - room and board in a semi-private room (i.e., a room with two or more beds); and
  - ambulance transfer from one Hospital to another if necessary because services are not available at the first Hospital**.**

  An "Inpatient Stay" means an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.
- **Infertility Services.** Covered Health Services only for the diagnosis and treatment of the underlying medical condition when provided by or under the direction of a Physician.

- **Injections Received in a Physician's Office.** Injections administered in a Physician's office when no other health service is received; testing in a Physician's office and serum for allergy care is also covered. (Also see "Physician's Office Services.")
- **Maternity Services.** Maternity-related medical services for pregnancy, including prenatal care, postnatal care, delivery and any related complications. Charges for a period of hospitalization of at least 48 hours for a vaginal delivery and at least 96 hours for a cesarean delivery will be covered. If, at the option of the mother and attending Physician, discharge occurs earlier than those specific time periods, at least one home care visit will be covered.

  Services furnished by a nurse-midwife are covered, provided that he or she is legally authorized to perform in the state in which services are furnished, and that the services would otherwise be covered if furnished by a Physician. Services may be provided in the nurse-midwife's office, in the patient's home or in a Hospital or other facility such as a clinic or birthing center.

  For the EPO medical option, the co-payment applies only to the first prenatal office visit for a pregnancy to the network obstetrician or gynecologist who has primary responsibility for maternity care.
- **Mental Health and Substance Abuse Services – Outpatient.** Mental Health services and Substance Abuse services received on an outpatient basis in a provider's office or at an Alternate Facility, including
  - mental health, Substance Abuse and chemical dependency evaluations and assessment;
  - diagnosis;
  - treatment planning;
  - referral services;
  - medication management;
  - short-term individual, family and group therapeutic services (including intensive outpatient therapy);
  - crisis intervention; and
  - psychological testing.

  "Mental Health services" means Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service
- **Mental Health and Substance Abuse Services – Inpatient and Intermediate.** Mental Health services and Substance Abuse services received on an inpatient or

intermediate care basis in a Hospital, an Alternate Facility or a Residential Treatment Facility, including detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect the physical health and well-being of a covered person.

- "Residential Treatment Facility" means a facility that provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:
    - it is established and operated in accordance with applicable state law for residential treatment programs;
    - it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
    - it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
    - it provides at least the following basic services in a 24-hour per day, structured milieu:
    - room and board;
    - evaluation and diagnosis;
    - counseling; and
    - referral and orientation to specialized community resources.

    A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

♦ **Neurobiological Disorders - Autism Spectrum Disorder Services**. Psychiatric services for Autism Spectrum Disorder Services including Applied Behavior Analysis (ABA), provided by the direction of an experienced psychiatrist and/or experienced licensed psychiatric provider focused on treating maladaptive/stereotypic behavior that poses a danger to self, others, property and impairment in daily functioning.

♦ **Nutritional Counseling.** Covered Health Services provided by a registered dietician in an individual session for covered persons with medical conditions that require a special diet, including diabetes mellitus, coronary artery disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, and hyperlipidemias. Nutritional counseling to treat obesity is also a Covered Service for a covered person whose body mass index (BMI) exceeds 40. Benefits are limited to three individual sessions during a covered person's lifetime for each medical condition.

- **Orthotics** (except foot or shoe orthotics) -- an appliance or brace that straightens or re-shapes a body part. It must be prescribed by a Physician, approved and recognized in the accepted practice of medicine for the involved specialty, durable and only for appropriately diagnosed diseases or disabilities. Orthotics are not covered if they are for prevention, sports enhancement or experimental purposes. (Also see Foot Care and Durable Medical Equipment.)
- **Ostomy Supplies.** Benefits for ostomy supplies are limited to:
    - pouches, face plates and belts;
    - irrigation sleeves, bags and ostomy irrigation catheters; and
    - skin barriers.
- **Outpatient Surgery, Diagnostic and Therapeutic Services.** Services received on an outpatient basis at a Hospital or Alternate Facility including:
    - surgery and related services;
    - lab and radiology/X-ray;
    - mammography testing; and
    - other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).

  Benefits under this category include only the facility charge and the charge for required services, supplies and equipment.
- **Physicals (Routine)**. See “Physician’s Office Services.”
- **Physician’s Office Services.** Services received in a Physician’s office including
    - treatment of a sickness or injury;
    - preventive medical care (see below);
    - the fitting and removal of an intrauterine device (IUD) or diaphragm and the administering of injectible and implantable contraceptives, and the insertion and removal of a contraceptive implant (see “Family Planning” for more information);
    - well-baby and well-child care;
    - routine well woman examinations, including pap smears, pelvic examinations and mammograms;
    - routine well man examinations, including prostate specific antigen (PSA) examinations;
    - routine physical examinations, including vision and hearing screenings (but not refractive examinations to detect vision impairment); and

- immunizations other than those required solely for travel or pre-employment purposes, and subject to the age-appropriate recommendation of a Physician.

♦ **Pre-deployment Physicals.** Procedures recommended and provided by a Physician are covered at 100% with no deductible for in-network providers when conducted as part of a physical exam required by the Company in advance of an assignment outside of the U.S. with the Company or one of its subsidiaries or affiliates.

♦ **Preventive Care or Wellness Benefits.** Procedures recommended and provided by a Physician when conducted as part of a preventive wellness exam are covered at 100% with no deductible for in-network providers under all Medical Plan options.

♦ **Private Duty Nursing.** Services for private duty nursing care on an outpatient basis when provided by a licensed nurse (R.N., L.P.N., or L.V.N). See Appendix B for limits.

♦ **Professional Fees for Surgical and Medical Services.** Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

If multiple surgical procedures are performed by the same Physician on the same date of service, in the same operative setting, the Plan may pay a reduced benefit for the second (and subsequent, if applicable) procedures.

♦ **Prosthetic Devices.** Prosthetic devices that replace a limb or body part including artificial limbs, artificial eyes, and breast prostheses as required by the Women's Health and Cancer Rights Act of 1998.

- If more than one prosthetic device can meet the functional needs of a covered person, only the most cost-effective prosthetic device will be covered.
- Prosthetic devices must be ordered or provided by, or under the direction of, a Physician.
- Benefits are provided for a single purchase, including repairs, of a type of prosthetic device, and for the replacement of each type of prosthetic device every three calendar years, if necessary.

♦ **Reconstructive Procedures.** Services with respect to reconstructive procedures performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part.

- Reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry.
- Other services mandated 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 Covered Health Service.

- **Rehabilitation Services – Outpatient Therapy.** Short-term outpatient rehabilitation services for physical therapy, occupational therapy, vision and speech therapy, pulmonary rehabilitation therapy and cardiac rehabilitation therapy. See Appendix B for limits.
    - Rehabilitation services must be performed by a licensed therapy provider under the direction of a Physician (when required by state law).
    - Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in a covered person's condition within two months of the start of treatment.
    - Speech and vision therapy is covered only when the vision or speech impediment or dysfunction results from injury, sickness, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder.
    - Benefits for all types of therapy other than cardiac rehabilitation are limited as indicated in Appendix B. However, additional visits may be available if authorized by the Claims Administrator for medical necessity.
- **Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.** Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility, including services and supplies received during the Inpatient Stay and room and board in a semi-private room (i.e., a room with two or more beds). See Appendix B for limits.
- **Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy.** Services for Spinal Treatment, chiropractic and osteopathic manipulative therapy, including diagnosis and related services. "Spinal Treatment" means the detection or correction, by manual or mechanical means, of subluxation (partial dislocation or displacement of a vertebra) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. See Appendix B for limits.
- **Temporomandibular Joint (TMJ) Dysfunction.** Services for diagnostic, surgical and non-surgical treatment of conditions affecting the TMJ when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology. Services that are considered to be dental rather than medical are not covered.

  Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Benefits for surgical services include arthrocentesis, arthroscopy, arthrotomy, open or closed reduction of dislocations. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections. Benefits are provided if:

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

♦ **Transplantation Services.** Services for organ and tissue transplant when ordered by a Physician provided that the transplant meets the definition of a Covered Health Service. Benefits are available to the donor and the recipient if the recipient is covered under this Plan. The transplant is not covered if it is an Experimental and/or Investigational Service or an Unproven Service (see "What's Not Covered – Exclusions"). Transportation by professional air ambulance to a medical facility for the purpose of receiving a transplant is covered.

To ensure that you receive the highest level of service you should contact the Claims Administrator at the number shown on your medical I.D. card before you receive services. UnitedHealthcare's transplant management program directs you to designated health care providers who specialize in treating costly, complex conditions and promotes safe, successful and cost-effective treatment options for transplants. You will be directed to a designated transplant network facility that can best manage your care according to your needs.

The following transplants are covered:

- Bone marrow transplants (either from the covered person receiving the transplant or a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Service.
- The search for a bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a facility designated by the Claims Administrator.
- If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.
- Heart transplants;
- Heart/lung transplants;
- Lung transplants;
- Kidney transplants;
- Kidney/pancreas transplants;
- Liver transplants;
- Liver/kidney transplants;

- Liver/intestinal transplants;
- Pancreas transplants;
- Intestinal transplants; and
- Corneal transplants. Corneal transplants need not be provided at a facility designated by the Claims Administrator in order for a covered person to receive the highest level of benefits available.

Other transplants may also be covered if prior authorization is obtained from the Claims Administrator.

In certain cases, expenses for travel and lodging for the transplant recipient and a companion are available under the Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are available only if the transplant recipient resides more than a certain distance from the designated facility (see Appendix A for limits).
- If the patient is a child, under the age of 18, covered under the Plan, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

♦ **Urgent Care Center Services.** Services received at an Urgent Care Center.

♦ **Wigs.** Covered for hair loss due to chemotherapy, radiology or other medical conditions, such as alopecia, limited to one wig per hair loss.

WHAT'S NOT COVERED – EXCLUSIONS

This section contains information about medical services, treatments, items or supplies that are not covered under the Plan. These are called exclusions. It's important for you to know what services and supplies are not covered under the Plan. To help you find specific exclusions more easily, the exclusions are grouped by services, treatments, items or supplies that fall into a similar category.

The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either or both of the following is true:

♦ The service, treatment, item or supply is recommended or prescribed by a Physician.

- It is the only available treatment for your condition.

The services, treatments, items or supplies described in this section are not Covered Health Services, except as may be specifically provided in the What's Covered section. The following list constitutes a sample of services not covered under the Medical Plan. The list of services not covered can be modified or added to at any time. The Medical Plan will not pay benefits for expenses or charges for the following:

- **Alternative Treatments.** Alternative treatments, including acupressure, aroma therapy, hypnotism, massage therapy, rolfing, services and supplies provided by a naturopath, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institute of Health.
- **Comfort or Convenience.** Comfort or convenience items, including television, telephone, beauty/barber service, guest service, supplies, equipment and similar incidental services and supplies for personal comfort, devices and computers to assist in communication and speech, home remodeling to accommodate a health need (including, but not limited to, ramps and swimming pools).
- **Dental.** Dental care except as set forth in the "What's Covered" section, and also excluding preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, dental implants, dental braces, dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia for certain circumstances (except for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer or cleft palate), and treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident" and benefits are not available for repairs to teeth that are injured as a result of such activities.
- **Drugs.** Except as otherwise provided for under this Plan, self-injectable medications, non-injectable medications given in a Physician's office except as required in an Emergency, over the counter drugs and treatment, and medications that fall within the definition of Experimental and/or Investigational Services or Unproven Services.
- **Experimental and/or Investigational Services and Unproven Services**.

  "*Experimental and/or Investigational Services*" is defined as:

  - Any medical, surgical, diagnostic, psychiatric, Substance Abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination is made by the Claims Administrator, in its discretion, is:

- Not approved by the 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 (devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational);
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

"*Unproven Services*" is defined as:

- Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:
  - Well-conducted randomized controlled trials (i.e., two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received); or
  - Well-conducted cohort studies (i.e., patients who receive study treatments are compared to a group of patients who receive standard therapy, and the comparison group must be nearly identical to the study treatment group).

Decisions about whether to cover new technologies, procedures and treatments are made in the sole and absolute discretion of the Claims Administrator, and will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described above.

♦ **Foot Care.** Foot care, as follows: except when needed for severe systemic disease including diabetes, routine foot care (including the cutting or removal of corns and calluses) and nail trimming, cutting, or debriding, and hygienic and preventive maintenance foot care, of flat feet, treatment of subluxation of the foot and shoe orthotics.

♦ **Medical Supplies and Appliances**, including:

- Devices used specifically as safety items or to affect performance in sports-related activities; and

- Prescribed or non-prescribed medical supplies and disposable supplies, tubings, nasal cannulas, connectors and masks (except for ostomy supplies, and other supplies when used with Durable Medical Equipment).

♦ **Mental Health/Substance Abuse.** Except as otherwise provided in the "What's Covered" section, mental health and Substance Abuse services as follows:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis;
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Claims Administrator; services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine or their equivalents;
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Claims Administrator;
- Services or supplies for the diagnosis or treatment of Mental Illness, Alcoholism or Substance Abuse Disorders that, in the reasonable judgment of the Claims Administrator, are any of the following:
    - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
    - not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome;
    - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
    - not consistent with the Claims Administrator's guidelines or best practices as modified from time to time (the Claims Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria);
- Pastoral counselors;

- Applied behavior analysis provided in connection with autism;
- Treatment provided in connection with tobacco dependency; and
- Routine use of psychological testing without specific authorization.

♦ **Neurobiological Disorders - Autism Spectrum Disorder Services.**

- Services performed in connection with conditions not classified in current edition of *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Outside of an initial assessment:
  - treatments for primary diagnosis of conditions and problems which may be a focus of clinical attention, but specifically noted not to be mental disorders within current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
  - treatments for primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
  - unspecified disorders for which provider is not obligated to provide clinical rationale as defined in current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Educational/behavioral services focused on primarily building skills and capabilities in communication, social interaction and learning.
- Tuition or services which 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*.
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
- Transitional Living services.

♦ **Nutrition.** Charges for megavitamin and nutrition based therapy, nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs (except as otherwise covered under the “What’s Covered” section), and nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins and oral minerals. (However, enteral feeding is covered as provided under “What’s Covered.”)

- **Physical Appearance.** Charges for Cosmetic Procedures, including pharmacological regimens, nutritional procedures or treatments; scar or tattoo removal or revisions; replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure; physical conditioning programs such as athletic training; body-building; exercise; fitness; flexibility; and diversion or general motivation weight loss programs whether or not they are under medical supervision (including weight loss programs for medical reasons).
- **Providers.** Charges for:
    - Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child, including any service the provider may perform on himself or herself;
    - Services performed by a provider with the covered person's same legal residence;
    - Services performed by a Christian Science Practitioner;
    - Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider;
    - Services that are self-directed to a free-standing or Hospital-based diagnostic facility;
    - With respect to the EPO Option, services provided in a foreign country, unless required as Emergency Health Services; and
    - Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service or is not actively involved in your medical care after the service is received; provided, however, that this exclusion does not apply to mammography testing.
- **Reproduction.** Charges for surrogate parenting, the reversal of voluntary sterilization, fees or direct payment to a donor for sperm or ovum donations, and monthly fees for maintenance and/or storage of frozen embryos.
- **Services Provided Under another Plan**. Charges for:
    - Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. (This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for the covered person and he or she does not elect such coverage, benefits will not be paid for any injury, Sickness or Mental

Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected);

- Health services for treatment of military service-related disabilities, when the covered person is legally entitled to other coverage and facilities are reasonably available to him or her; and
- Health services while on active military duty.

♦ **Transplants.** Charges for:

- Health services for organ and tissue transplants, except as set forth in "What's Covered";
- Health services connected with the removal of an organ or tissue from the covered person for purposes of a transplant to another person; provided however, that donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan;
- Health services for transplants involving mechanical or animal organs; and
- Any multiple organ transplant not listed in the Covered Health Services section, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

♦ **Travel**. Except as provided in connection with Transplantation services, charges for travel or transportation expenses, even though prescribed by a Physician; provided, however, that some travel expenses related to covered services rendered at facilities designated by the Claims Administrator may be reimbursed at the discretion of the Claims Administrator.

♦ **Vision.** Charges for the purchase cost or fitting of eye glasses or contact lenses; surgery that is intended to allow a covered person to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery; and eye exercise therapy (except as allowed for Rehabilitative Services – Outpatient Therapy).

♦ **All Other Exclusions**. All other charges, including, but not limited to:

- Health services and supplies that do not meet the definition of a Covered Health Service;
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; or required to obtain or maintain a license of any type;

- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- Health services received after the date a person's coverage under the Plan ends, including health services for medical conditions arising before the date coverage under the Plan ends;
- Health services for which the person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
- Charges in excess of any specified limitation;
- Services for the evaluation and treatment of TMJ, when the services are considered to be dental in nature, including oral appliances (but see Temporomandibular Joint (TMJ) Dysfunction under Covered Services)
- Speech therapy to treat stuttering, stammering, or other articulation disorders. Other speech therapy (except as required for treatment of a speech impediment or speech dysfunction that results from injury, sickness, stroke, cancer or a Congenital Anomaly);
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer;
- Surgical or non-surgical treatment of obesity, including morbid obesity;
- Growth hormone therapy;
- Sex transformation operations;
- Custodial Care, including room and board charges;
- Domiciliary care;
- Respite care;
- Rest cures;
- Psychosurgery;
- Treatment of benign gynecomastia (abnormal breast enlargement in males);
- Medical and surgical treatment of excessive sweating (hyperhidrosis);
- Medical and surgical treatment for snoring, except when provided as part of a treatment for documented obstructive sleep apnea;
- Appliances for snoring;
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;

- Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment;
- Any charge for services, supplies or equipment advertised by the provider as free;
- Any charges by a provider sanctioned under a federal program for reasons of fraud, abuse or medical competency;
- Any charges prohibited by federal anti-kickback or self-referral statutes;
- Any additional charges submitted after payment has been made and the covered person's account balance is zero;
- Any outpatient facility charge in excess of payable amounts under Medicare;
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services;
- Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other Physician, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring;
- Spinal treatment, including chiropractic or osteopathic manipulative treatment, to treat an illness, such as asthma or allergies; and
- With respect to the CDHP and PPO options, in the event that a Non-Network provider waives copayments and/or the annual Deductible for a particular health service, no benefits are provided for the health service for which the copayments and/or annual Deductible are waived.

PRESCRIPTION DRUG BENEFITS

If you are covered under the CDHP, EPO or PPO medical option, your pharmacy benefit is administered by OptumRx, a UnitedHealth Group company. OptumRx is the Claims Administrator for these benefits.

You pay a specific copayment that varies depending on whether the prescribed medication is a generic drug or is on the list of drugs that are classified as "preferred" or "formulary." If a drug is on the preferred list, you generally pay less than for a non-preferred drug. The Claims Administrator periodically reviews and clinically evaluates the list of preferred drugs and changes may result, so you are encouraged to check with the Claims Administrator when you refill a prescription to make sure it is still included in this category.

Prescription benefits under the CDHP

Under the CDHP option, you pay the full negotiated discounted price of a drug until you have satisfied the annual deductible. This cost is applied toward your deductible. After you satisfy the deductible you pay the same copayment as under the other medical options for the rest of the calendar year. Certain preventive drugs are not subject to the CDHP deductible, so the deductible is waived for those drugs and you pay only the copayment.

Preventive drugs are used to prevent disease or other adverse health events. OptumRx periodically reviews the list of approved preventive drugs and changes may result, so you are encouraged to check with OptumRx when you refill a prescription for a preventive drug to make sure it still is included in this category.

Cost of prescription drugs

Below is a chart showing drug copayments. Except as explained above for the CDHP, the same copay amounts apply under all medical options.

You can log in to the Claims Administrator's member website to price a medication and learn how much a prescription will cost and if lower-cost alternatives are available.

Prescription Drug Costs – OptumRx	
Retail: 30-Day Supply	$7 generic $25 brand-name formulary (preferred) $50 non-formulary
Mail: 90-Day Supply	$14 generic $50 brand-name formulary (preferred) $100 non-formulary

Preferred (Formulary) Drugs

The Claims Administrator has teams of medical directors, Physician providers and pharmacists who meet regularly to review and update the list of formulary, or preferred drugs. Drugs listed as formulary or preferred usually will cost you less than those that are not on the list. To determine whether a drug is included on the preferred list, call the Claims Administrator or ask your pharmacist or health care provider to check for you. Lists of preferred drugs are also available on the Claims Administrator's web site.

Choosing Brand-Name or Generic Drugs

If a generic drug contains the same ingredients as a brand-name drug and you choose the brand-name drug instead of the generic drug, you will pay the difference between the brand-name drug and the generic drug in addition to your copayment. The same is true if you choose a non-formulary drug when an equivalent brand-name formulary drug is

available. The additional cost you pay for the brand name drug will not apply towards satisfaction of your out-of-pocket maximum.

> *Example:* Medication for a sleep disorder is prescribed but you choose a brand-name drug. A generic drug ($7 copay) is available and has a full cost of $50 for a 30-day supply from a retail pharmacy. Also available is a brand-name version of the same drug, with a negotiated cost of $87 for a 30-day supply at the pharmacy. The difference in cost between the brand-name drug and the generic drug is $37. If you choose the brand-name drug your cost will be the $7 generic copay plus the difference in the cost between the brand and generic, so you will pay $44 ($37 + $7) for the brand name drug.

If your physician writes a prescription for a brand-name drug when a generic equivalent is available, you will only pay the brand name drug copayment. Your physician will be required to indicate Dispense as Written or Physician-Required on your prescription.

If no generic drug is available you may want to ask your Physician if he or she can prescribe a drug that is on the preferred list in order for your cost to be as low as possible.

Retail Pharmacies and Home Delivery

If you have a new prescription for a drug you're not expected to use for more than 30 days, you can fill it at a retail pharmacy. For a prescription that you expect to need over a longer period of time (also referred to as a maintenance medication), you can order up to a 90-day supply through the home delivery program.

To use the home delivery program, ask your Physician for a prescription for a 90-day supply and submit it to your Claims Administrator's home delivery program. Prescription drugs will be delivered by U.S. mail, along with instructions for reordering by mail, phone or internet. If you need assistance getting started with the home delivery program, call the Claims Administrator.

Using Your I.D. Card at a Participating Pharmacy

To fill a prescription at a participating retail pharmacy, simply present your medical I.D. card. You will pay your copayment (or if you are enrolled in the CDHP option and have not satisfied your annual deductible, you will pay the full negotiated discount price of the drug).

Using Non-participating Pharmacies

You must pay the full retail cost for your prescription and then submit a claim for reimbursement to the Claims Administrator. Your reimbursement will be based upon the amount allowed under the Plan, not necessarily what the pharmacy charged you. Exceptions may apply in the case of an emergency purchase or if you travel outside the United States. Contact the Claims Administrator for a claim form.

Specialty Drugs

Specialty pharmacies provide personalized care and access to medications for patients with chronic, often serious health conditions that require a specialty drug. Many of these medications require injection and have special shipping and handling needs. If you are eligible for specialty pharmacy services you will receive support from pharmacists and nurses who are trained in specialty medications, their side effects, and the conditions they treat. Additional services may be available, such as expedited shipping of specialty medications to your home or Physician's office, where allowable by law, along with supplemental supplies such as needles and syringes that are needed to administer the medication. The Claims Administrator will determine if your prescription requires dispensing from a specialty pharmacy and will route your prescription accordingly.

Compound Drugs

If your Physician prescribes a compound drug that costs more than $250, you or your Physician must obtain prior authorization by contacting the Claims Administrator at the customer service telephone number shown on your I.D. card. Compound drugs are medications with one or more ingredients that are prepared individually by a pharmacist, and are not produced on a large scale. All ingredients contained in a compound drug must be approved by the Food and Drug Administration (FDA).

Prescription Drug Exclusions

Charges for prescription drugs or certain quantities of prescription drugs that are not expressly covered by the Plan are not Covered Prescription Drug expenses. The following list of charges (which is a sample list and is not intended to be all-inclusive) will not be considered Covered Prescription Drug expenses:

- Charges for prescription drugs not prescribed by a Physician or other licensed prescriber.
- Drugs that can be obtained without a prescription.
- Charges for Prescription Drugs incurred before you or your dependent became a covered person.
- Prescription Drugs for which there would not have been a charge if coverage under this Plan had not been in effect.
- Prescription Drugs furnished by a program or agency funded by any government or privately supported medical research program, except to the extent required by Medicare, Medicaid, or other programs specified under federal law.
- Any charges for Prescription Drugs incurred for an occupational injury or illness that is covered by workers’ compensation, an occupational disease law or similar law or a

group medical plan established and maintained by an employer that provides medical benefits for occupational injuries or illnesses.

- Charges that you are not legally obligated to pay.
- Charges for completion of claim forms and billing statements.

SOME IMPORTANT TERMS

- **Alcoholism** means a condition caused by regular excessive drinking of alcohol that results in a chronic disorder affecting physical health and/or personal social functioning.
- **Alternate Facility** means a health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an alternate facility, that provides one or more of the following services on an outpatient basis, as permitted by law: pre-scheduled surgical services; Emergency health services; or pre-scheduled rehabilitative, laboratory or diagnostic services. An alternate facility may also provide mental health services or Substance Abuse services on an outpatient or inpatient basis.
- **Claims Administrator** means the person or entity appointed by the Plan Administrator to perform those duties specifically allocated to the Claims Administrator in this Plan, to process claims under the Plan and to perform such duties as may be delegated to it by the Plan Administrator from time to time. Information about the Medical Plan's Claims Administrator is located at the end of this summary.
- **Congenital Anomaly** means a physical developmental defect that is present at birth.
- **Cosmetic Procedure** means any procedure or service that changes or improves appearance without significantly improving physiological function, as determined by the Claims Administrator.
- **Covered Health Services** – See the section entitled "Obtaining Benefits" for a definition of this term.
- **Covered Prescription Drug** means a prescription drug for which the Plan will pay benefits.
- **Custodial Care** means services that are non-health related, such as assistance in activities of daily living including but not limited to feeding, dressing, bathing, transferring and ambulating; or health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

- **Designated Network Facility** means a Hospital designated by the Claims Administrator that has entered into an agreement with the Claims Administrator to render services that are Covered Health Services for the treatment of specified diseases or conditions.
- **Eligible Expenses** – See the section entitled “Obtaining Benefits” for a definition of this term.
- **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.
- **Formulary** – A clinically based list of brand name medications designated by a team of medical directors, Physicians and pharmacists.
- **Emergency** means a serious medical condition or symptom resulting from injury, sickness or Mental Illness which arises suddenly, and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.
- **Home Health Care** means skilled nursing, skilled teaching, and skilled rehabilitation services when 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 must be ordered by a Physician; and not delivered for the purpose of assisting with activities of daily living, such as dressing, feeding, bathing or transferring from a bed to a chair. Home Health Care requires clinical training in order to be delivered safety and effectively; and is not Custodial Care.
- **Hospital** means a legally constituted institution operated pursuant to state law and engaged in providing, on an inpatient basis at the patient’s expense, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injuries and illnesses by or under the supervision of a Physician and continuous 24 hour-a-day services by registered nurses. It must be licensed as a Hospital as approved by the Claims Administrator.
- **Inpatient Rehabilitation Facility** means a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.
- **Medicare** means Parts A, B and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. 1394, et seq. and as later amended.
- **Medicaid** means the government insurance program for persons of all ages whose income and resources are insufficient to pay for health care that is jointly funded by the state and federal governments and managed by the states.

- **Mental Illness** means those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.
- **Physician** means an individual legally licensed to practice medicine, who is operating within the scope of his or her license. This includes a legally licensed chiropractor, osteopath or podiatrist, or a state certified psychologist operating within the scope of his or her certification. A doctor of dental surgery (D.D.S.) and a doctor of dental medicine (D.M.D.) are also considered Physicians with respect to dental services that are covered under the Plan.
- **Plan Administrator** means the Benefits Administration Committee established by the Company's Board of Directors. Many of the day-to-day functions of the Plan Administrator are assigned to and carried out by the HR Service Center.
- **Prescription Drug** means any drug or supply that may be dispensed only upon the written prescription of a Physician or other licensed prescriber.
- A **Skilled Nursing Facility** means a facility that
    - is licensed by the state in which the facility operates to provide 24 hour per day inpatient care under the full-time supervision of a Physician or a registered nurse (R.N.) for persons convalescing from injury or Illness;
    - provides professional services for compensation by an R.N. or by a licensed practical nurse (L.P.N.) under the direction of an RN; and
    - provides physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

    The facility must maintain a complete medical record on each patient, have an effective utilization review plan, be approved and licensed by Medicare, and not be a facility providing primarily Custodial Care, Mental Health services and Substance Abuse services.
- **Substance Abuse Disorders** means conditions related to the abuse of alcohol or substances that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.
- **Substance Abuse Services** means Covered Health Services for the diagnosis and treatment of Alcoholism and Substance Abuse Disorders.
- An **Urgent Care Center** is a facility, other than a Hospital, that provides services that are Covered Health Services that are required to prevent serious deterioration of a

covered person's health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

COORDINATION OF BENEFITS

The Medical Plan has coordination of benefits rules that apply to Covered Medical Expenses if you, your spouse or child is covered by this Plan and another medical plan.

Note: There is no coordination of benefits for Covered Prescription Drug expenses.

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- The order of benefit determination rules (determining which plan is primary and which plan is secondary).
- The reimbursement approach specific to your Medical Plan option.

When You Have Coverage under More than One Plan

Coordination of benefits rules determine which plan pays first (is primary) and which plan pays second (is secondary). The secondary plan pays benefits after the primary plan has made its determination and payment.

The Medical Plan will coordinate benefits with other group medical coverage, group practice and other prepayment group coverage, labor management trusteed plans, union welfare plans, employer organization plans, any coverage provided under governmental programs and required by statute and coverage required or provided by statute, except otherwise provided under Medicare, Medicaid or other federal law.

You should file claims with each plan that covers you, your spouse or child. To avoid a delay or error in your Plan's benefit payment, completely fill out all information about the other plan coverage that's asked for on the claim form. The Plan Administrator for the Plan has the right to exchange information about benefit payments by your Medical Plan with other insurance companies, organizations or individuals. In addition, the Plan Administrator of your Medical Plan has the right to recover any overpayments made to you or a medical provider because of duplicate coverage.

Order of Benefit Determination Rules

The order of benefit determination rules described below determine which plan is primary and which plan is secondary. If you or your covered dependents are covered by more than one medical plan, claims are submitted to the primary plan first, and then any remaining expenses are submitted to the secondary plan. Here's how it works:

- The Freeport-McMoRan Inc. Medical Plan is the primary plan for covered employees' expenses.

- Your covered spouse's medical plan is the primary plan for his or her expenses.
- Benefits for eligible children will be paid first by the plan of the parent whose birth month and day occurs earlier in the calendar year. For example, if you were born in January and your spouse was born in May, the children's expenses would be paid under your plan first. If you are separated or divorced, the plan of the parent with custody pays first — unless the divorce decree indicates otherwise. If joint custody has been established, eligible children will be paid first by the plan of the parent whose birth month and day occurs earlier in the calendar year. If both parents have the same birthday, the plan that has covered the person for the longer period of time is primary.

Coordination of Benefits Reimbursement

When the Freeport-McMoRan Inc. Medical Plan is secondary, the Plan will pay for Covered Expenses after the primary plan pays its benefits. The benefits payable under this Plan, when combined with the benefits paid under the primary plan, depends on your medical plan option.

- If this Plan's CDHP or PPO option is secondary, this Plan first determines the amount it would have paid had it been the only coverage. It then compares this figure to the amount outstanding after the primary carrier has paid. This Plan will pay 100% of the remaining covered expenses – as long as that amount is not more than it would have paid had it been the only coverage involved in this claim.
- If this Plan's EPO option is secondary, this Plan pays only the difference between what the primary plan actually paid and what this Plan would have paid if it had been the primary carrier. The amount paid by the primary plan will be subtracted from the amount that would have been paid by this Plan if the EPO had been primary.

Coordination with Medicare

If you are an active employee and you or your dependent also has Medicare coverage, this Plan will be considered the primary plan. However, if you and/or your covered dependent is covered under this Plan through COBRA and you or your dependent has Medicare coverage, Medicare will be primary for coordination of benefits purposes.

ABOUT YOUR MEDICAL AND PRESCRIPTION DRUG CLAIMS

How to File a Medical Claim

You must file claims within a specified period following the date service was provided, as follows:

- UnitedHealthcare claims must be filed within 12 months.

Different deadlines may apply to claims that are filed by service providers. Contact the Claims Administrator for more information.

If you receive covered health services from network providers

Network providers generally will file claims for you and the Plan will pay network providers directly for your Covered Health Services. There are no claim forms to complete. It is your responsibility to make sure that claims are filed within the limit specified above.

You are responsible for meeting the annual deductible, if any, and for the copayment and/or coinsurance amount owed to a network provider at the time of service, or when you receive a bill from the provider.

If you receive covered health services from non-network providers

When you receive Covered Health Services from a non-network provider, you are responsible for requesting payment through the Claims Administrator by submitting a claim form along with an itemized bill for services rendered. You must file the claim in a format that contains all the information required, as described below.

- Requests for payment of benefits must be submitted within the applicable period specified above. If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you or the provider does not provide this information to the Claims Administrator within the required period of time, benefits for that health service will be denied or reduced. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.
  - If you provide written authorization to allow direct payment to a provider, all or a portion of any amounts due to a provider may be paid directly to the provider instead of being paid to you. The Plan will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.
  - You can obtain a claim form by contacting the Claims Administrator at the toll-free customer service number on your medical coverage I.D. card. Claim forms are also available or through the HR Service Center.

Required Information

When you request payment of benefits from the Plan, you must provide the Claims Administrator with all of the following information:

- Your name and address;
- The patient's name, age and relationship to you;
- The member number shown on your I.D. card;
- An itemized bill from the provider that includes the following: patient diagnosis; date(s) of service; procedure code(s) and descriptions of service(s) received; charge for each service received; provider of service, including name, address and tax identification number; and
- A statement indicating either that you are, or are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier.

Payment of Benefits

Through the Claims Administrator, the Plan will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning 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.

How to File a Prescription Drug Claim

If you obtain prescriptions from a participating network pharmacy, you will pay your copayment at the pharmacy. No claim form needs to be filed. If you use a pharmacy that does not participate in the network, you must pay the full retail cost for your prescription and then submit a claim for reimbursement. You will need:

- A receipt for your prescription;
- The National Drug Code (NDC) number for your prescription from the pharmacist;
- The 7-digit pharmacy National Counsel for Prescription Drug Programs (NCPDP) number.

You can obtain a claim form by contacting the Claims Administrator or calling the toll-free customer service number on your medical I.D. card. Claim forms are also available through the HR Service Center.

Benefit Determinations

If you or your Physician submits a claim to the Claims Administrator for payment and the claim is denied (in full or in part), you can request a review of your claim in accordance with the Plan's claims procedures. Pursuant to the U.S. Department of Labor regulations under ERISA, claimants are entitled to a full and fair review of any claims made under the Plan. The steps described below are intended to comply with Department of Labor

regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and review of adverse benefit determinations.

Initial Claims Determination

The Claims Administrator will process claims for Covered Expenses and make reimbursements at such time and in such manner as the Claims Administrator may prescribe consistent with this procedure and the applicable Department of Labor (DOL) regulations.

If the Claims Administrator makes an adverse benefit determination with respect to any claimant under this Plan, the Claims Administrator will notify the affected claimant of its decision within the applicable period of time established by law for each type of claim. Periods of time during which the Claims Administrator is waiting for additional information requested from the claimant and/or his or her Physician or other service provider will not be taken into account for purposes of calculating the appropriate time period for the Claims Administrator to make its decision on any claim. The Plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant.

In the event a claim is denied, appropriate written, electronic, or oral notice, as may be permitted under this procedure or the applicable law, will be mailed or otherwise delivered by the Claims Administrator to the claimant. This notice will include:

- the specific reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional information required to perfect the claim, if any (including an explanation of why such information is necessary);
- a description of the Plan's claim review procedures and the applicable time limits (including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review);
- if an internal plan rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such internal rule was relied on and that the claimant may receive free of charge, on request, a copy of any such internal rule, guideline, protocol, or other similar criterion;
- if the adverse benefit determination was based on a medical necessity, experimental treatment or other similar exclusion, the determination will include an explanation of the reason for applying this judgment to the determination or a statement that a copy of the explanation for the use of this judgment will be provided free of charge, on request; and
- in the case of an Urgent Care claim, a description of the expedited review process applicable to those claims.

Urgent care claims.

An Urgent Care claim means a claim that requires notification or approval prior to receiving medical care or treatment where delay in receiving such care or treatment may seriously jeopardize a claimant's life or health or the ability to regain maximum function or could cause severe pain (or such other meaning as may be required by the regulations promulgated by the Department of Labor).

In the case of a claim involving urgent care, the Claims Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. This period may be extended if the claimant fails to provide sufficient information to the Claims Administrator to determine if benefits are covered under the Plan. The Claims Administrator will inform the claimant as soon as possible of any such failure, but not later than 24 hours after the receipt of the claim, of the specific additional information required.

The claimant will have a reasonable amount of time to provide the requested additional information, but not less than 48 hours. The Claims Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no event later than 48 hours after the earlier of (I) the Plan's receipt of the required information or (II) the end of the period afforded to claimant to provide the specified additional information. This determination may be provided to claimant orally within the required time periods, provided that a written or electronic notice is furnished to the claimant not later than three days after the oral notification. This notice will include the information required as described herein and the applicable Department of Labor regulations.

Pre-Service claims.

A Pre-Service claim means a claim that requires notification or approval prior to receiving medical care or treatment (or such other meaning as may be required by Department of Labor regulations).

In the case of a Pre-Service claim, the Claims Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time, but not later than 15 days after receipt of the claim by the Plan.

This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant prior to the expiration of the initial 15 day period of the circumstances requiring the extension and the expected date of the decision. If an extension is necessary because of the failure of the claimant to submit the necessary information, the claimant will be given at least 45 days from the receipt of the notice within which to provide the necessary information.

The Claims Administrator will provide written or electronic notice to the claimant of any adverse benefit determination and this notice will include the information required as described herein and the applicable Department of Labor regulations.

Post-Service claims.

A Post-Service claim means a claim that is filed for payment of benefits already received under the Plan (or such other meaning as may be required by the regulations promulgated by the Department of Labor).

The Claims Administrator will notify the claimant of the Plan's adverse benefit determination not later than 30 days after receipt of the claim. This notice will be provided in a written or electronic notification setting forth the information required by this Section and the applicable Department of Labor regulations.

This period may be extended one time by the Plan for up to 15 days provided that the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30-day period of the circumstances requiring the extension. If the extension is due to the claimant not submitting the necessary information, the notice will include the specific information required and give the claimant at least 45 days to provide the information.

Claims Review Procedure

In the event of an adverse benefit determination on an initial claim, on review the claimant will be provided the opportunity to submit written comments, documents, records and other information related to the benefits claim; to have access to, and copies of (free of charge) documents, records, and other information relevant to the claim and as otherwise may be required by the applicable Department of Labor regulations; and to obtain a full and fair review by a Plan fiduciary of the claim and the adverse benefit determination.

The procedure will provide the Participant with a review that takes into account all comments, documents, records, and other information submitted by the claimant (or the claimant's authorized representative) without regard to whether such information was submitted or considered in the initial benefit determination.

The claimant will have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal or otherwise seek review of that determination. The review provided by the Plan will not afford deference to the initial adverse benefit determination and the review will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination nor a subordinate to the individual who made the initial adverse determination. With respect to any claim reviews based on medical judgment, those reviews will be conducted in accordance with the requirements of the applicable Department of Labor regulations and in consultation with appropriate health care professionals.

In the event that a claimant fails to follow the Plan's claim review procedures for filing a pre-service claim, the claimant's (or the claimant's authorized representative) will be notified of the failure and the proper procedures to be followed in filing a claim. This notification may be oral unless a written notification is requested by the claimant. This notification will be provided as soon as possible, but no later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure.

Any claimant whose claim has been denied (or the authorized representative of the claimant) may make a request to the Claims Administrator to give further consideration to his or her claim. This request must be in writing except in those cases described below where an oral request is permitted by the applicable Department of Labor regulations. In the request, the claimant must list the specific issues to be considered by the Claims Administrator. Such a request, together with a statement of the claimant's position, should be submitted in writing to the Claims Administrator.

Within the applicable period of time for each such claim or appeal, the Claims Administrator will inform the claimant of its decision regarding the claim review. This notice will be in written or approved electronic format and will include the same information described above with respect to the Claims Administrator's denial of a benefit plus a statement on whether there may be other voluntary alternative dispute resolution options available and those agencies to contact for further information.

If special circumstances require an extension of the applicable period of time to respond for each type of claim, if applicable and in accordance with the regulations promulgated by the Department of Labor, the Claims Administrator will advise the claimant of the need for the extension and the date by which it expects to make a decision regarding such claim or appeal.

The claimant may not bring a legal or equitable action with respect to Plan Benefits until the claimant has exhausted all administrative procedures for every issue the claimant deems relevant. To the extent permitted by law, completion of the claims review procedures described in this Section is a mandatory precondition that must be complied with prior to the commencement of a legal or equitable action by a person claiming rights under the Plan. The Plan Administrator may, in its sole and absolute discretion, waive compliance with the claims procedures as a mandatory precondition to such an action. Any legal or equitable action filed in connection with the Plan by a person claiming rights under the Plan or by another person claiming rights through such a person must be commenced not later than the earlier of: (1) the shortest applicable statute of limitations provided by law; or (2) two years from the date the written copy of the Plan Administrator's decision on final appeal is delivered to the claimant in accordance with this Section. The special rules that may alter or modify the general procedures set forth above with respect to the following types of claims are set forth below.

Urgent Care claims.

Any Participant whose Urgent Care claim has been denied by the Claims Administrator may request an expedited review by making a written or oral request to the Claims Administrator to review his or her claim. All necessary information including the Plan's determination on review will be transmitted between the Claims Administrator and the claimant by telephone, facsimile, or other available similarly expeditious method.

In the request, the claimant must list the specific issues to be considered by the Claims Administrator. Such a request, together with a statement of the claimant's position, will be submitted to the Claims Administrator.

If the claimant does not request review within 180 days after receiving written notice of the Claims Administrator's disposition of the claim, the claimant will be deemed to have accepted the initial decision of the Claims Administrator, unless the claimant has been physically or mentally incapacitated so as to be unable to request review within the 180 day period.

No later than 72 hours after the receipt of claimant's request for review, the Claims Administrator will inform the claimant by written or electronic notification of its decision on review. This notice will include all information required as described above and the applicable Department of Labor regulations. To the extent permitted by law, a decision by the Claims Administrator will be binding and conclusive upon all persons whomsoever.

Pre-Service claims – first level appeal.

Any Participant whose Pre-Service claim has been denied by the Claims Administrator may make a written request to the Claims Administrator to review his or her claim.

In the request, the claimant must list the specific issues to be considered by the Claims Administrator. The request, together with a statement of the claimant's position, should be submitted to the Claims Administrator.

If the claimant does not request review within 180 days after receiving written or electronic notice of the Claims Administrator's disposition of the claim, the claimant will be deemed to have accepted the decision of the Claims Administrator, unless the claimant was physically or mentally incapacitated so as to be unable to request review within the 180 day period.

No later than 15 days after the receipt of the claimant's request for review, the Claims Administrator will notify the claimant with written or electronic notification of its decision regarding the claim. This notice will include the information required as described above and the applicable Department of Labor regulations.

Pre-Service claims – second level appeal.

Any Participant whose Pre-Service claim appeal has been denied by the Claims Administrator may make a written request to the Plan Administrator, within 180 days of

the receipt of the Claims Administrator's denial of the claim appeal, for a review of the denied appeal. In the request, the claimant must list the specific issues to be considered by the Plan Administrator.

The Plan Administrator will provide written or electronic notification to the claimant of its decision regarding the claim and such notice will contain the information required as described above and the applicable Department of Labor regulations. This notice will be provided no later than 15 days after the receipt of the claim for review by the Plan Administrator.

The Claims Administrator and Plan Administrator will have the right to request of and receive from a claimant such additional information, documents or other evidence as it may reasonably require to assure that the claimant has an opportunity for a full and fair review. To the extent permitted by law, a decision by the Claims Administrator and Plan Administrator will be binding and conclusive upon all persons whomsoever.

Post-Service claims – first level appeal.

Any Participant whose Post-Service claim has been denied by the Claims Administrator pursuant to this Article may make a written request to the Claims Administrator to review his or her claim.

In the request, the claimant must list the specific issues to be considered by the Claims Administrator. Such a request, together with a statement of the claimant's position, should be submitted to the Claims Administrator.

If the claimant does not request review within 180 days after receiving written notice of the Claims Administrator's disposition of the claim, the claimant will be deemed to have accepted the decision of the Claims Administrator, unless the claimant is physically or mentally incapacitated so as to be unable to request review within the 180 day period.

No later than 30 days after the receipt of a request for review, the Claims Administrator will provide the claimant with a written or electronic notice of its decision regarding the claim. This notice will include the information required as described above and the applicable Department of Labor regulations.

Post Service claims – second level appeal.

Any claimant whose Post-Service claim appeal has been denied by the Claims Administrator may make a written request to the Plan Administrator, within 180 days of the Claims Administrator's denial of his or her claim appeal, to review his or her denied appeal. In the request, the claimant must list the specific issues to be considered by the Plan Administrator.

The Plan Administrator will provide the claimant with written or electronic notice of its decision regarding the claim. This notice will be provided no later than 30 days after the

filing of a request for review and will include the information required as described above and the applicable Department of Labor regulations.

The Claims Administrator and Plan Administrator have the right to request of and receive from a claimant such additional information, documents or other evidence as it may reasonably require. To the extent permitted by law, a decision by the Claims Administrator and Plan Administrator will be binding and conclusive upon all persons whomsoever.

Concurrent (ongoing) care decisions.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination.

The Claims Administrator will notify the Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. If the claimant requests a review of an adverse benefit determination, the request must list the specific issues to be considered by the Claims Administrator.

Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care will be decided as soon as possible, taking into account the medical exigencies. The Claims Administrator will notify the Participant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, must be made in accordance with the procedures described above for initial claims determination. Any review will be governed by the appeal procedures described above. To the extent permitted by law, a decision by the Claims Administrator and Plan Administrator will be binding and conclusive upon all persons whomsoever.

External review

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Plan Administrator or if the Plan 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 Plan 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:

- 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 contacting the Claims Administrator to begin the process. A request for external review must be made within four months after the date you received the Plan 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 the applicable timeframe 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;
- 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.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. 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.

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

- all relevant medical records;
- all other documents relied upon by the Plan 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 or the Plan 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 Plan 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 both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; 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 I.D. card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Where to send appeal requests

Claims Administrator (First level appeals)

For the PPO, CDHP and EPO Medical Plan Option

Medical Claims

UnitedHealthcare
P.O. Box 30432
Salt Lake City, UT 84130-0432

Prescription Drug Claims

OptumRx
UnitedHealthcare
P.O. Box 30432
Salt Lake City, UT 84130-0432

Plan Administrator (Second level appeals)

Employees of Freeport Minerals Corporation, FM Services and MMR and Freeport-McMoRan Oil & Gas

Freeport-McMoRan Inc.
Benefits Administration Committee
c/o Benefit Services – 20th Floor
333 North Central Avenue
Phoenix, AZ 85004

External Review

If you have exhausted your internal appeal options and a denial was upheld, you will receive a letter from the Plan Administrator with instructions as to how to file for an external review.

Definitions

When used in connection with the claims procedures, the following definitions apply:

Adverse Benefit Determination: An adverse benefit determination means any of the following: a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of the eligibility of an employee or his or her dependent to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Authorized Representative: An authorized representative may act on behalf of a claimant with respect to a benefit claim or review under these procedures. However, no person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives a letter appointing an authorized representative, except that for urgent care claims the Plan will, even in the absence of a signed letter, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating Physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise. The signed letter appointing an authorized representative must be submitted to the Plan Administrator. An assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an authorized representative under these claims procedures. Once an authorized representative is appointed, the Plan will direct all information, notification, etc. regarding the claim to the authorized representative. The claimant will be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant appointment in compliance with the above procedures.

Claim: A claim is any request for a plan benefit or benefits made by a claimant or by an authorized representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. A request for benefit includes a request for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant: A covered person and/or his or her dependent who makes a request for a Plan benefit or benefits in accordance with these claims procedures.

Day: When used in these claims procedures, the term day means calendar day.

Incorrectly Filed Claim: Any request for benefits that is not made in accordance with these claims procedures is an incorrectly filed claim.

Right to Third Party Payment

The Plan has the right of first reimbursement from any recovery you or one of your dependents receives even if you or one of your dependents has not been made whole.

If you or your covered dependent receives benefits for Covered Health Services and has a claim for damages against a third party personally or under a liability, casualty, self-insurance or other insurance program that is based, in whole or in part, on those Eligible Expenses, the Medical Plan has the right of subrogation and reimbursement with respect to any recovery you receive on that claim. This includes recovery from claims against an automobile insurance policy maintained by you, your covered dependent, or any other person. This right can be exercised in the sole discretion of the Plan Administrator. In addition, the Plan will have a lien on any amounts payable by a third party or under an insurance policy or program to the extent Covered Health Services are paid by the Plan.

As a condition of receiving medical benefits under the Plan, your or your covered dependent must:

- Complete any reimbursement agreement that may be provided by the Claims Administrator;
- Notify the Claims Administrator in writing of any claim against a third party or under an insurance policy or program, within 31 days of making the claim(s);
- Notify the third party and/or the issuer of the insurance policy or program that the Medical Plan has a lien on any amounts payable by such third party and/or under the insurance policy or program to the extent Covered Health Services are paid by the Medical Plan; and
- Provide any information about the claim to the Claims Administrator upon request.

If you or a covered dependent fails to complete any of the steps listed above, you or your covered dependent will not be eligible for benefits from the Plan with respect to any Covered Health Services attributable, directly or indirectly, to the injuries or illness which are, or could be, the subject of a claim against the third party or under an insurance policy or program.

The Plan is not responsible for paying any expenses you or your covered dependent incurs while pursuing a claim, including legal fees and costs, unless the Plan Administrator has agreed in writing, in advance, to pay those expenses.

LEAVES OF ABSENCE

How long you can continue your coverage during a leave of absence depends on the type of leave. For more information about continuing your medical coverage during a leave of absence or the amount you will be required to pay, contact the HR Service Center.

WHEN COVERAGE ENDS

Your medical coverage will end on the earliest day that one of the following events occurs:

- Your employment terminates, or you die.
- You reach the end of an approved leave of absence unless you return to work in an eligible position.
- The last day for which you pay your share (if any) of the cost of coverage.
- You are no longer eligible to participate in the plan because you transfer to a non-participating Company subsidiary, affiliate or location, or to an ineligible jot status such as a non-participating union-represented job.
- The Plan is terminated.

Your covered dependents' medical coverage will end on the earliest day that one of the following events occurs:

- Your coverage ends.
- Your dependent no longer meets the Plan's eligibility rules (for example, your child reaches age 26).
- The last day for which you pay your share of the cost of your dependent's coverage (if any).
- Dependent coverage is terminated under the Plan.

In addition, your coverage may be terminated if you engage in fraud or intentionally misrepresent a material fact, such as providing false information on an enrollment form or change in status form.

Your coverage cannot be terminated retroactively unless (i) you engage in fraud or intentionally misrepresent a material fact, or (ii) you fail to pay your portion of the cost in a timely manner. You will receive at least 30 days' advance written notice before any retroactive termination of your coverage.

CONTINUING MEDICAL PLAN COVERAGE

When medical coverage ends, you may be eligible to continue coverage for a limited period of time under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**"). Please see the "Important Plan Information" document for information on how you can continue your medical coverage after it would otherwise end.

ADMINISTRATIVE INFORMATION

This Plan is subject to the requirements of ERISA. Administrative information regarding this Plan and any required federal and/or state law disclosures can be found in the

“Important Plan Information” document. Please refer to this section for information about the Plan Sponsor, Plan Administrator, the Claims Administrators, your COBRA rights, your ERISA rights and other Plan details.

CLAIMS ADMINISTRATORS

UnitedHealthcare is the Claims Administrator for the CDHP, EPO and PPO medical options. OptumRx is the Claims Administrator for pharmacy benefits under those medical options. Both can be contacted at:

UnitedHealthcare (or OptumRx)
P.O. Box 30555
Salt Lake City, UT 84130-0555
Telephone: (877) 771-5348
www.myuhc.com

HR SERVICE CENTER

Contact the HR Service Center as shown below if you have questions, need assistance or if you would like to request a form.

Employees of Freeport Minerals Corporation, FM Services and MMR and Freeport-McMoRan Oil & Gas

HR Service Center
333 North Central Avenue
Phoenix, AZ 85004
Telephone: (888) 855-HELP (4357)
FAX: (602) 366-7330
Email: HRSC@fmi.com

APPENDIX A

UnitedHealthcare Programs

NurseLine

UnitedHealthcare's NurseLine and Live Nurse Chat services are available 24 hours a day to help you make smart health care decisions with immediate access to experienced registered nurses. The nurse can help you:

- Understand your symptoms
- Learn more about a diagnosis
- Explore treatment options
- Understand medications

To talk to a NurseLine nurse, call 1-877-771-5348 or the customer care number on the back of your I.D. card. Or if you prefer talking to a nurse online, log in to myuhc.com to access Live Nurse Chat.

Mental Health/Substance Abuse

UnitedBehavioral Health will coordinate all of your in-network Mental Health/Substance Abuse care. Call UnitedHealthcare's Member Services toll-free number on the back of your I.D. card prior to receiving services so that a customer service representative can assist you in locating the appropriate services to meet your needs.

Transplants

Travel and lodging expenses are available only if the transplant recipient resides more than 50 miles from the designated facility.

APPENDIX B

UnitedHealthcare Consumer Driven Health Plan (CDHP) Refer to the last page for benefit limits		
Plan Provision	**In Network**	**Out of Network**
Annual Deductible Applies to all services below unless otherwise specified For family coverage, the entire family deductible must be met before the Plan pays benefits.	$1,300 Employee Only Coverage $2,600 Employee + 1 or more dependents	
Annual Medical Out-of-Pocket Maximum Includes the deductible and prescription costs		
Employee Only	$3,000	$6,000
Employee + 1 or more dependents	$6,000	12,000
Physician Services		
Office Visit	80%	60%
Inpatient	80%	60%
Surgeon's fees	80%	60%
Wellness Benefits Routine physicals and preventive screenings, including OB/GYN, mammograms, well man and well baby/well child	100% No deductible	60% No deductible
Hospital Services		
Inpatient	80%	60%
Outpatient	80%	60%
Emergency room	80%	80%
Other Medical Services		
Hospice care	80%	60%
Home health care	80%	60%
Skilled nursing facility	80%	60%
Durable medical equipment	80%	60%
Outpatient X-ray and lab service	80%	60%
Ambulance – Emergency	100%	100%
Ambulance – non-Emergency	80%	60%
Urgent Care	80%	60%
Infertility – diagnostic testing and treatment of medical condition only	80%	60%
Chiropractor	75%	75%
Rehabilitation Services Physical, occupational, speech and vision therapy	80%	60%
Mental Health and Substance Abuse		
Inpatient	80%	60%
Outpatient	80%	60%

UnitedHealthcare Consumer Driven Health Plan (CDHP) **Refer to the last page for benefit limits**		
Plan Provision	**In Network**	**Out of Network**
OptumRx	Before deductible, you pay a negotiated discounted prescription price.	
Retail: 30-Day Supply	**After Deductible:**	$7 generic $25 brand-formulary $50 non-formulary
Mail: 90-Day Supply *Deductible is waived for most preventive drugs*	**After Deductible:**	$14 generic $50 brand-formulary $100 non-formulary
Annual Prescription Out-of-Pocket Maximum	Included in medical out-of-pocket maximum shown above	Does not apply to out-of-pocket maximum

APPENDIX B

UnitedHealthcare Exclusive Provider Organization (EPO)

Refer to the last page for benefit limits

Plan Provision	Services from Network Providers
Annual deductible	$250 Individual $500 Family
Annual medical out-of-pocket maximum (includes copays)	
Individual	$2,900
Family	$5,800
Physician Services	
Office Visit	$20 primary care Physician/$40 specialist copay per visit
Inpatient	85%
Surgeon's fees	85%
Wellness Benefits Routine physicals and preventive screenings, including OB/GYN, mammograms, well man and well baby/well child	No charge
Hospital Services	
Inpatient	85% plus $150 copay
Outpatient	85%
Emergency care	85% plus $100 copay per visit (waived if admitted)
Other Medical Services	
Hospice care	No charge
Home health care	No charge
Skilled nursing facility	No charge
Durable medical equipment	No charge
Outpatient X-ray and lab service	85%
Ambulance – Emergency	No charge
Ambulance – non-Emergency	85%
Urgent Care	$50 copay per visit
Infertility – diagnostic testing and treatment of medical condition only	$40 per visit copay for diagnosis of a medical condition; diagnostic testing and treatment covered at 85%
Chiropractor	$40 copay per visit
Rehabilitation Services Physical, occupational, vision and speech therapy	$40 copay per visit
Mental Health and Substance Abuse	
Inpatient	85% plus $150 copay
Outpatient	85%

UnitedHealthcare Exclusive Provider Organization (EPO) **Refer to the last page for benefit limits**	
Plan Provision	**Services from Network Providers**
OptumRx Retail: 30-Day Supply	 $7 generic $25 brand-formulary $50 non-formulary
Mail: 90-Day Supply	$14 generic $50 brand-formulary $100 non-formulary
Annual Prescription Out-of-Pocket Maximum (does not include medical out-of-pocket expenses)	$4,250 Individual $8,500 Family

APPENDIX B

UnitedHealthcare Preferred Provider Organization (PPO)

Refer to the last page for benefit limits

Plan Provision	In Network	Out of Network
Annual Deductible Applies to all services below unless otherwise specified	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family
Annual Medical Out-of-Pocket Maximum Includes the deductible		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Physician Services		
Office Visit	80%	60%
Inpatient	80%	60%
Surgeon's fees	80%	60%
Wellness Benefits Routine physicals and preventive screenings, including OB/GYN, mammograms and well baby/well child	100% No deductible	60%
Hospital Services		
Inpatient	80%	60%
Outpatient	80%	60%
Emergency room	80%	80%
Other Medical Services		
Hospice care	80%	60%
Home health care	80%	60%
Skilled nursing facility	80%	60%
Durable medical equipment	80%	60%
Outpatient X-ray and lab service	80%	60%
Ambulance – Emergency	100%	100%
Ambulance – non-Emergency	80%	60%
Urgent Care	80%	60%
Infertility – diagnostic testing and treatment of medical condition only	80%	60%
Chiropractor	75%	75%
Rehabilitation Services Physical, occupational, speech and vision therapy	80%	60%
Mental Health and Substance Abuse		
Inpatient	80%	60%
Outpatient	80%	60%

UnitedHealthcare Preferred Provider Organization (PPO) **Refer to the last page for benefit limits**		
Plan Provision	**In Network**	**Out of Network**
OptumRx Retail: 30-Day Supply	$7 generic $25 brand-formulary $50 non-formulary	
Mail: 90-Day Supply	$14 generic $50 brand-formulary $100 non-formulary	
Annual Prescription Out-of-Pocket Maximum (does not include medical out-of-pocket expenses)	$4,150 Individual $8,300 Family	Does not apply to out-of-pocket maximum

BENEFIT LIMITS – ALL MEDICAL OPTIONS	
Hearing Aids	Services and supplies up to $5,000 per ear every three calendar years
Home Health Care	120 visits per calendar year
Outpatient Private Duty Nursing (Note: every four hours of Private Duty Nursing services constitute one visit)	120 visits per calendar year
Rehabilitation Services, outpatient (network and non-network combined, where applicable), for physical therapy, occupational therapy, pulmonary rehabilitation therapy; speech and vision therapy	20 visits per calendar year (for each type of therapy)
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	120 days per calendar year
Spinal Treatment/Chiropractic (Network and Non-Network combined, where applicable))	24 visits per calendar year
Transplantation Services – Transportation, lodging and meal expenses – Lifetime maximum (Benefit available only if a Designated Network Facility is used)	$10,000 See Transplantation Services under What's Covered for more details