Valero

HIGHLIGHTS – $1,000 DEDUCTIBLE RETIREE CHOICE PLUS

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Annual Deductible and Out-of-Pocket Maximum. For more details, refer to the *Medical Summary*. The *Medical Summary* provides more detailed information regarding items such as exclusions and limitations, claims and appeals procedures, coordination of benefits and prior authorization.

Coverage Features	Designated Network and Network Amounts	Non-Network Amounts
Copays In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.		
• Mental Health Services - Outpatient	$15	Not Applicable
• Neurobiological Disorders – Autism Spectrum Disorder Services – Outpatient	$15	Not Applicable
• Substance-Related and Addictive Disorder – Outpatient	$15	Not Applicable
• Virtual Care Services	$15	Not Applicable
Copays do not apply toward the Annual Deductible Copays apply toward the Out-of-Pocket Maximum.		
Annual Deductible • Individual • Family (not to exceed the applicable Individual amount per Covered Person) **Coupons**: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$1,000 Not Applicable	$1,000 Not Applicable
Annual Out-of-Pocket Maximum • Individual • Family (not to exceed the applicable Individual amount per Covered Person) The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. **Coupons**: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.	$2,500 $5,000	$5,000 $10,000

Coverage Features	Designated Network and Network Amounts	Non-Network Amounts
Lifetime Maximum Benefit The lifetime maximum is the amount the coverage will pay for essential Benefits during the entire period you are enrolled in this coverage. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act*: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	$2,000,000	

Schedule of Benefits - $1,000 Deductible Retiree Choice Plus

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

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	Non-Network
Acupuncture Services See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Ambulance Services • Emergency Ambulance • Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for Ground or Air Ambulance transport provided by a non-Network provider will be determined as described in the section of this document titled How the Coverage Works.	*Ground and/or Air Ambulance* 90% after you meet the Annual Deductible 90% after you meet the Annual Deductible	*Ground and/or Air Ambulance* Same as Network 70% after you meet the Annual Deductible
Cellular and Gene Therapy Services must be received at a Designated Provider.	90% after you meet the Annual Deductible	Non-Network Benefits are not available
Clinical Trials - Routine Patient Care Costs Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Accident Only	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care Diabetes Self-Management Items • Diabetes equipment • Diabetes supplies	90% after you meet the Annual Deductible Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section. Benefits for diabetic supplies are provided under the separate prescription drug plan administered by Express Scripts.	70% after you meet the Annual Deductible Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section. Benefits for diabetic supplies are provided under the separate prescription drug plan administered by Express Scripts.
Durable Medical Equipment (DME) • Durable Medical Equipment • Disposable Medical Supplies See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under "Eligible Expenses" in How the Coverage Works.	90% after you meet the Annual Deductible	Same as Network
Enteral Nutrition	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Fertility Preservation for Iatrogenic Infertility See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Gender Dysphoria	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hearing Aids (up to age 18) See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hearing Aids Exam See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Home Health Care See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Infertility Services You must enroll in the Fertility Solutions Program to receive services from a Designated Provider, a Network Physician that is not a Designated Provider or a Non-Network Provider. (Limited to $25,000 lifetime maximum per covered person) See *Additional Coverage Details* in the *Medical Summary* for limits. This limit does not include Physician office visits for the treatment of Infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Lab, X-Ray and Diagnostics - Outpatient • Lab Testing - Outpatient • X-Ray and Other Diagnostic Testing - Outpatient	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Mental Health Services • Inpatient • Outpatient	90% after you meet the Annual Deductible 100% after you pay a Copayment of $15 per visit	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services • Inpatient • Outpatient • Virtual Behavioral Health Therapy and Coaching	90% after you meet the Annual Deductible 100% after you pay a Copayment of $15 per visit Designated Network (AbleTo) 100%	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible Non-Network Benefits are not available.
Nutritional Counseling	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery A Bariatric Resource Service (BRS) program is available. See *Obesity Surgery* in the *Additional Coverage Details* of the *Medical Summary*	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Ostomy Supplies See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Pharmaceutical Products - Outpatient	90% after you meet the Annual Deductible *Routine (Preventive) immunizations and flu shots covered, deductible does not apply* 100%	70% after you meet the Annual Deductible *Routine (Preventive) immunizations and flu shots covered, deductible does not apply* 70%
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Coinsurance and applicable deductible) as if those services were provided by a Network provider; however, Eligible Expenses will be determined as described in How the Coverage Works under "Eligible Expenses".	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury (Lab, radiology/X-ray or other diagnostic services are included when billed with Physician office visit charges) • Primary Physician. • Specialist Physician.	 90% after you meet the Annual Deductible 90% after you meet the Annual Deductible	 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Preventive Care Services • Physician Office Services. • Lab, X-ray or Other Preventive Tests. • Breast Pumps.	 100% 100% 100%	 70% 70% 70%
Private Duty Nursing - Outpatient See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Prosthetic Devices	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See *Additional Coverage Details* in the *Medical Summary* for visit limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See *Additional Coverage Details* in the *Medical Summary* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance-Related and Addictive Disorder • Inpatient • Outpatient	90% after you meet the Annual Deductible 100% after you pay a Copayment of $15 per visit	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Surgery - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Transplantation Services Non-Network Benefits includes services provided at a Network facility by a non-Designated Provider and services provided at a non-Network facility.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Urgent Care Center Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Urinary Catheters	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	100% after you pay a Copayment of $15 per visit	Non-Network Benefits are not available.

[1]Please obtain prior authorization before receiving Covered Health Services, as described in *Additional Coverage Details* in the UHC Medical Summary.
[2]Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

HOW THE COVERAGE WORKS – $1,000 DEDUCTIBLE RETIREE CHOICE PLUS

Accessing Benefits

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

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

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits. You must show your identification card (ID card) every time you request health care services.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that has been identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in the section titled Highlights - $1,000 Deductible Active Choice Plus. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

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

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-

Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

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

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

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

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

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind,

a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Valero or UnitedHealthcare.

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

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

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

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

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

Designated Providers

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

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

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not

notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

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

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

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses.

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

provider which is based on the Recognized Amount as defined in the *Medical Summary*.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the *Medical Summary*. The summary provides more detailed information regarding items such as exclusions and limitations, claims and appeals procedures, coordination of benefits and prior authorization.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fees with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The benefit will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

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

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

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

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

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

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

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

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

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined as follows: an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law), or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service. The coverage will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment and any deductible. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment and deductible) is yours.

Advocacy Services

Valero has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at the number on your ID card to access

these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and UnitedHealthcare, or its designee, determines that it would serve the best interests of the coverage and its retirees (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

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

Annual Deductible

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

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

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

When a Covered Person was previously covered under a benefit that was replaced by the coverage due to a change in service locations, any amount already applied to that annual deductible provision of the prior coverage will apply to the Annual Deductible provision.

Copayment

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

Coinsurance

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

Out-of-Pocket Maximum

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

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network

individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

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

Coverage Features	Applies to the Designated Network and Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, except for those Covered Health Services provided under the prescription drug coverage administered by Express Scripts	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable	No	No

Please refer to the UnitedHealthcare $1000 Deductible Retiree Choice Plus Summary of Benefits and Coverage (SBC).

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Annual Deductible and Out-of-Pocket Maximum. For more details, refer to the *Medical Summary.* The *Medical Summary* provides more detailed information regarding items such as exclusions and limitations, claims and appeals procedures, coordination of benefits and prior authorization.

Coverage Features	Designated Network and Network Amounts	Non-Network Amounts
Copays In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.		
• Acupuncture	$35	Not Applicable
• Emergency Health Services	$200	$200
• Mental Health Services - Outpatient	$15	Not Applicable
• Neurobiological Disorders – Autism Spectrum Disorder Services – Outpatient	$15	Not Applicable
• Physician's Office Services - Primary Physician	$25	Not Applicable
• Physician's Office Services - Specialist	$35	Not Applicable
• Rehabilitation Services	$35	Not Applicable
• Substance-Related and Addictive Disorder – Outpatient	$15	Not Applicable
• Urgent Care Center Services	$100	Not Applicable
• Virtual Care Services	$15	Not Applicable
Copays do not apply toward the Annual Deductible. Copays apply toward the Out-of-Pocket Maximum.		
Annual Deductible		
• Individual	$500	$1,000
• Family (not to exceed the applicable Individual amount per Covered Person)	$1,000	$2,000
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		

Coverage Features	Designated Network and Network Amounts	Non-Network Amounts
Annual Out-of-Pocket Maximum • Individual • Family (not to exceed the applicable Individual amount per Covered Person) The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. **Coupons**: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.	$2,500 $5,000	$5,000 $10,000
Lifetime Maximum Benefit The lifetime maximum is the amount the coverage will pay for essential Benefits during the entire period you are enrolled in this coverage. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act*: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	$2,000,000	

Schedule of Benefits – Copay/$500 Deductible Retiree Choice Plus

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

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Acupuncture Services See *Additional Coverage Details* in the *Medical Summary* for limits.	100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
Ambulance Services • Emergency Ambulance • Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for Ground or Air Ambulance transport provided by a non-Network provider will be determined as described in the section titled How the Coverage Works.	Ground and/or Air Ambulance 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	Ground and/or Air Ambulance Same as Network 60% after you meet the Annual Deductible
Cellular and Gene Therapy Services must be received at a Designated Provider.	Physician's Office 100% after you pay the applicable Copayment per visit All other places of service 80% after you meet the Annual Deductible	Non-Network Benefits are not available
Clinical Trials - Routine Patient Care Costs Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Congenital Heart Disease (CHD) Surgeries Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetes Self-Management Items • Diabetes equipment	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.
• Diabetes supplies	Benefits for diabetic supplies are provided under the separate prescription drug coverage administered by Express Scripts.	Benefits for diabetic supplies are provided under the separate prescription drug coverage administered by Express Scripts.

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Durable Medical Equipment (DME) • Durable Medical Equipment • Disposable Medical Supplies See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible *Physician's Office* 100% after you pay the applicable Copayment per visit *Outpatient Professional* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this copay. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under "Eligible Expenses" in How the Coverage Works.	100% after you pay a Copayment of $200 per visit	Same as Network
Enteral Nutrition	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Fertility Preservation for Iatrogenic Infertility See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Gender Dysphoria	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hearing Aids (up to age 18) See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hearing Aids Exam See *Additional Coverage Details* in the *Medical Summary* for limits.	100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
Home Health Care See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Infertility Services You must enroll in the Fertility Solutions Program to receive services from a Designated Provider, a Network Physician that is not a Designated Provider or a Non-Network Provider. (Limited to $25,000 lifetime maximum per covered person) See *Additional Coverage Details* in the *Medical Summary* for limits. This limit does not include Physician office visits for the treatment of Infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient • Lab Testing – Outpatient • X-Ray and Other Diagnostic Testing - Outpatient	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services • Inpatient • Outpatient • Virtual Behavioral Health Therapy and Coaching	80% after you meet the Annual Deductible 100% after you pay a Copayment of $15 per visit Designated Network (AbleTo) 100%	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible Non-Network Benefits are not available.
Neurobiological Disorders - Autism Spectrum Disorder Services • Inpatient • Outpatient	80% after you meet the Annual Deductible 100% after you pay a Copayment of $15 per visit	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling	100% after you pay the applicable Copayment per visit	60% after you meet the Annual Deductible
Obesity Surgery A Bariatric Resource Services (BRS) program is available. See Obesity Surgery in *Additional Coverage Details* in the *Medical Summary*.	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies See *Additional Coverage Details* in the *Medical Summary* for limits.	*Physician's Office* 100% after you pay the applicable Copayment per visit *Outpatient Professional* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Pharmaceutical Products - Outpatient	*Physician's Office* 100% after you pay a Copayment of $35 per visit *Outpatient Professional* 80% after you meet the Annual Deductible *Routine (Preventive) immunizations and flu shots covered, deductible does not apply* 100%	60% after you meet the Annual Deductible *Routine (Preventive) immunizations and flu shots covered, deductible does not apply* 60%
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however, Eligible Expenses will be determined as described in How the Coverage Works under "Eligible Expenses".	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury (Lab, radiology/X-ray or other diagnostic services are included when billed with Physician office visit charges)		
• Primary Physician	100% after you pay a Copayment $25 per visit	60% after you meet the Annual Deductible
• Specialist Physician	100% after you pay a Copayment $35 per visit	60% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Preventive Care Services • Physician Office Services • Lab, X-ray or Other Preventive Tests • Breast Pumps	100% 100% 100%	60% 60% 60%
Private Duty Nursing - Outpatient See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See *Additional Coverage Details* in the *Medical Summary* for visit limits.	*Physician's Office* 100% after you pay a Copayment of $35 per visit *Outpatient Professional* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Substance-Related and Addictive Disorder • Inpatient • Outpatient	80% after you meet the Annual Deductible 100% after you pay a Copayment of $15 per visit	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Surgery - Outpatient	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	*Physician's Office* 100% after you pay a Copayment of $35 per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services Non-Network Benefits include services provided at a Network facility by a non-Designated Provider and services provided at a non-Network facility.	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Urgent Care Center Services	100% after you pay a Copayment of $100 per visit	60% after you meet the Annual Deductible
Urinary Catheters	*Physician's Office* 100% after you pay the applicable Copayment per visit *All other places of service* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	100% after you pay a Copayment of $15 per visit	Non-Network Benefits are not available.

[1]Please obtain prior authorization before receiving Covered Health Services, as described in *Additional Coverage Details* in the UHC Medical Summary.
[2]Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

HOW THE COVERAGE WORKS – COPAY/$500 DEDUCTIBLE RETIREE CHOICE PLUS

Accessing Benefits

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

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

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits. You must show your identification card (ID card) every time you request health care services.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that has been identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in the section titled Highlights – Copay/$500 Deductible Retiree Choice Plus. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

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

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

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

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

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

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

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Network Providers

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

Network providers are independent practitioners and are not employees of Valero or UnitedHealthcare.

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

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

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

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

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

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require

certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

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

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

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

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

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

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses.

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

- For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the *Medical Summary*.
- For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Medical Summary*.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the *Medical Summary.* The *Medical Summary* provides more detailed information regarding items such as exclusions and limitations, claims and appeals procedures, coordination of benefits and prior authorization.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fees with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The benefit will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

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

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

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

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

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

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

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

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

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined as follows: an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law), or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service. The coverage will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment and any deductible. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described

below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment and deductible) is yours.

Advocacy Services

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

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

Annual Deductible

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

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

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

When a Covered Person was previously covered under a benefit that was replaced by the coverage due to a change in service locations, any amount already applied to that annual deductible provision of the prior coverage will apply to the Annual Deductible provision.

Copayment

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

Coinsurance

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

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Out-of-Pocket Maximum

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

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

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

Coverage Features	Applies to the Designated Network and Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, except for those Covered Health Services provided under the prescription drug coverage administered by Express Scripts.	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable	No	No

Please refer to the UnitedHealthcare Copay/$500 Deductible Retiree Choice Plus Summary of Benefits and Coverage (SBC).

Payment Terms and Features

The table below provides an overview of the Annual Deductible and Out-of-Pocket Maximum. For more details, refer to the *Medical Summary.* The *Medical Summary* provides more detailed information regarding items such as exclusions and limitations, claims and appeals procedures, coordination of benefits and prior authorization.

Coverage Features	PPO Without Differential
Annual Deductible • Individual • Family (not to exceed the applicable Individual amount per Covered Person) **Coupons**: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$500 $1,000
Annual Out-of-Pocket Maximum • Individual • Family (not to exceed the applicable Individual amount per Covered Person) The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. **Coupons**: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.	$2,500 $5,000
Lifetime Maximum Benefit The lifetime maximum is the amount the coverage will pay for essential Benefits during the entire period you are enrolled in this coverage. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act*: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	$2,000,000

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Schedule of Benefits – $500 Deductible Retiree Out-of-Area PPO

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

Covered Health Services[1,2]	**Benefit** ***(The Amount Payable based on Eligible Expenses)***
Acupuncture Services	80% after you meet the Annual Deductible
Ambulance Services • Emergency Ambulance • Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for Ground or Air Ambulance transport provided by a non-Network provider will be determined as described in the section of this handbook titled How the Coverage Works.	*Ground and/or Air Ambulance* 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Cellular and Gene Therapy	80% after you meet the Annual Deductible
Clinical Trials – Routine Patient Care Costs	80% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries	80% after you meet the Annual Deductible
Dental Services – Accident Only	80% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care Diabetes Self-Management Items • Diabetes equipment • Diabetes supplies	 80% after you meet the Annual Deductible Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section. Benefits for diabetic supplies are provided under the separate prescription drug coverage administered by Express Scripts.
Durable Medical Equipment (DME) • Durable Medical Equipment • Disposable Medical Supplies See *Additional Coverage Details* in the *Medical Summary* for limits.	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*	
	Designated Network and Network	**Non-Network**
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under "Eligible Expenses" in How the Coverage Works.	80% after you meet the Annual Deductible	
Enteral Nutrition	80% after you meet the Annual Deductible	
Fertility Preservation for Iatrogenic Infertility See *Additional Coverage Details* in the *Medical Summary* for limits	80% after you meet the Annual Deductible	
Gender Dysphoria	80% after you meet the Annual Deductible	
Hearing Aids (up to age 18) See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	
Hearing Aids Exam See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	
Home Health Care See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	
Hospice Care See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible	
Hospital – Inpatient Stay	80% after you meet the Annual Deductible	

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*
Infertility Services You must enroll in the Fertility Solutions Program to receive services from a Designated Provider, a Network Physician that is not a Designated Provider or a Non-Network Provider. (Limited to $25,000 lifetime maximum per covered person) See *Additional Coverage Details* in the *Medical Summary* for limits. This limit does not include Physician office visits for the treatment of Infertility for which Benefits are described under *Physician's Office Services – Sickness and Injury* below.	80% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient • Lab Testing – Outpatient • X-Ray and Other Diagnostic Testing – Outpatient	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	80% after you meet the Annual Deductible
Mental Health Services • Inpatient • Outpatient • Virtual Behavioral Health Therapy and Coaching	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible (AbleTo) 100%
Neurobiological Disorders – Autism Spectrum Disorder Services • Inpatient • Outpatient	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Nutritional Counseling	80% after you meet the Annual Deductible
Obesity Surgery A Bariatric Resource Services (BRS) program is available. See *Obesity Surgery* in *Additional Coverage Details* in the *Summary*.	80% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient	80% after you meet the Annual Deductible Routine (Preventive) immunizations and flu shots covered, deductible does not apply 100%

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Coinsurance and applicable deductible) as if those services were provided by a Network provider; however, Eligible Expenses will be determined as described in How the Coverage Works under "Eligible Expenses".	80% after you meet the Annual Deductible
Physician's Office Services – Sickness and Injury	80% after you meet the Annual Deductible
Pregnancy –Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	80% after you meet the Annual Deductible
Preventive Care Services • Physician Office Services • Lab, X-ray or Other Preventive Tests • Breast Pumps	100% 100% 100%
Private Duty Nursing – Outpatient See *Additional Coverage Details* in the *Medical Summary* for limits.	80% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible
Reconstructive Procedures	80% after you meet the Annual Deductible
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment See *Additional Coverage Details* in the *Medical Summary* for visit limits	80% after you meet the Annual Deductible
Scopic Procedures – Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Additional Coverage Details in the *Medical Summary* for visit limits.	80% after you meet the Annual Deductible
Substance-Related and Addictive Disorder	
• Inpatient	80% after you meet the Annual Deductible
• Outpatient	80% after you meet the Annual Deductible
Surgery – Outpatient	80% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	80% after you meet the Annual Deductible
Therapeutic Treatments – Outpatient	80% after you meet the Annual Deductible
Transplantation Services	80% after you meet the Annual Deductible
Urinary Catheters	80% after you meet the Annual Deductible

Covered Health Services[1,2]	Benefit *(The Amount Payable based on Eligible Expenses)*
Urgent Care Center Services	80% after you meet the Annual Deductible
Virtual Care Services Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible

1Please obtain prior authorization before receiving Covered Health Services, as described in *Additional Coverage Details* in the UHC Medical Summary.
[2]Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

HOW THE COVERAGE WORKS – $500 DEDUCTIBLE RETIREE OUT-OF-AREA PPO

Accessing Benefits

As a participant, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay.

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit does not provide a Network Benefit level or a Non-Network Benefit level.

UnitedHealthcare arranges for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

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

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

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

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

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled.

Network Providers

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

Network providers are independent practitioners and are not employees of Valero or UnitedHealthcare. It is your responsibility to select your provider.

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

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

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

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

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

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct

you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

Eligible Expenses

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

Eligible Expenses are the amount UnitedHealthcare determines that the coverage will pay for Benefits. For Covered Health Services from non-Network providers, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses.

- For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or deductible which is based on the Recognized Amount as defined in the *Medical Summary*.

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

- For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or deductible which is based on the Recognized Amount as defined in the *Medical Summary*.

- For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the *Medical Summary.* The *Medical Summary* provides more detailed information regarding items such as exclusions and limitations, claims and appeals procedures, coordination of benefits and prior authorization.

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

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary, the Eligible Expenses is based on either:

- The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.
- The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the non-Network provider and UnitedHealthcare.
- The amount determined by Independent Dispute Resolution (IDR).

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

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

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

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

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

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

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

Except as described above, Eligible Expenses are based on the following:

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

- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, including when there is no Network provider who is reasonably accessible or available to provider Covered Health Services, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The coverage will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined as follows: an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law), or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service. The coverage will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance and any deductible. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance and deductible) is yours.

Advocacy Services

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

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

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Annual Deductible

The Annual Deductible is the amount of Eligible Expenses, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to receive Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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

When a Covered Person was previously covered under a benefit that was replaced by the coverage due to a change in service locations, any amount already applied to that annual deductible provision of the prior coverage will apply to the Annual Deductible provision.

Coinsurance

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

Out-of-Pocket Maximum

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

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

Coverage Features	Applies to the Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support as required.	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable	No

Please refer to the UnitedHealthcare $500 Deductible Retiree Out-of-Area PPO Summary of Benefits and Coverage (SBC).

AMENDMENT AND TERMINATION

The Company reserves the right, in its sole discretion, to amend or modify, in whole or in part, any provision of the plan or the medical coverage offered thereunder, including the right to terminate altogether, at any time and for any reason, without regard to whether expenses have already been incurred by a participant or whether a course of treatment has been initiated. Participants should remember that any such amendment or termination could affect their future benefits and expectations from the plan. If the plan or medical coverage should end, benefits will be paid for eligible charges incurred before the termination.

Valero

EXPRESS SCRIPTS PRESCRIPTION DRUG PROGRAM - $1,000 DEDUCTIBLE RETIREE CHOICE PLUS, COPAY/$500 DEDUCTIBLE RETIREE CHOICE PLUS AND $500 DEDUCTIBLE RETIREE OUT-OF-AREA PPO

HIGHLIGHTS

Prescription drug coverage is available through Express Scripts, Inc. (ESI) to all covered retirees and dependents in the UHC $1,000 Deductible Retiree Choice Plus, Copay/$500 Deductible Retiree Choice Plus and $500 Deductible Retiree Out-of-Area PPO.

Each covered retiree will receive a prescription card from ESI that should be presented to the pharmacist when filling a prescription. The pharmacist will fill the prescription with a generic substitute unless the physician indicates otherwise. If a physician does not indicate that a brand name drug is required and the participant requests the brand name drug, the participant will pay the difference between the cost of the brand name and the generic, in addition to the copayment and/or deductible.

If a participant needs help determining if a particular drug is eligible to be covered under this benefit, they can call ESI at (800) 294-5060.

The following table is a summary of the deductibles, copayments/coinsurance and out-of-pocket maximums.

<table>
<tr><th colspan="5">$1,000 Deductible Retiree Choice Plus,
Copay/$500 Deductible Retiree Choice Plus and
$500 Deductible Retiree Out-of-Area PPO †</th></tr>
<tr><th>Drug Type</th><th>Individual Deductible (per calendar year)</th><th>Retail Pharmacy Copay
(up to 30-day supply)</th><th>Retail90
(84 to 90-day supply)
or Home Delivery
(up to 90-day supply)
Copay</th><th>OOP Maximum (includes Specialty)</th></tr>
<tr><td>Generic</td><td>$0</td><td>$7</td><td>$15</td><td rowspan="3">$4,100 individual

$8,200 family</td></tr>
<tr><td>Preferred Brand Name</td><td rowspan="2">$50</td><td>$20</td><td>$40</td></tr>
<tr><td>Non-preferred Brand Name</td><td>$35</td><td>$70</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td>Accredo Specialty Drug Program*</td><td>$50</td><td colspan="3">20% coinsurance
$250 max per prescription
$1,000 individual calendar year max
Specialty drugs are covered only when obtained through Accredo Pharmacy</td></tr>
</table>

†For prescription drugs filled at an out-of-network pharmacy, the cost is the applicable copay plus the difference between the actual drug cost and the in-network contracted pharmacy rate.
*For certain specialty drugs, the benefit provides copay assistance from the drug manufacturer. Only the amount that the participant pays applies toward the out-of-pocket maximum. For more information call ESI at (800) 803-2523.

PRESCRIPTION DEDUCTIBLE

Participants will pay a $50 individual calendar year deductible for retail and/or Home Delivery preferred brand name and non-preferred brand-name drugs each calendar year. The $50 individual calendar

year deductible will be waived for all generic drugs filled at a retail location or through Home Delivery. There is an additional $50 deductible for Accredo specialty drugs.

OUT-OF-POCKET MAXIMUM

The prescription drug program has an annual individual out-of-pocket maximum of $4,100 and an annual family out-of-pocket maximum of $8,200, which includes any specialty medication out-of-pocket maximum. After an individual or family reaches the applicable annual out-of-pocket maximum, they will no longer be responsible for additional copayments for medications during that plan year.

PRESCRIPTION PREVENTIVE MEDICATION

Under the Patient Protection and Affordable Care Act (ACA) guidelines, plan sponsors are required to cover certain preventive drugs at no charge to participants. The preventive drugs or categories of drugs that are offered at no charge to participants in the Valero-sponsored medical coverages are listed below. Certain restrictions and limitations may apply. For more information, participants can call ESI at (800) 294-5060. *Please note, coverage associated with ACA may be subject to change throughout the year.*

- Aspirin
- Fluoride
- Folic Acid
- Immunizations
- Smoking Cessation Agents
- Bowel Preps
- Contraceptives
- Certain breast cancer medications
- Statins
- HIV Pre-exposure Prophylaxis

RETAIL PHARMACY PRESCRIPTIONS

Participants pay the pharmacy a retail copayment of $7 for generic drugs, $20 for preferred brand-name drugs and $35 for non-preferred brand-name drugs for a maximum 30-day supply. ESI will bill the Company for the balance. Completion of claim forms is necessary when prescriptions are filled at a non-participating pharmacy or when a participant pays out-of-pocket at a participating pharmacy. Claims filed by the participant will be paid by ESI according to the contracted rate, minus the appropriate copayment, coinsurance and/or deductible.

RETAIL90 MAINTENANCE DRUG PROGRAM (MDP)

The Retail90 MDP allows participants to fill the first two 30-day prescriptions of maintenance medication through a retail pharmacy at the normal copayment before requiring the participant to either

submit their maintenance medication through the Home Delivery program or through a participating Retail90 MDP pharmacy. Beginning with the third prescription fill, Retail90 MDP requires the prescription for maintenance medications to be between an 84 to 90-day supply. The Retail90 MDP allows participants to fill an 84 to 90-day supply of maintenance medication for a $15 copayment for generic drugs, a $40 copayment for preferred brand-name drugs and a $70 copayment for non-preferred brand-name drugs. To find a Retail90 MDP participating pharmacy, go online to www.express-scripts.com or contact ESI at (800) 294-5060.

HOME DELIVERY

The Home Delivery program allows participants to fill up to a 90-day supply of maintenance and non-maintenance medication for a $15 copayment for generic drugs, a $40 copayment for preferred brand-name drugs and a $70 copayment for non-preferred brand-name drugs. Home Delivery does not apply to Accredo specialty drugs. Specialty drug prescriptions for a 90-day supply will be rejected. For additional information regarding Accredo specialty drug copayments, refer to the section titled Accredo Specialty Program.

STEP THERAPY

Step Therapy is a program for people who take prescription drugs regularly to treat an ongoing medical condition. Only new prescriptions under the Step Therapy drug classes will be affected by these guidelines. To find out if a particular drug is part of the Step Therapy program, a participant can call ESI at (800) 294-5060.

The program makes prescription drugs more affordable for most participants and helps the Company control the rising cost of drugs. Within all Step Therapy programs, all brand drugs that have a generic equivalent are non-formulary. In Step Therapy, the covered drugs are organized in a series of steps with a physician approving and writing the prescriptions. The first step is generic drugs. Generic drugs covered by the program have been tested and approved by the United States Food and Drug Administration and have been proven to be effective in treating many medical conditions. The first step allows participants to receive treatment with safe, effective prescription drugs that are also affordable. The second step is a more expensive brand-name drug. The participant must have tried one or two first step medication within the past 130 days before a second step medication will be covered (unless otherwise indicated). The participant's physician is consulted, approving and writing prescriptions based on the list of Step Therapy drugs covered by the program. The participant's physician must write a new prescription when changing to a drug covered under a different step in the program.

PRIOR AUTHORIZATION

The Prior Authorization program monitors certain prescription drugs to ensure that the participant is receiving the right medication for their medical condition and treatment plan, and that it is a covered benefit. To obtain a prior authorization, the prescribing physician must submit the request to ESI. For specific information regarding drugs that may require prior authorization, participants should contact ESI at (800) 294-5060.

BLOOD GLUCOSE MONITORING SYSTEM

The Blood Glucose Monitoring program encourages diabetes management by offering one free blood glucose monitoring system (meter) to participants. Glucose monitors are limited to the brand(s) listed on the Express Scripts National Formulary. Participants may receive a Freestyle or OneTouch® meter by contacting ESI at (800) 294-5060.

Valero

DRUG QUANTITY LIMITS

Drug quantity limits align the dispensed quantity of certain prescription medication with FDA-approved dosage guidelines. In addition, consolidation of dosing ensures that the most cost-effective product strength is dispensed. Online edits at the point of service will allow coverage up to a predefined amount per dispensing or days supply. These edits help ensure optimal quantities of medication are dispensed for a defined list of drugs as based on manufacturer and FDA guidelines. The Drug Quantity Management list is created and maintained internally by the Express Scripts Utilization Management Team.

HOW TO USE THE PRESCRIPTION BENEFITS

Retail Pharmacy or a Retail90 MDP for Maintenance Medications

1. Participants should visit a participating ESI pharmacy.

   Participating pharmacies are available nationwide and include most national chains and independent pharmacies. To determine if a pharmacy is part of the ESI network, the participant should ask the pharmacist, go online to www.express-scripts.com, or contact ESI at (800) 294-5060.

2. Present the ESI card and your prescription to the retail pharmacy or the Retail90 MDP pharmacist.

   The pharmacist may ask the participant to verify certain information. The pharmacist may also contact ESI's Pharmacy Help Desk at (800) 922-1557 for claim assistance or additional information.

3. Pay the required copayment and/or deductible.

Home Delivery Service

1. Participants should have a prescription for up to a 90-day supply with three refills.

   If a medication is needed immediately, the participant should ask the physician to issue two prescriptions: one for an immediate supply to be taken to a local participating pharmacy and a second for an extended supply to be mailed to ESI's Home Delivery service.

2. Participants should complete all sections of the Home Delivery information form for the first Home Delivery order.

   Forms are available in the ESI packet that is sent with the ID cards. To update a participant's personal profile, they should complete section 1 of the ESI Home Delivery form and mail the form to ESI.

3. Refill a prescription online or by completing a Home Delivery form.

4. To file an original prescription, the Home Delivery form must be completed and mailed with the copayment to:

   Express Scripts
   P.O. Box 66567
   St. Louis, MO 63166-6567

Participants should include the appropriate payment, or provide credit card information with the order. Participants should allow 10 to 14 days from the date that the participant mails the prescription order for delivery.

5. Order refills by phone or online:

   - To order refills by phone, participants should call patient services at (800) 294-5060.
   - Prescriptions may also be refilled online to www.express-scripts.com.

6. Transferring current prescriptions from retail to Home Delivery.

   Participants interested in transferring current prescriptions from retail to Home Delivery may call ESI at (800) 294-5060 or go online to www.express-scripts.com and request to convert the current retail prescription to home delivery. ESI will contact the physician to obtain a new 90-day prescription. Once the prescription is received, ESI will fill the medication for standard home delivery at no extra shipping charge. The cost of overnight shipping is $21 (does not include processing time).

NATIONAL PREFERRED FORMULARY

The Express Scripts National Preferred Formulary may be subject to change. For the most up-do-date drug type listing and specific information regarding preferred brand name, non-preferred brand name, generic and non-covered drugs, participants should contact ESI at (800) 294-5060 or log on to the ESI member portal page to price a medication.

ACCREDO SPECIALTY PROGRAM

The ESI prescription program includes a delivery service for specialty drugs through Accredo pharmacy. There is an additional $50 deductible for specialty drugs. The participant also pays a 20% coinsurance, with a maximum out-of-pocket of $250 per script. There is also an individual maximum out-of-pocket maximum of $1,000 per year. After a participant reaches the $1,000 maximum, the benefit pays 100% of covered specialty drugs. Routine drugs such as insulin and allergy serum are not considered specialty drugs. After one fill at any network pharmacy, specialty drugs are covered only through the Accredo program.

Under the Accredo program, participants will receive additional benefits of:

1. Program enrollment with just one phone call to Accredo. Accredo will then call the participant's physician for a prescription, and call the participant to schedule delivery,
2. Convenient overnight delivery to the participant's home, work or physician's office within 48 hours of ordering,
3. Contact by the Accredo team initiating delivery arrangements and refill reminders each month,
4. Free administration supplies. Participants are not charged for needles, syringes, bandages, sharps containers or any supplies needed for the injection program,
5. Consultation with a pharmacist or nurse experienced in specialty drugs is available 24 hours a day, and

6. Dedicated customer service representatives trained to handle Accredo calls.

Participants should contact ESI at (800) 294-5060 for information concerning specific prescription drug coverage. Other drugs covered under the program are available through the retail or Home Delivery service program. **For more information or to begin using Accredo call ESI at (800) 803-2523.**

WHAT THE PRESCRIPTION BENEFIT DOES NOT COVER

Certain services and supplies may be excluded or limited. Some of the expenses not covered are listed below:

- Anti-wrinkle agents, depigmentation products or any drugs prescribed for cosmetic purposes,
- Hair growth stimulants,
- Dietary supplements,
- Non-prescription drugs,
- Over the counter drugs or prescription drugs with equivalent products available over the counter,
- Lifestyle enhancing drugs and devices,
- Therapeutic devices or appliances, including support garments and other non-medicinal substances,
- Charges for the administration or injection of any drug,
- Experimental or investigational drugs,
- DME, including peak flow meters and ostomy supplies,
- Legend homeopathic drugs,
- Medical foods, and
- Prescriptions that exceed the ESI quantity limit.

Summaries of Benefits and Coverage

*Please refer to the UnitedHealthcare $*1000 Deductible Retiree Choice Plus, Copay/$*500 Deductible Retiree* Choice Plus and $500 Deductible Retiree Out-of-Area PPO *Summary of Benefits and Coverage (SBC).*

WHEN MEDICAL (INCLUDES PRESCRIPTION DRUG COVERAGE) COVERAGE BEGINS AND ENDS

For information on when coverage begins and ends, refer to the section in the handbook titled Plan Administration.

Participants may have the option to continue this coverage through COBRA. Refer to the section in the handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

USE AND DISCLOSURE OF HEALTH INFORMATION

The plan is permitted in some circumstances to disclose information relating to a participant's health or coverage. Federal law limits the uses and disclosures ESI may make of a participant's Protected Health Information (PHI). Refer to the section in the handbook titled HIPAA Privacy Notice for more details.

AMENDMENT AND TERMINATION

The Company reserves the right, in its sole discretion, to amend or modify, in whole or in part, any provision of the plan or the prescription drug coverage offered thereunder, including the right to terminate altogether, at any time and for any reason, without regard to whether expenses have already been incurred by a participant or whether a course of treatment has been initiated. Participants should remember that any such amendment or termination could affect their future benefits and expectations from the plan. If the plan or prescription coverage should end, benefits will be paid for eligible charges incurred before the termination.