Columbia University in the City of New York
Non-Union Support Staff, Members of 2110 and
TWU Local 241(Maintenance and Custodial
Employees and Security Officers) or 1199 SEIU
United Healthcare Workers East SSA Area hired
prior to April 1, 2013
UnitedHealthcare Choice Plus 100

Effective: January 1, 2016
Group Number: 712790
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6
Introduction

Columbia University in the City of New York ("the University") is pleased to provide you with this Benefits Summary which describes the health benefits available to you and your covered family members under the Columbia University in the City of New York Group Benefits Plan (the “Plan”). This Benefit Summary provides information about:

- Who is eligible
- Services that are covered, called Covered Health Services
- Services that are not covered, called Exclusions
- How benefits are paid
- Your rights and responsibilities under the Medical Plan

This Benefit Summary is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic Benefit Summary for this Plan – including previously released Benefits in Brief, and Benefits Highlights. You are responsible for using this Benefit Summary and other resources provided to you to understand your benefits.

The rest of this Benefit Summary provides details about how the coverage works as well as information about who is eligible, processes and events that can affect coverage, administrative information, and your rights as a participant in the Plan. Please note that the words “you” and “your” refer to eligible Covered Persons enrolled in the Plan.

If there is a conflict between this Benefit Summary and any summaries provided to you and/or any verbal representations, this Benefit Summary will govern in every respect and instance.

How To Use This Benefit Summary

Please read the entire Benefit Summary and share it with your family.

Many of the sections of this Benefit Summary are related to other sections. You may not have all the information you need by reading just one section.

You can find copies of this Benefit Summary and any future Amendments at www.hr.columbia.edu or you can request a printed copy by contacting the Columbia Benefits Service Center at 212-851-7000.

If this Benefit Summary has been delivered to you by electronic means, you have the right to receive a paper copy of this Benefit Summary and may request a paper copy of this Benefit Summary at no charge by contacting the Columbia Benefits Service Center at 212-851-7000.

Overview of the Plan

What the Plan Covers

The Plan covers medically necessary health care services provided for the purpose of preventing, diagnosing or treating an acute Sickness, Injury, mental disorder, substance use disorder or symptoms.

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1 The terms “you” and “your” as used in this Benefit Summary refer to an employee of the University who is otherwise eligible to participate in the Plan and is actually participating in the Plan pursuant to its terms. Your receipt of this Benefit Summary is not an indication that you are in fact a participant in the Plan.
Only eligible preventive care services that follow age and gender guidelines are covered. All Plan coverage is subject to conditions, limits and exceptions explained in the sections, “Covered Services” and “Exclusions”. The University and its medical carriers administering the Plan assume no responsibility for the outcome of any covered services or supplies.

The health benefits under the Plan are not insured with UnitedHealthcare (“UHC”) or any of their affiliates but are paid from University funds. UHC provides certain administrative services under the Plan including claim determination, application of Copays, Coinsurance and limitations.

**Medically Necessary Services**

The Plan covers only *medically necessary* services and supplies that are provided for the purpose of preventing, diagnosing or treating an acute Sickness, Injury, mental disorder, substance use disorder or symptoms subject to the terms and conditions of the selected medical plan. In addition, certain preventive care services are covered within limitations.

For a service or supply to be considered medically necessary, it must be:

- Ordered by a licensed Physician
- Supported by national medical standards of practice and is consistent with conclusions of prevailing medical research (based on well-conducted, randomized, controlled trials or well-conducted cohort studies)
- Consistent with the diagnosis of the condition
- Required for reasons other than the convenience of the patient or his/her Physician
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the selected Claims Administrator
- Other than experimental or educational in nature

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, illness or Pregnancy does not mean that it is a medically necessary service or supply as defined above. The definition of “medically necessary” used in this Benefit Summary relates only to benefit coverage and may differ from the way you or your doctor define medical necessity.

**Claim Filing Deadline**

The Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, Injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

You have 12 months to submit a claim to the Claims Administrator for a covered service under the Plan. In-Network providers submit claims on behalf of the patient. If you receive services from an out-of-network provider, you are responsible for submitting your claim to the Claims Administrator for a covered service within the 12 months from the date of service.
**Notice of Provider Directory/Networks**

**Notice Regarding Provider Directories and Provider Networks**
If the coverage option you elect under the Plan utilizes a Network of Providers, you will have access to a list of Providers who participate in the Network by visiting their website or by calling the toll-free telephone number on your ID card.

Your Participating Provider Network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with UHC.

**Pre-Existing Conditions**
There are **no** pre-existing condition limits under the Plan.

**Prior Authorization Requirements**
Certain procedures, services and/or supplies require you to obtain prior authorization from UHC for you to receive the maximum benefits under the Plan. You must get prior authorization for certain procedures and treatments before the procedure is performed or before the treatment starts; otherwise, your benefits will be subject to a significant reduction in reimbursement. See the sections **Covered Health Services** and **Additional Coverage Details** for those procedures or services that require prior authorization.

**Financial Penalty If You Do Not Get Prior Authorization**
You must obtain prior authorization before receiving certain services; otherwise, your benefits will be significantly reduced. Note that each health plan may call this process something different including "pre-certification", "preauthorization", and "Personal Health Support Notification". If you do not obtain prior authorization as required, you will have to pay a $500 penalty, and the $500 will not count toward your Out-of-Pocket Maximum. If the service or treatment is not medically necessary, no Benefits will be paid. Become familiar with the specific services that require prior authorization. If you have questions, call your UHC’s member services (phone number on your member ID card).

**Overview of Choice Plus**
The Plan has a Network of participating Hospitals, Physicians and other healthcare providers who have agreed to accept lower negotiated fees for services and supplies for eligible patients. When you use providers who are in the Choice Plus Network, your cost toward healthcare expenses is lower.

**In-Network Services**
When you use a provider who participates in the Choice Plus Network, you do not have to submit claim forms to receive reimbursement for your expenses. The Choice Plus plan pays the provider directly. In addition, if the charges exceed the Network negotiated rates, you are not responsible for the difference in cost. Participating Network providers are not permitted to bill you for any balance.

**Out-of-Network Services**
Choice Plus plans allow you the flexibility to use providers who are not in the Network - at any time. However, your cost toward your healthcare expenses is significantly higher because there are no negotiated fees. In addition, the Choice Plus plan limits the amount they will pay for any service obtained outside of the Network. The reimbursement is indexed to 190% of the Medicare Maximum Allowable Charge. **You are responsible for paying the full amount of any charges that exceed this limit.**
For all out-of-network claims, reimbursement is limited to **190% of the Medicare Maximum Allowable Charge**. This reimbursement maximum is significantly less than Reasonable & Customary limits – it may be as low as 20% of the billed amount. If you use an out-of-network provider, your claim reimbursement will be based on the 190% of Medicare’s Maximum Allowable Charge, and your Deductible of $600 and Coinsurance will be applied to this limit. Once you have met your Deductible, the plan pays 60% up to the 190% of Medicare Maximum Allowable Charge – not the billed amount. You are responsible for the difference between what the plan pays and the amount billed by your provider.

In addition, you must file claim forms with UHC for each service or supply and wait for reimbursement.

**Administrative and Legal Information about the Plan**

**Your Relationship with Providers**

The relationship between you and any Provider is that of Provider and patient. Your Provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Provider;
- are responsible for paying, directly to your Provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Provider, the cost of any non-Covered Health Service;
- must decide if any Provider treating you is right for you (this includes Network Providers you choose and Providers to whom you have been referred); and
- must decide with your Provider what care you should receive.

**Information and Records**

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

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish The Plan Administrator and UHC with all information or copies of records relating to the services provided to you. The Plan Administrator and UHC have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee’s enrollment form. The Plan Administrator and UHC agree that such information and records will be considered confidential.

The Plan Administrator and UHC have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UHC and its related entities may use and
transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the Plan Administrator recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UHC, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Plan Administrator and UHC will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

**Incentives to Providers**

In-Network Providers may be provided financial incentives by UHC to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for In-Network Providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of In-Network Providers receives a monthly payment from UHC for each Covered Person who selects an In-Network Provider within the group to perform or coordinate certain health services. The In-Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person’s health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your In-Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your In-Network Provider.

**Incentives to You**

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

**Rebates and Other Payments**

The University and UHC may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The University and UHC do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.
Worker's Compensation Not Affected
Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Eligibility for Benefit Coverage

Eligibility for Support Staff
If you are a full-time or part-time active Columbia University Non-Union Support Staff or a member of Local 2110 or 1199 SEIU United Healthcare Workers East SSA Area or a member TWU Local 241 (maintenance and custodial employees and security officers hired before April 1, 2013), you and your family are eligible for medical coverage under the UnitedHealthcare Choice Plus Union 100 plan, a component program of the Plan.

When Your Benefits Start
The benefits of eligible full-time and part-time Non-Union Support Staff and Members of Local 2110, SSA and TWU Local 241 (hired before April 1, 2013) are effective the first day of the month following completion of the applicable waiting period as defined in your Collective Bargaining Agreement or otherwise under procedures adopted by the Plan Administrator should you not be covered by a Collective Bargaining Agreement. Part-time employees must work 20 hours per week to be eligible for benefits. In order for your Benefits to be effective on your earliest enrollment date, you must enroll within 31 days of your date of hire. You must select the coverage you want and whom you want to cover. If you do not enroll within 31 days of your date of hire, you will not have any group health plan coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

Exception for Newborns
A Dependent child born while you are covered under the Plan will automatically be covered on the date of his or her birth for a period of 31 days. However, you must enroll your newborn in your coverage no later than 31 days after the birth. Go to the CU Benefits Enrollment System at www.hr.columbia.edu/benefits to report the birth; if you need assistance, call the Columbia Benefits Service Center at 212-851-7000. If you do not elect to cover your newborn child within 31 days, coverage for that child will end on the 31st day. No Benefits for expenses incurred beyond the 31st day will be payable.

Your Eligible Dependents
You can also elect to cover your Dependents. Your eligible Dependents include your:

- Spouse
- Same-sex Domestic Partner, provided your Domestic Partner is:
  - At least 18 years old
  - Not related to you by blood
  - Not legally married to another person
  - In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender or treats a relationship between people of the same gender as marriage
And meets two or more of the following requirements:

- Shares the same principal residence with you full-time and for the past 12 continuous months
- Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.
- Has power of attorney for medical purposes

Legally dependent children, including adopted children, foster children and stepchildren of your Spouse or same-sex Domestic Partner, provided that you declare the child(ren) as dependents on your federal income tax return. Dependent children are covered:

- Until the end of the month in which they turn 26;
- If a court has appointed you legal guardian (for any child from birth to 26); and
- At any age if they have a mental or physical disability provided they are incapable of self-sustaining employment and depend chiefly upon you for support. You must either apply for continued coverage for a disabled child either when you are initially eligible for Benefits or prior to the end of the Plan month in which the Dependent turns age 26. Approval by UHC is required. See How to Continue Coverage for a Disabled Child, below.

Eligible Dependent children do not include:

- A dependent who lives outside the United States unless he or she is living with you or attending college or University full time; or
- A dependent who is in the military or similar forces anywhere; or
- A dependent who is employed by the University.

UHC may require certain documentation in order to verify an individual’s status as a Dependent.

**How to Continue Coverage for a Disabled Child**

Coverage for an unmarried mentally or physically disabled child who is not capable of self-sustaining employment and who depends chiefly upon you for support and maintenance may continue beyond age 26, as follows:

- If you’re an eligible Employee whose child is already covered under the Plan, you must apply for continued coverage before the end of the month in which he or she turns age 26.
- If you’re a newly eligible Employee and your disabled child is older than age 26 when you are electing coverage, you may apply to cover your child when your coverage begins.

To cover a disabled child who is over age 26, you must complete and submit the required form(s) to your medical plan carrier UHC. Forms are available from the Columbia Benefits Service Center at 212-851-7000.

Your medical carrier may request that you provide proof of your child’s incapacity and dependency within 31 days of the date coverage would have otherwise ended. You must supply this proof to your medical carrier within the requested timeframe or the Plan will no longer pay Benefits for that child.

**Who is Not Eligible for the Plan**

The term “employee” in this document does not include:
- Support Staff employees who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures

- TWU local 241 (maintenance and custodial employees and security officers) members hired after April 1, 2013

- Any individual who has entered into an oral or written agreement with the University whereby such individual acknowledges his or her status as an independent contractor and that he or she is not entitled to participate in the University’s employee benefit plans, notwithstanding that such person is later determined by a court of competent jurisdiction or the Internal Revenue Service (IRS) to be a common law employee for tax purposes.

- Any individual who is performing services for the University under a leasing arrangement entered into between the University and some other person, notwithstanding the fact that he or she is later determined by a court of competent jurisdiction or the IRS to be a common law employee or a leased employee.

- An employee who is a non-resident alien who received no earned income from the University that constitutes income from sources within the United States (as defined by the IRS).

- Temporary employees.

**You Are Responsible forCovering Only Eligible Dependents**

You are responsible for ensuring that only your eligible Dependents are enrolled in the Medical and Dental Plans. An Employee who covers an individual whom he or she knows does not meet the definition of an eligible Dependent will be subject to disciplinary action up to and including dismissal and may be liable for other punishment under the law. If the University learns that you have enrolled an ineligible dependent (such as a former spouse or a child over the age limit), the dependent will not be covered by the Plan for any medical and/or dental expenses incurred while he or she was ineligible.

You will be required to repay all costs to the University of providing coverage and any Benefits paid on behalf of your ineligible dependent. Also, if you don’t notify the University when a dependent has become ineligible, the dependent could lose his or her ability to continue coverage under COBRA health care continuation rules.

**Report Changes in Dependent Eligibility**

When a dependent is no longer eligible, it is your responsibility to report any changes in the status of your dependents within 31 days of the change. Examples of changes include, but are not limited to, divorce, child reaching the limiting age under the Plan, etc. Go to the CU Benefits Enrollment System at [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits) and update any changes in the status of your Dependents online. If you need assistance, call the Columbia Benefits Service Center at 212-851-7000.

**Proof of Eligibility**

The Plan Administrator has a responsibility to ensure that only Eligible Expenses are paid from the benefit Plans. This is a requirement of the Internal Revenue Service (IRS) regulations that govern qualified benefit plans.

You must be prepared to provide satisfactory proof that your enrolled Dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all Dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for an audit, you will receive a letter detailing the audit process. Examples of proof of dependent eligibility include, but are not limited to, birth certificates for each covered child, a marriage certificate, etc. If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.
You Choose Who to Cover Under Your Benefits

You must select from one of the following coverage options to ensure your dependents have medical and dental Benefits:

- Yourself and your Spouse or yourself and your same-sex Domestic Partner
- Yourself and a child or children
- Family

Qualified Medical Child Support Order (QMCSO)

Federal law requires the University to honor a QMCSO issued by a state court as part of a judgment or decree under state domestic relations law or under a law relating to medical child support. A QMCSO relates to and must specify that it arises from medical child support. You will be notified if the Plan Administrator receives a QMCSO that requires you to provide coverage for your dependent identified in the QMCSO.

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

Payment of Benefits

Any payment of Benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- The order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child’s mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.
Payment of Benefits
Any payment of Benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

If You and Your Spouse or Same-Sex Domestic Partner Work for the University
If you and your Spouse or same-sex Domestic Partner work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

- One Spouse or same-sex Domestic Partner makes the medical choice for the entire family, including eligible Dependent children, if any. In this case, the other Spouse or same-sex Domestic Partner must select “No Coverage.”
- Each Spouse or same-sex Domestic Partner can make his or her own medical choice. In this case, all eligible Dependents must be covered by you or your Spouse or same-sex Domestic Partner.

Enrollment

How to Enroll

Newly Eligible Employee
If you are newly hired, you must enroll for benefits within 31 days of your date of hire. If you do not make your benefit elections during your first 31 days of employment, you and any eligible dependents will not receive Medical and Prescription benefit coverage from the University for the remainder of the calendar year.

You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 3 weeks of your date of hire, please contact the Columbia Benefits Service Center at 212-851-7000.

Annual Enrollment Opportunities
After your initial enrollment, you have the opportunity to make changes each fall during the Benefits Open Enrollment period. You will receive notification from the University about this opportunity to change your health plan and the eligible dependents that you want to cover. The selections you make during annual Benefits Open Enrollment are effective the following January 1.

Limited Changes During the Year—Qualified Life Status Changes
The IRS restricts when you can add coverage for a dependent or make changes to your healthcare benefits during the year.

After your initial enrollment when you are hired, or after annual Benefits Open Enrollment, you will only be able to change most benefits for the remainder of the calendar year if you experience a Qualified Life Status Change.
Examples of a Qualified Life Status Change include:

- Marriage, divorce or the beginning or end of a same-sex domestic partnership;
- Birth, adoption or placement for adoption or foster care;
- Death of a dependent (spouse, same-sex domestic partner, child);
- A dependent losing eligibility for coverage, such as a child reaching maximum age;
- Losing coverage under another plan, such as a Spouse/domestic partner losing coverage from his or her employer;
- A Spouse or eligible dependent being called to military duty in the U.S. Armed Forces;
- Job promotions and/or transfers that change the benefit offerings.

If you experience a Qualified Life Status Change, you must go to [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits) and make your changes within 31 days of the event. If you need assistance, please contact the Columbia Benefits Service Center at 212-851-7000 and a specialist will help you with your changes. Please remember that you must provide proper documentation for your change, such as a birth certificate, marriage certificate or divorce decree. Your benefit changes must be consistent with the nature of your Qualified Life Status Change. If you have Qualified Life Status Changes after mid-November, you may not be able to make changes to certain benefits for the remainder of the current calendar year.

### Adding Your Newborn Child

For a newborn’s Hospital and medical expenses to be eligible for reimbursement, you must add your child by reporting a qualified life status change online through the CU Benefits enrollment system at [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits) within 31 days of the child’s birth. If you need assistance, please contact the Columbia Benefits Service Center at 212-851-7000. Please remember that you must provide proper documentation for your change, such as a birth certificate.

### Your Cost

#### Your Cost for Benefit Coverage

You and the University share the cost of your coverage. The costs are negotiated as part of your Collective Bargaining Agreement. Costs vary depending on the plan you choose, and the number of eligible Dependents that you cover.

Information about your share of the cost is provided with your enrollment materials when you are newly hired and is also provided to you each year during the fall annual Benefits Open Enrollment period.

Your contributions toward the cost of coverage are regularly deducted from your University paycheck on a pre-tax basis as allowed under Internal Revenue Service Code 125. Your pre-tax “premium” for healthcare coverage is based on these factors:

- The plan you select
- The coverage level you select (individual vs. family, etc.)

#### Your Cost for Same-Sex Domestic Partner or Same-Sex Spouse

Federal income tax rules require that your contributions toward the coverage of a same-sex Domestic Partner be deducted from your pay on an after-tax basis unless your Domestic Partner is your legal spouse or your federal tax dependent for group health plan purposes. In addition, University contributions
toward premiums for covering your Domestic Partner are taxable to you unless your Domestic Partner is your legal spouse or your federal tax dependent for group health plan purposes.

Effective October 1, 2013, eligible Employees who are legally married to their same-sex Spouse are eligible to have their payroll contributions, made to the Plan deducted on a pre-tax basis and are not subject to imputed income on the employer-sponsored portion of the costs of medical plan coverage. You must contact the Columbia Benefits Service Center at 212-851-7000 to provide a marriage certificate or to request recognition of your same-sex domestic partner as a federal tax dependent for group health plan purposes.

**Group Plan Coverage Instead of Medicaid**

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

**When Coverage Ends**

This section summarizes what happens to your medical coverage when certain events occur including:

- Your employment ends
- You become disabled
- You take a leave of absence
- You or a covered family member dies

Generally, in situations when the University-provided coverage ends, you and your eligible Dependents will be provided with the opportunity to continue coverage for a period of time under COBRA continuation rules. See the section, COBRA Continuation Rights.

**When Your Employment Ends**

If your employment with the University ends, your University-provided medical coverage for you and your Dependents ends after 21 days or the end of the month – whichever is greater.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the University will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- 21 days after your employment ends or the end of the month – whichever is greater.
- the date the Plan ends;
- the last day of the month you stop making the required “premium” contributions;
- the last day of the month you are no longer eligible;

Coverage for your eligible Dependents will end on the earliest of:
• the date your coverage ends;
• the last day of the month you stop making the required “premium” contributions;
• the last day of the month your Dependents no longer qualify as Dependents under this Plan.

However, you may continue the medical coverage in effect for you and your eligible dependents for up to 18 months under COBRA provisions. Under COBRA, the same plans are available as under the Plan and the same rules apply for eligible dependents and qualifying changes in status. See the section, COBRA Continuation Rights.

When Your Employment Ends: Are You Eligible for Support Staff Retiree Medical Benefits?
If you separate from employment after age 45 and you have 10 years of full-time continuous service (determined using your service credited while employed as a Support Staff or a combination of Support Staff and Officer), you will be eligible for Support Staff Retiree Medical Benefits coverage through, and subject to the terms of, the Columbia University Retiree Medical Plan. You must separate from service as Support Staff to be eligible for Support Staff Retiree Medical coverage.

If you qualify for and elect to participate in the Columbia University Retiree Medical Plan, you and your covered dependents will remain covered by your selected active medical plan until the end of the month in which your employment ends.

Contact the Columbia Benefits Service Center at 212-851-7000 if you think you have attained the age and service requirements for Support Staff Retiree Medical Benefits. The Columbia Benefits Service Center will confirm your retirement eligibility. You then are responsible for communicating to your department administrator your effective date of retirement. The Columbia Benefits Service Center will enroll you and your covered dependents in the Support Staff Retiree Medical coverage provided under the Columbia University Retiree Medical Plan. If you are a member of Local 2110 or 1199 SEIU United Healthcare Workers East SSA Area or a member TWU Local 241 (maintenance and custodial employees and security officers) hired before April 1, 2013, you should refer to your Collective Bargaining Agreement for further information. Otherwise, you may request a copy of the appropriate Benefit Summary for further details on Support Staff Retiree Medical coverage.

If You Become Disabled
If you become disabled, and are placed on an unpaid medical leave of absence, you may continue your medical coverage on direct billing. Any contributions you make for your health coverage under the Plan will be on an after-tax basis.

If You Take a Leave of Absence
In general, during an approved leave of absence, the coverage in effect before the leave will continue provided that you make the necessary monthly premium payments. However, additional rules apply to military leaves or you may qualify for a protected leave under the Family and Medical Leave Act (see the next page). Please contact the Columbia Benefits Service Center to discuss these rules.

Please note that for certain coverages to remain in effect during your leave of absence, you must pay the monthly premium costs associated with them. You will be billed separately for these coverages by Employee Benefit Plan Administrators (EBPA), an outside vendor. The Columbia Benefits Service Center will notify EBPA of your leave of absence status and calculate the monthly costs for those coverages that will require payment during your leave. You will be charged your regular monthly contribution rate for 6 months.
EBPA will bill you for these monthly costs using a payment coupon. Payment must be remitted to EBPA at the address shown on the payment coupon. Failure to make the required premium payments will result in termination of coverage retroactive to the date for which the last contribution was received.

Coverage While on a Leave Under the Family and Medical Leave Act of 1993 (FMLA)
If you meet the criteria, you are entitled by Federal law to up to 12 weeks of unpaid leave under the FMLA for specified family medical purposes, such as the birth or adoption of a child, or to care for a spouse, child, or parent who is seriously ill or for your own illness. You are entitled to continue your group health coverage under the Plan during your FMLA leave period at the same rate as if you were still at work, as long as you continue to make payments. If you don’t timely return to covered employment after your leave ends, you are entitled to COBRA continuation coverage.

Coverage While on Military Duty in the United States Armed Forces
If you enter the United States armed forces, you’ll be offered the opportunity to continue medical coverage for yourself and your covered dependents based on the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may elect to either stop or continue your medical coverage during the period of your military absence. If you elect to continue your medical coverage:

- During the first six months of your military absence, you will continue to pay your portion of the cost for the medical coverage you have in effect at the time your military absence began.
- During the seventh through the 24th month of your military absence, you will be directly billed for the cost of the medical coverage you have in effect at the time your military absence began, or, in the following calendar year, based on the coverage and cost in effect under COBRA rules. No further medical coverage will be provided beyond the twenty-fourth month of a military absence.

If you choose not to continue coverage during the period of military service, you’re entitled to have your coverage reinstated provided you return to employment with the University on a timely basis. No additional exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed service that ends honorably.

If You Die
If you die, your surviving Dependents who are covered under the Plan at the time of your death will be offered COBRA as of the date of your death.

If you were eligible for Retiree Medical benefits at the time of your death, your surviving Dependents will be given the choice between COBRA or Retiree Medical coverage.

If Your Eligible Dependent Dies
If an eligible Dependent dies, you can change your medical plan and coverage tier. Any change must be made within 31 days of your Dependent’s death; otherwise, you’ll have to wait until the next fall annual Benefits Open Enrollment period.

Other Events Ending Your Coverage
The Plan will provide written notice to you that your coverage will end on the date identified in the notice if:
• You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person’s eligibility or status as a Dependent; or

• You commit an act of physical or verbal use that imposes a threat to the University’s staff, the staff of your selected healthcare plan, or a provider.

**Uniformed Services Employment and Reemployment Rights Act**

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms “Uniformed Services” or “Military Service” mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

• the 24 month period beginning on the date of the Employee's absence from work; or

• the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

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

**When Coverage Ends for Your Dependents**

When you drop coverage for one or more of your covered Dependents either during Benefits Open Enrollment or through a Qualified Change in Status, coverage will end as follows:

**Spouse**

The date of your divorce, or commencement of other medical coverage (through Spouse’s employer, etc.).

**Same-Sex Domestic Partner**

The date of the dissolution of the partnership or commencement of other medical coverage (through partner’s employer).
Child
Coverage ends at the end of the calendar month in which your child turns age 26.

Disabled Child
Health Expense Coverage for your disabled dependent child may be continued past the maximum age for a Dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

In addition, coverage will cease on the first to occur of:

- Cessation of the disability.
- Failure to give proof that the disability continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

General Notice of the COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction
You are receiving this notice because you have recently become covered under the Columbia University Group Benefits Plan (the “Plan”). This notice contains important information about your right to continue your healthcare coverage in the Plan, as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice before you make your decision. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse or same-sex domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or same-sex domestic partner of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or same-sex domestic partner dies;
- Your spouse’s or same-sex domestic partner’s hours of employment are reduced;
- Your spouse’s or same-sex domestic partner’s employment ends for any reason other than his or her gross misconduct;
- Your spouse or same-sex domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or your domestic partnership ends.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee’s hours of employment are reduced;
- The parent-Employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve make your choice, it can be difficult or impossible to switch to another coverage option.
**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

BenefitConnect | COBRA  
P. O. Box 919501  
San Diego, CA 92191-9863  
877-292-6272

**How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee’s hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

**When COBRA Ends**

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

What is the health insurance marketplace?
The marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-costs coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at [www.HealthCare.gov](http://www.HealthCare.gov).

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?
You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.HealthCare.gov](http://www.HealthCare.gov).

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." Be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be able to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.
**Disability Extension of 18-Month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide written proof of the disability to BenefitConnect | COBRA at P.O. Box 919501, San Diego, CA 92191-9863 within 60 days of receiving a Social Security disability determination and before the end of the 18-month period of continuation coverage.

**Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Plan Contact Information**

This Notice does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available from the Plan Administrator.

Contact the Plan’s COBRA Administrator using the below contact information if you have any questions regarding COBRA continuation coverage or your Plan.

BenefitConnect | COBRA  
P. O. Box 919501  
San Diego, CA 92191-9863  
877-292-6272

For more information about health insurance options available through the health insurance Marketplace, and to locate an Employee Benefits Security Administrator in your area who can talk to you about the different options, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Personal Health Support**

**What this section includes:**
An overview of the Personal Health Support program;  
Covered Health Services for which you need to contact Personal Health Support; and  
Covered Health Service which Require Prior Authorization

**Care Management**

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.
UHC provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

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

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

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

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.

- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

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

**Requirements for Receiving Prior Authorization for Medical Necessity**

The Plan requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from an Out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. There are some Network Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are identified below within each Covered Health Service category.
It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been pre-authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the toll-free telephone number on the back of your ID card.

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

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

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

The out-of-network services (except where indicated In-Network) that require Prior Authorization from UHC are:

- Ambulance non-emergency air;
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- Congenital Heart Disease surgeries;
- Durable Medical Equipment that costs more than $1,000 to purchase or rent including rent for the management of Prosthetics;
- Genetic Testing for BRCA;
- Home health care;
- Hospice care - inpatient;
- Hospital Inpatient Stay, including Emergency admission to an Out-of-Network hospital;
- Lab, X-Rays and diagnostic outpatient;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing;
- Obesity surgery;
- Pregnancy- Maternity Services that exceed 48 hours for a normal vaginal delivery, 96 hours for a cesarean delivery;

- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery; (In-Network and Out-of-Network);

- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;

- Sleep Studies;

- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing;

- Surgery – diagnostic catherization and electrophysiology implant and sleep apnea surgeries, orthognathic;

- Therapeutics- dialysis treatments, intensity modulated radiation therapy and MR-guided focused ultrasound, all out patient therapies; and

- Transplantation services (In-Network and Out-of-Network).

**Contacting UHC is easy. Simply call the toll-free number on your ID card.**

**Special Note Regarding Medicare**

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Coordination of Benefits (COB).

**Plan Highlights**

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

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays and Coinsurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>$150 copay waived if admitted</td>
<td>$150 copay waived if admitted</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>$500 copay</td>
<td>60% after deductible Pre-authorization required or $500 penalty</td>
</tr>
<tr>
<td>Outpatient Hospital care including lab and radiology; see NOTE on page 31 for NYP exception</td>
<td>$150 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician’s Office Services</td>
<td>$30 copay</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

2 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. With the exception of Emergency Health Services, a Copay does not apply when you visit an Out-of-Network provider.
Plan Features

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center Services</td>
<td>$30 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Note that network providers may practice out of multiple locations; please confirm with UHC to ensure that both the provider and facility are in-network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Annual Deductible**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>None</td>
<td>$600 per person</td>
</tr>
<tr>
<td>Family</td>
<td>$3,500</td>
<td>$4,000</td>
</tr>
<tr>
<td></td>
<td>$7,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

**Annual Out-of-Pocket Maximum**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$3,500</td>
<td>$4,000</td>
</tr>
<tr>
<td></td>
<td>$7,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

**Lifetime Maximum Benefit**

<table>
<thead>
<tr>
<th></th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There is no dollar limit to the amount the Plan will pay for essential health benefits during the entire period you are enrolled in this Plan.</td>
</tr>
</tbody>
</table>

**NOTE:**

100: Hospital-based outpatient radiology and laboratory services performed at certain New York-Presbyterian (NYP) locations (2016 Benefits Highlights) are exempt from the $150 Copay. Call UHC for locations where the $0 (Zero) Copay applies.

**What is Coinsurance?**

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

For example, if the Plan pays 60% of Eligible Expenses for care received from an Out-of-Network provider, your Coinsurance is 40%.

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

**Covered Health Services**

3 Copays apply toward the Out-of-Pocket Maximum but not the Annual Deductible. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

4 Generally, the following are considered to be essential health benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; Emergency services, hospitalization; maternity and newborn care, mental health and Substance Use Disorder Services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services. The Plan further defines essential health benefits by reference to New York state-law. Whether a particular benefit under the Plan is an “essential health benefit” will be determined by the Plan Administrator or the Claims Administrator, as the case be, using its full discretion in interpreting the terms of the Plan and applicable law at the time the determination is made.
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td>$30 copay</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>(In lieu of anesthesia only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services - Emergency Only</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Ambulance Services - Non-Emergency</strong></td>
<td>100%</td>
<td>60% after you meet the Annual Deductible Prior Authorization required for air ambulance or a $500 penalty</td>
</tr>
<tr>
<td><strong>Cancer Resource Services (CRS)</strong></td>
<td>100% after you pay a $500 per admission copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hospital Inpatient Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td>100% after you pay a $500 per admission copay</td>
<td>60% after you meet the Annual Deductible Prior Authorization required</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services – Accident Only, Orthognathic Surgery and Wisdom Teeth Extractions</strong></td>
<td>Accident Only Based on place of service:</td>
<td>Accident Only 60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>(Copay is per visit)</td>
<td>- $30 Copay at Physician’s office</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $150 Copay at non-hospital facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $150 Copay at outpatient Hospital (see page 31 for NYP exception)</td>
<td></td>
</tr>
</tbody>
</table>

5 You must notify Personal Health Support, as described in Personal Health Support to receive full Benefits before receiving certain Covered Health Services from an Out-of-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Personal Health Support before you receive certain Covered Health Services. See Additional Coverage Details for further information.

6 These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under Physician’s Office Services, Physician Fees for Surgical and Medical Services, Hospital – Inpatient Stay, Surgery – Outpatient, Scopic Procedures – Outpatient Diagnostic and Therapeutic Lab, X-Ray and Diagnostics – Outpatient, and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.
<table>
<thead>
<tr>
<th>Covered Health Services&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Orthognathic Surgery</td>
<td>Based on place of service:</td>
</tr>
<tr>
<td></td>
<td>• $30 Copay at Physician’s office</td>
</tr>
<tr>
<td></td>
<td>• $150 copay100% at non-hospital facility</td>
</tr>
<tr>
<td></td>
<td>• $150 Copay at outpatient Hospital (see page 31 for NYP exception)</td>
</tr>
<tr>
<td></td>
<td>• Prior Authorization Required</td>
</tr>
<tr>
<td>Wisdom Teeth Extractions</td>
<td>Based on place of service:</td>
</tr>
<tr>
<td></td>
<td>• $30 Copay at Physician’s office</td>
</tr>
<tr>
<td></td>
<td>• $150 Copay at non-hospital facility</td>
</tr>
<tr>
<td></td>
<td>• $150 Copay at outpatient Hospital (see page 31 for NYP exception)</td>
</tr>
<tr>
<td></td>
<td>Wisdom Teeth Extractions Not Covered</td>
</tr>
<tr>
<td>Diabetes Services</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section. Benefits for diabetes equipment will be the same as those stated under <em>Durable Medical Equipment</em> in this section.</td>
</tr>
<tr>
<td></td>
<td>• insulin pumps</td>
</tr>
<tr>
<td></td>
<td>• diabetic supplies</td>
</tr>
<tr>
<td></td>
<td>(Copay is per item)</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $30 Copay</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization Required for Diabetes supplies if in excess of $1,000 to rent or purchase</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>$30 Copay at Physician’s office, if office visit billed, otherwise 100%</td>
</tr>
<tr>
<td></td>
<td>DME replacement once every two years</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td><strong>Emergency Health Services – Outpatient</strong></td>
<td>100% after you pay a $150 Copay</td>
</tr>
<tr>
<td>If you are admitted as an inpatient to a Hospital within 48 hours of receiving outpatient Emergency treatment for the same condition, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead. Non-Emergency- Emergency room visits</td>
<td></td>
</tr>
</tbody>
</table>

| **Gender Dysphoria Treatment** | 100% after you pay a $30 Copay |
| Physician’s Office Services (Copay is per visit) | Based on place of service: |
| Lab and Xray | Not covered |
| - $30 Copay at Physician’s office |
| - 100% at non-hospital facility |
| - $150 Copay at Hospital (see page 43 for NYP exception) |
| Hospital _ Inpatient Stay | 100% after a $500 per admission copay |
| Physician Fees for Surgical and Medical Services | 100% |
| **Home Health Care** | 100% |
| Up to 200 visits per Covered Person per calendar year combined Network and Out-of-Network | Pre-Authorization required or $500 penalty |
| **Hospice Care** | 60% after you meet the Annual Deductible |
| Up to 6 months per Covered Person per Lifetime combined In- Network and Out-of-Network | Pre-authorization required or $500 penalty |
| **Hospital – Inpatient Stay** | $500 per admission Copay |
| 60% after you meet the Annual Deductible | Pre-authorization required or $500 penalty |
## Covered Health Services

### Infertility Services

- **Physician’s Office Services** (Copay is per visit)
  - 100% after you pay a $30 Copay
- **Outpatient services**
  - Based on place of service:
    - $30 Copay at Physician’s office
    - 100% at non-hospital facility
    - $150 Copay at Hospital (see page 31 for NYP exception)

### Infertility Expenses

- **(Artificial Insemination, Ovulation Induction) and Advanced Reproductive Technology (ART) Expenses**
  - Basic and Comprehensive Infertility Treatment: Unlimited benefit for diagnosis and basic medical treatment, including artificial insemination
  - Advanced Infertility Treatment: $30,000 lifetime maximum for advanced treatments and Assisted Reproductive Technology including IVF, GIFT and ZIFT In and out-In-Network combined.

See *Additional Coverage Details* for limits

### Injections in a Physician’s Office

- **Allergy injections with no Physician’s office visit**
  - 100%
- **Shots other than Allergy in Physician’s Office Only**
  - 100%
- **Allergy Testing in Physician’s Office Only**
  - $30 copay
- **Chemotherapy Injections**
  - 100%

### Lab, X-Ray and Diagnostics - Outpatient

- Based on place of service:
  - 100% at Physician’s office
  - 100% at non-hospital facility
  - $150 Copay at outpatient Hospital (see page 31 for NYP exception)

- 60% after you meet the Annual Deductible

- Prior Authorization required or $500 penalty
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td>Based on place of service:</td>
</tr>
<tr>
<td></td>
<td>• 100% at Physician’s office</td>
</tr>
<tr>
<td></td>
<td>• 100% at non-hospital facility</td>
</tr>
<tr>
<td></td>
<td>• $150 Copay at outpatient Hospital (see page 31 for NYP exception)</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required or $500 penalty</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient Stay</td>
<td>100% after you pay a $500 per admission Copay</td>
</tr>
<tr>
<td>Physician Office Services (Copay is per visit)</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required or $500 penalty</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>100% after you pay a $30 Copay</td>
</tr>
<tr>
<td>Physician's Office Services (Copay is per visit)</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required or $500 penalty</td>
</tr>
<tr>
<td>Physician Fees for Surgical and Medical Services</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>100% after you pay a $500 per admission Copay</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on place of service:</td>
</tr>
<tr>
<td></td>
<td>• 100% at Physician’s office</td>
</tr>
<tr>
<td></td>
<td>• 100% at non-hospital facility</td>
</tr>
<tr>
<td></td>
<td>• $150 Copay at outpatient Hospital (see page 31 for NYP exception)</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required or $500 penalty</td>
</tr>
<tr>
<td>See Additional Coverage Details for limits</td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>100% at Physician’s office when no office visit billed</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

36
<table>
<thead>
<tr>
<th>Covered Health Services&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>

**Important Note:**
Out-of-network Benefits may be reduced for multiple surgical procedures performed on the same day; see Multiple Surgical Procedures under *Additional Coverage Details.*

**Physician’s Office Services - Sickness and Injury**
(Copay is per visit)

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after you pay a $30 Copay</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Pregnancy – Maternity Services**

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after you pay a $30 Copay</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization required if hospital stay is in excess of 48 hours for vaginal delivery and 96 hours for cesarean section.

**Physician Fees for Surgical and Medical Services**

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after you pay a $500 per admission Copay</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
</tbody>
</table>

A Copay ($500) will not apply for a newborn child whose length of stay in the Hospital is the same as the mother’s length of stay.

**Preventive Care Services**

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after you pay a $30 Copay</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
</tbody>
</table>

Based on place of service:
- 100% at Physician’s office
- 100% at non-hospital facility
- 100% at outpatient Hospital (see page 31 for NYP exception)

Note that Blood work and certain tests prescribed by your physician during your annual physical may not be considered preventive. Call UHC for confirmation.

**Private Duty Nursing - Outpatient**

Up to a $5,000 maximum per Covered Person per calendar year for In-Network and Out-of-Network Benefits

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after you pay a $500 per admission Copay</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
</tbody>
</table>

Based on place of service:
- 100% at Physician’s office
- 100% at non-hospital facility
- 100% at outpatient Hospital (see page 31 for NYP exception)

Note that Blood work and certain tests prescribed by your physician during your annual physical may not be considered preventive. Call UHC for confirmation.
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic Devices</td>
<td>Network: 100%</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization Required if to rent or purchase the devise is greater than $1000</td>
</tr>
<tr>
<td></td>
<td>Replacement once every three years</td>
</tr>
</tbody>
</table>

**Reconstructive Procedures**

- **Physician's Office Services (Copay is per visit)**: 100% after you pay a $30 Copay
- **Hospital - Inpatient Stay**: 100% after you pay a $500 per admission Copay
- **Physician Fees for Surgical and Medical Services**: 100%
- **Prosthetic Devices Surgery - Outpatient**:
  - Based on place of service:
    - $30 Copay at Physician's office
    - 100% at non-hospital facility
    - $150 Copay at outpatient Hospital see page 31 for NYP exception

**Rehabilitation Services**

- **Outpatient Therapy (Copay is per visit)**: $30 Copay
  - Cardiac Rehabilitation: 60 visits per calendar year, in and out-of-network combined
  - Occupational and Physical Therapy: 60 Visits per calendar year in and out-of-network combined. Autism is a covered diagnosis.
  - Speech Therapy: 60 visits per calendar year, In and Out-of-network combined. Autism is a covered diagnosis.
  - Cognitive Therapy: 60 visits per calendar year, in and out-of-network combined.

See Additional Coverage Details on pages 70-71 for visit limits
<table>
<thead>
<tr>
<th><strong>Covered Health Services</strong></th>
<th><strong>Percentage of Eligible Expenses Payable by the Plan:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td><strong>Scopic Procedures - Outpatient</strong></td>
<td>Based on place of service:</td>
</tr>
<tr>
<td><strong>Diagnostic and Therapeutic</strong></td>
<td>- $30 Copay at Physician’s office</td>
</tr>
<tr>
<td></td>
<td>- $150 Copay at non-hospital facility</td>
</tr>
<tr>
<td></td>
<td>- $150 Copay at outpatient Hospital (see page 31 for NYP exception)</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Up to 120 days per Covered Person per calendar year for In-Network and Out-of-Network Benefits combined</td>
</tr>
<tr>
<td><strong>Spinal Manipulation Treatment</strong></td>
<td>(Copay is per visit)</td>
</tr>
<tr>
<td></td>
<td>Up to 60 visits per Covered Person per calendar year for In-Network and Out-of-Network Benefits combined</td>
</tr>
<tr>
<td><strong>Substance Use Disorder Services</strong></td>
<td>Hospital - Inpatient Stay</td>
</tr>
<tr>
<td></td>
<td>Physician’s Office Services (Copay is per visit)</td>
</tr>
<tr>
<td><strong>Important Notice</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not all types of services are covered. For example, wilderness treatment programs, educational services and certain types of therapies are not covered. See the Exclusions section for more information.</td>
</tr>
<tr>
<td><strong>Surgery - Outpatient</strong></td>
<td>Based on place of service:</td>
</tr>
<tr>
<td></td>
<td>- $30 Copay at Physician’s office</td>
</tr>
<tr>
<td></td>
<td>- 100% at non-hospital facility</td>
</tr>
<tr>
<td></td>
<td>- $150 Copay at outpatient Hospital (see page 31 for NYP exception)</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint (TMJ) Disorder Treatment</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Therapeutic Treatments - Outpatient</strong></td>
<td>Includes dialysis (Both hemodialysis and peritoneal dialysis) intravenous chemotherapy or other intravenous infusion therapy and radiation oncology</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required or a $500 penalty</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section. <strong>Prior Authorization required</strong></td>
</tr>
<tr>
<td>Travel and Lodging (If services rendered by a Designated Facility)</td>
<td>For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures; see page 656 in <em>Additional Coverage Details</em>.</td>
</tr>
<tr>
<td>Urgent Care Center Services (Copay is per visit)</td>
<td>100% after you pay a $30 Copay</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $30 Copay</td>
</tr>
<tr>
<td>Vision Care</td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td></td>
</tr>
<tr>
<td>Materials</td>
<td>• 100% after you pay a $10 copay once every 12 months</td>
</tr>
<tr>
<td></td>
<td>• Adult</td>
</tr>
<tr>
<td></td>
<td>o $30 allowance for frames</td>
</tr>
<tr>
<td></td>
<td>o $20 allowance for single lenses,</td>
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<tr>
<td></td>
<td>o $30 allowance for bifocal lenses,</td>
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<tr>
<td></td>
<td>o $40 allowance for trifocal lenses</td>
</tr>
<tr>
<td></td>
<td>o $75 allowance for lenticular lenses</td>
</tr>
<tr>
<td></td>
<td>o $75 allowance for contacts</td>
</tr>
<tr>
<td></td>
<td>• Every 24 months</td>
</tr>
<tr>
<td></td>
<td>• Pediatric Vision (child under age 19)</td>
</tr>
<tr>
<td></td>
<td>o Lenses covered in full.</td>
</tr>
<tr>
<td></td>
<td>o Frames with a retail cost of $100 or less covered in full; cost above $100 covered at 60%.</td>
</tr>
<tr>
<td></td>
<td>o Single purchase of a pair of contact lenses or 1 box of contact lenses per eye covered at 100%.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One pair of eyeglasses (lenses and frames) OR one pair of contact lenses (or a 12 month supply) every 12 months. More frequently if medically necessary.</td>
</tr>
<tr>
<td>Call UHC for details using the number on the back of your medical ID card</td>
<td></td>
</tr>
</tbody>
</table>
Additional Coverage Details

**What this section includes:**
- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in *Exclusions*.

**Did you know…**
*You generally pay less out-of-pocket when you use a Network provider?*

**Acupuncture Services**
The Plan pays for acupuncture services when performed as an alternative to anesthesia and performed by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

**Ambulance Services - Emergency Only**
The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See *Glossary* for the definition of Emergency.

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

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

- from an Out-of-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
• to a more Cost-Effective acute care facility; or
• from an acute facility to a sub-acute setting.

In most cases, UHC will initiate and direct non-Emergency ambulance transportation. If you are requesting air non-emergency ambulance services, please remember that you must receive authorization from UHC as soon as possible prior to the transport. If authorization is not received, Benefits for covered services will be subject to a $500 reduction. No benefits will be paid if the transport is not medically necessary.

**Autism Spectrum Disorder (refer to Neurobiological Disorders and Rehabilitation)**

**Cancer Resource Services (CRS)**
The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in *Glossary*.

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

• be referred to CRS by a Personal Health Support Nurse;
• call CRS toll-free at (866) 936-6002; or
• visit [www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com).

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

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

*Note:* The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

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

**Clinical Trials**
The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

• Cancer;
• Cardiovascular disease (cardiac/stroke);
• Surgical musculoskeletal disorders of the spine, hip, and knees.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Clinical Trial as defined by the researcher. Benefits are not available for preventive Clinical Trials.

Routine patient care costs for Clinical Trials include:

• Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
• Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
• Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

• The Experimental or Investigational Service or item. The only exceptions to this are:
  ♦ certain Category B devices;
  ♦ certain promising interventions for patients with terminal illnesses; or
  ♦ other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
• Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
• Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying Clinical Trial, a Clinical Trial must meet all of the following criteria:

• Be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:
  ♦ National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  ♦ Centers for Disease Control and Prevention (CDC);
  ♦ Agency for Healthcare Research and Quality (AHRQ);
  ♦ Centers for Medicare and Medicaid Services (CMS);
  ♦ Department of Defense (DOD); or
  ♦ Veterans Administration (VA).
• Have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UHC may, at any time, request documentation about the trial; and
• The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Benefits are available when the Covered Health Services are provided by either In-Network or Out-of-Network providers, however the Out-of-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial.
(Out-of-Network Benefits are not available if the Out-of-Network provider does not agree to accept the Network level of reimbursement.)

Please remember that you must obtain prior authorization from Personal Health Support as soon as the possibility of participation in a clinical trial arises. If authorization from Personal Health Support is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

**Congenital Heart Disease (CHD) Surgeries**

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

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

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

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

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

Please remember for Out-of-Network Benefits, you must receive authorization from United Resource Networks or UHC as soon as CHD is suspected or diagnosed. If United Resource Networks or UHC does not authorize, Benefits for Covered Health Services will be subject to a $500 reduction.

**Note:** The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

**Dental Services – Accident Only and Orthognathic Surgery**

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

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident.

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

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

Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, and that it:

- has no decay;
- has no filling on more than two surfaces;
- has no gum disease associated with bone loss;
- has no root canal therapy;
- is not a dental implant; and
- functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident.

Orthognathic Surgery is covered in the following situations:

- a jaw deformity resulting from facial trauma or cancer; or
- a skeletal anomaly or either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
  - inability to incise solid foods;
  - choking on incompletely masticated solid foods;
  - damage to soft tissue during mastication;
  - speech impediment determined to be due to the jaw deformity; or
  - malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Orthognathic surgery is not a Covered Health Service for the following symptoms because it is considered to be an Unproven Service:

- myofascial, neck, head and shoulder pain;
- irritation of head/neck muscles;
- popping/clicking of temporomandibular joint dysfunction; and
- teeth grinding.

Treatment of malocclusion is considered dental in nature and therefore not a Covered Health Service.

Dental Related General Anesthesia and Facility Charges.
Please remember that orthognatic surgery requires prior authorization. You should check with your network provider to make sure they have gotten the appropriate prior authorization from UHC.

If a patient is severely disabled or has a complicating medical condition that indicates dental treatment should be provided in a hospital facility under general anesthesia, coverage may be available under the Medical Plan. The treatment and recommended treatment setting must meet UHC specific medical criteria for dental-related general anesthesia in an inpatient or outpatient hospital so you are required to obtain prior authorization from UHC. Therefore you, or your oral surgeon must contact UHC for prior authorization 14 days prior to receiving these services or no benefits will be paid. Note: there is no coverage for anesthesia in conjunction with any type of cosmetic surgery.

**Diabetes Services**

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

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

Please remember for Out-of-Network Benefits, you must receive prior authorization from UHC before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed $1,000. If prior authorization is not received, Benefits will be subject to a $500 reduction. To receive network Benefits, you must purchase or rent DME from a vendor UHC identifies, or purchase it directly from the prescribing network physician.
Durable Medical Equipment (DME)
The Plan pays for Durable Medical Equipment (DME) that is:

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

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under Diabetes Services in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section;
- cranial banding for the treatment of moderate to severe plagiocephaly when its use prevents or treats a physiological functional defect, including but not limited to ocular and oromotor abnormalities. The use of a cranial orthotic device is covered as consolidation treatment following craniofacial surgery when prescribed by the treating neurosurgeon. The use of a cranial orthotic device is excluded from coverage for treatment of mild plagiocephaly where its primary purpose is to improve the shape of the head and where no identified physiological functional impairment exists;
- wigs for temporary loss of hair resulting from chemotherapy treatment of a malignancy or permanent loss of hair from an accidental Injury, one wig every three years - per Covered Person; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Note: DME is different from prosthetic devices – see Prosthetic Devices in this section.
Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

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

Please remember for Out-of-Network Benefits, you must receive prior authorization from UHC if the retail purchase cost or the cumulative rental cost of a single item will exceed $1,000. If prior authorization is not received, Benefits will be subject to a $500 reduction. To receive Network Benefits, you must purchase or rent the DME from the vendor UHC identifies or purchase it directly from the prescribing Network Physician.

**Emergency Health Services - Outpatient**

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

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to an Out-of-Network Hospital as long as Personal Health Support is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to an Out-of-Network Hospital. If you continue your stay in an Out-of-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Out-of-Network Benefits will apply.

Please remember for Out-of-Network Benefits, you must receive prior authorization from UHC within 48 hours of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If prior authorization is not received, Benefits for the Inpatient Hospital Stay will be subject to a $500 reduction.

**Family Planning Services**

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury. Refer to the Plan Highlights for the frequency limits that apply to these services, if not specified below.

Covered expenses include charges for family planning services, including:

Voluntary sterilization.
Voluntary termination of pregnancy.

The plan does not cover the reversal of voluntary sterilization procedures, including related follow-up care.
**In-Office/Surgical Contraception**

The Columbia healthcare plans cover the following In-Network services at no cost to you:

- For patient education and counseling on contraceptives
- Administration of certain contraceptives, such as the insertion of IUDs or injections
- Women’s sterilization procedures

Also see section on pregnancy and infertility related expenses on a later page.

**Gender Dysphoria Treatment:**

The Plan pays Benefits for the treatment of gender identity disorder as follows:

- psychotherapy for gender identity disorders and associated co-morbid psychiatric diagnoses;
- continuous hormone replacement - hormones of the desired gender;
- surgery to change the genitalia and specified secondary sex characteristics, specifically:
  - thyroid chondroplasty (reduction of the Adam’s Apples);
  - bilateral mastectomy; and
  - augmentation mammoplasty if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role;
- laboratory testing to monitor the safety of continuous hormone therapy.

The Covered Person must meet all of the following eligibility qualifications for hormone replacement (in addition to the Plan’s overall eligibility requirements.):

- age 18 years or older;
- demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
- the Covered Person must meet the definition of Gender Dysphoria as shown in the, Glossary; and
- initial hormone therapy must be preceded by either:
  - a documented real-life experience of at least three months prior to the administration of hormones; or
  - a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

The Covered Person must meet all of the following eligibility qualifications for genital surgery and surgery to change secondary sex characteristics (in addition to the Plan’s overall eligibility requirements.):

- the surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender dysphoria;
- the treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards (please note that not all WPATH standards are covered under the Plan. If you have questions, please call the number on your ID card.);
- age 18 years or older;
- has completed 12 months of continuous hormone therapy for those without contraindications;
- has completed 12 months of successful continuous full time real life experience in the desired gender; and your Physician who is performing the surgery must notify at United Healthcare.
There is a lifetime maximum benefit of $75,000.

**Home Health Care**

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

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

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

Any combination of Network Benefits and Out-of-Network Benefits is limited to 200 visits per calendar year. One visit equals four hours of Skilled Care services.

Please remember for Out-of-Network Benefits, you must receive prior authorization from UHC five business days before receiving services or as soon as reasonably possible. If prior authorization is not received, Benefits will be subject to a $500 reduction.

**Hospice Care**

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Any combination of In-Network and Out-of-Network Benefits is limited to 6 months per Covered Person during the entire period you are covered under the Plan.

Please remember for Out-of-Network Benefits, you must receive prior authorization from UHC five business days before receiving services. If prior authorization is not received, Benefits will be subject to a $500 reduction.

**Hospital - Inpatient Stay**

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.
Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Please remember for out-of-Network Benefits, you must receive prior authorization from UHC as follows:
- For elective admissions: five business days before admission or as soon as reasonably possible;
- For Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.
If prior authorization is not received, Benefits will be subject to a $500 reduction.

**Infertility Services**

The Plan pays Benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.

The Plan pays Benefits for infertility services and associated expenses including:
- diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician;
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);
- embryo transport;
- donor ovum and semen and related costs, including collection, preparation and storage of; and
- insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).

Any combination of Network Benefits and out-of-Network Benefits for advanced treatments and Assisted Reproductive Technology (ART) including IVF, GIFT and ZIFT is limited to a lifetime maximum of $30,000 per Covered Person. Only charges for the following apply toward the infertility lifetime maximum: (?)
- surgeon;
- assistant surgeon;
- anesthesia;
- lab tests; and
- specific injections.

**Injections in a Physician's Office**

Benefits are paid by the Plan for injections administered in the Physician's office, for example allergy immunotherapy, when no other health service is received.

**Lab, X-Ray and Diagnostics - Outpatient**

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:
- lab and radiology/X-ray; and
- mammography.

Benefits under this section include:

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

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services. Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient in this section.

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

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

Benefits under this section include:

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

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

**Mental Health Services**

Mental health services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining Benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

**In-patient** – Services that are provided by a Hospital while you or your Dependent is confined in a Hospital for the treatment and evaluation of Mental Health. In-patient Mental Health Services include partial Hospitalization and Mental Health Residential Treatment Services. Partial Hospitalization sessions are series that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that result of sub-acute Mental Health conditions.

**Out-Patient** – Services of providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not confined in a Hospital and is provided in an individual or group or Intensive Outpatient Therapy Program. Covered services include but are not limited to outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning, emotional adjustment or concerns related to chronic conditions, such as psychosis or depression emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.
Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

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

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

**Special Mental Health Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services benefit. Depending on the type of programs or services available, the programs or services may be offered to you at no cost. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Out-of-Network In-Patient Benefits, you must notify UHC to receive these Benefits in advance of any treatment. Please refer to Requirements for Prior Authorization for Medically Necessity for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced by $500.

**Multiple Surgical Procedures on the Same Day**

**Covered expenses** for multiple surgical procedures are limited as follows:

- **Covered expenses** for a secondary procedure are limited to 50% of the covered expense that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
• **Covered expenses** for any subsequent procedure performed in addition to a secondary procedure are limited to 50% of the covered expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

The medical insurance carrier uses National Physician Fee Schedule (NPFS) developed by the Centers for Medicare and Medicaid Services (CMS) to determine which procedures are subject to the multiple procedure reductions.

If you are having surgery on an Out-of-Network basis that may involve multiple procedures, you can get information on any limitations that may be applied in advance. Get a statement of all the fees you will be billed and the corresponding billing codes. Call UHC and request a pre-treatment review.

**Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders**

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

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

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

Effective January 1, 2016, the Plan offers coverage for in-network pre-certified Applied Behavior Analysis (ABA) therapy. The ABA therapy benefit is provided under the Plan at the in-network, outpatient, mental health rate and is subject to deductible and coinsurance. This specific benefit is offered in addition to medical coverage for Developmental Delay conditions. For more information regarding the Plan's ABA therapy benefit you can call UnitedHealthcare at the number on the back of your ID card and ask to speak with a Behavioral Care Advocate. Your Advocate will support you and help you get answers. Treatment requires pre-certification, which includes provider eligibility verification and treatment plan review. Your Advocate will help you start the approval process and provide an explanation of benefits covered. Talk to your child's diagnosing provider, such as a pediatrician and/or psychologist, to see if ABA therapy is appropriate. They can help answer questions and are generally familiar with the pre-certification process that UnitedHealthcare has in place.

**Obesity Surgery**

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician the following are true:

- you have a minimum Body Mass Index (BMI) of 40 or a BMI of 35-39.9 with at least one of the following co-morbidities:
  - Cardiovascular disease including stroke, myocardial infarction, stable or unstable angina pectoris, coronary artery bypass or other procedures.
  - Hyperlipidemia uncontrolled by pharmacotherapy.
  - Type 2 diabetes uncontrolled by pharmacotherapy.
  - Hypertension uncontrolled by pharmacotherapy.
Moderate to severe sleep apnea with a respiratory disturbance index of 16 to 30 (moderate) or apnea-hypopnea index >30 (severe) as documented through the completion of a laboratory based polysomnography.

- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years; and
- you are over the age of 21.

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

- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in the Glossary and are not Experimental or Investigational or Unproven Services.

You will have access to a certain Network of Designated Facilities and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in the Glossary, for obesity surgery services.

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

If you receive obesity surgery services that are not performed as part of the Bariatric Resource Services program, the Plan pays Benefits as described under:

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

**Ostomy Supplies**

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

**Pharmaceutical Products - Outpatient**

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UHC), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include
medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

**Physician Fees for Surgical and Medical Services**

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

**Physician’s Office Services**

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UHC.

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

**Please Note**

Your Physician does not have a copy of your Benefit Summary, and is not responsible for knowing or communicating your Benefits.

**Pregnancy - Maternity Services**

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns’ and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

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

Please remember for Out-of-Network Benefits, you must receive authorization from UHC as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If prior authorization is not received, Benefits for the extended stay will be subject to a $500 reduction.
Healthy Moms and Babies:
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Resources to Help you Stay Healthy, for details.

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

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

Please Note: Blood work and certain tests prescribed by your physician during your annual physical may not be considered preventive.

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

Private Duty Nursing - Outpatient
The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to $5,000 per calendar year.

Prosthetic Devices
Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

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

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

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

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

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

Please remember, you must receive prior authorization from UHC if the retail purchase cost or cumulative retail rental cost of a single item exceeds $1,000. If prior authorization is not received, Benefits will be subject to a $500 reduction.

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

Reconstructive Procedures

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

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

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

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

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

Please remember that you must receive prior authorization from UHC five business days before undergoing a Reconstructive Procedure. When you receive authorization, UHC can determine whether
the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

**Habilitative Services**

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

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

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

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

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

**Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**

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

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

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician’s office or on an outpatient basis at a Hospital or Alternate Facility. This coverage does not include Applied Behavior Analysis (ABA).

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

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

Benefits are limited to:
• 60 visits per calendar year for physical and occupational therapy combined;
• 60 visits per calendar year for pulmonary rehabilitation therapy;
• 60 visits per calendar year for cardiac rehabilitation therapy;
• 60 visits per calendar year for Manipulative Treatment; and
• 60 visits per calendar year for speech therapy;
• 60 visits per calendar year for cognitive therapy
• 60 visits per calendar year for post cochlear implant aural therapy

These visit limits apply to In-Network Benefits and out-of-Network Benefits combined.

**Scopic Procedures - Outpatient Diagnostic and Therapeutic**

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

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

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

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

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

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

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

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

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

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive Skilled Care services that are not primarily Custodial Care.

Skilled Care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

You are expected to improve to a predictable level of recovery.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in the Glossary.

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to 120 days per calendar year.

Please remember for Out-of-Network Benefits, you must receive prior authorization from UHC as follows:

- For elective admissions: five business days before admission;
- For Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.

If prior authorization is not received, Benefits for the extended stay will be subject to a $500 reduction.
**Spinal Manipulation Treatment**

The Plan pays Benefits for Spinal Manipulation Treatment when provided by an In-Network or Out-of-Network Spinal Manipulation Treatment specialist in the specialist's office. Covered Health Services include chiropractic and osteopathic manipulative therapy.

The Plan gives UHC the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Benefits include diagnosis and related services. The Plan limits any combination of In-Network and Out-of-Network Benefits for Spinal Manipulation Treatment to one visit per day up to 60 visits per Covered Person per calendar year.

**Substance Use Disorder Services**

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

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

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

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

**Special Substance Use Disorder Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. Depending on the type of programs or services available, the programs or services may be offered to you at no cost. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be
referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Out-of-Network Benefits, you must receive authorization from UHC to receive these Benefits. Please refer to Requirements for Prior Authorization for Medical Necessity for the specific services that require notification. Please call the phone number that appears on your ID card Without prior authorization benefits will be subject to a $500 reduction.

**Surgery - Outpatient**

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

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

**Temporomandibular Joint (TMJ) Disorder Treatment**

The plan covers charges made by a Physician, Hospital or surgery center for the diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder as follows:

- **Arthrocentesis** for temporomandibular joint (TMJ) disorder as medically necessary when the following criterion is met:
  - Clinical examination and/or diagnostic imaging indicate the presence of hypomobility of the temporomandibular joint and symptoms persist despite at least six months of noninvasive therapy such as physical therapy and the use of intra-oral appliances.

- **Arthroscopy** for TMJ disorder as medically necessary when BOTH of the following criteria are met:
  - Pain or significant hypomobility persists despite at least six months of scientifically recognized noninvasive therapies such as pharmacologic pain control, physical therapy and the use of intra-oral appliances.
  - Clinical examination and diagnostic imaging indicate the presence of joint pathology that requires internal structural modification.

- **Arthrotomy** for TMJ disorder as medically necessary when the criteria for arthroscopy listed above are met but arthroscopy is not technically feasible, appropriate, or has previously failed to resolve the problem being treated.

- **Arthrotomy with total prosthetic joint replacement** as medically necessary using The TMJ Concepts Patient-Fitted TMJ Reconstruction Prosthesis for TMJ disorder when ANY of the following criteria are met, and the indication for surgery is confirmed by magnetic resonance imaging (MRI), computed tomography (CT) or corrected tomogram:
  - inflammatory arthritis involving the TMJ not responsive to other modalities of treatment
  - recurrent fibrosis and/or bony ankylosis not responsive to other modalities of treatment
- failed tissue graft
- failed alloplastic joint reconstruction
- loss of vertical mandibular condylar height due to bone resorption, trauma, developmental abnormality or pathologic lesion

Always excludes appliances and orthodontic treatment. Subject to medical necessity.

**Therapeutic Treatments - Outpatient**

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

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

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

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

**Transplantation Services**

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.
Benefits are also available for cornea transplants. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

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

Please remember you must receive prior authorization from United Resource Networks or UHC as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If prior authorization from United Resource Networks or UHC is not received, Benefits will be subject to a $500 reduction.

**Travel and Lodging**

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

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

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

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

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

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

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

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel, and lodging expenses reimbursed under this Plan in connection with all cancer treatments and transplant procedures and CHD treatments during the entire period that person is covered under this Plan.
Support in the Event of Serious Illness:
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UHC can put you in touch with quality treatment centers around the country.

Urgent Care Center Services
The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in the Glossary. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under Physician's Office Services earlier in this section.

Vision Care
- routine vision examinations, including refractive examinations to determine the need for vision correction; and
- purchase cost and associated fitting charges for eyeglasses or contact lenses.

Resources to Help You Stay Healthy

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

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

The University believes in giving you the tools you need to be an educated health care consumer. To that end, the University has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

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

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UHC and the University are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health4me – Your family’s healthcare resources, in your hands.

UHC's Health4me app provides instant access to your family’s critical health information anytime and anywhere. Whether you want to find a physician near you, check the status of a claim or speak directly with a health care professional, Health4me is your go to resource. Key features include:
• Search for physicians or facilities by location or specialty
• View claims
• Check status of deductible and out-of-pocket spending
• Check health-related financial account balance
• Have easy connect representatives contact you to answer any questions
• Locate convenience clinics, urgent care facilities and emergency rooms
• Store favorite physicians or facilities by locations or specialty
• Contact an experienced registered nurse 24/7

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

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

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

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

Online coaching is available for:

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

To help keep you on track with your Health Improvement Plan and online coaching, you’ll also receive personalized messages and reminders – the University’s way of helping you meet your health and wellness goals.

NurseLineSM
NurseLineSM is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the University has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:
• a recent diagnosis;
• a minor Sickness or Injury;
• men's, women's, and children's wellness;
• how to take prescription drugs safely;
• self-care tips and treatment options;
• healthy living habits; or
• any other health related topic.

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

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

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

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

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

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

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

This program offers:
• access to accurate, objective and relevant health care information;
• coaching by a nurse through decisions in your treatment and care;
• expectations of treatment; and
• information on high quality providers and programs.

Conditions for which this program is available include:
• back pain;
• knee & hip replacement;
• prostate disease;
• prostate cancer;
• benign uterine conditions;
• breast cancer;
• coronary disease and

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

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

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

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

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

With www.myuhc.com you can:

• receive personalized messages that are posted to your own website;
• research a health condition and treatment options to get ready for a discussion with your Physician;
• search for Network providers available in your Plan through the online provider directory;
• access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
• complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
• use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
• use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a www.myuhc.com subscriber, simply go to www.myuhc.com and click on “Register Now.” Have your UHC ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:

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

Want to learn more about a condition or treatment?
Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program
UHC provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (866) 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see Additional Coverage Details under the heading Cancer Resource Services (CRS).

Disease Management Services
If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

• educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
• access to educational and self-management resources on a consumer website;
• an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
• toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  ◆ education about the specific disease and condition,
  ◆ medication management and compliance,
  ◆ reinforcement of on-line behavior modification program goals,
  ◆ preparation and support for upcoming Physician visits,
  ◆ review of psychosocial services and community resources,
  ◆ caregiver status and in-home safety,
use of mail-order pharmacy and Network providers.

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

**HealtheNotesSM**

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

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

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

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

**Wellness Programs**

**Healthy Pregnancy Program**

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

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

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

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

What the medical plan will not cover

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Additional Coverage Details.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

Please review all limits in Plan Highlights and Additional Coverage Details carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments
1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary, and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Additional Coverage Details.

Advance Bills
Charges made in advance of services rendered are not covered. These are also known as "Advance Bills" or "Pre-Bills" and no reimbursement will be made by the Plan for these types of provider bills. Only charges for services rendered will be considered for reimbursement.

Comfort and Convenience
Supplies, equipment and similar incidentals for personal comfort. Examples include:

1. television;
2. telephone;
3. air conditioners;
4. beauty/barber service;
5. guest service;
6. air purifiers and filters;
7. batteries and battery chargers;
8. dehumidifiers and humidifiers;
9. ergonomically correct chairs;
10. electric scooters;
11. non-Hospital beds and comfort beds;
12. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under **Durable Medical Equipment** in Additional Coverage Details; and
13. home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

**Dental**
1. Dental care, except as identified under **Dental Services - Accident Only**, or orthognathic surgery and wisdom teeth;

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in **Additional Coverage Details**.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. preventive dental care;
3. diagnosis or treatment of the teeth or gums. Examples include:
   - extractions (including Out-of-Network wisdom teeth extractions);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

4. dental implants and braces;
5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and
6. treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

**Drugs**
1. prescription drugs for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by UHC, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);
3. non-injectable medications given in a Physician’s office except as required in an Emergency and consumed in the Physician’s office; and
4. over the counter drugs and treatments.

**Experimental or Investigational or Unproven Services**

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

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.
Foot Care

1. routine foot care, except when needed for severe systemic disease. Routine foot care services that are not covered include:
   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:
   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;
4. treatment of subluxation of the foot;
5. shoe inserts;
6. arch supports;
7. shoes (standard or custom), lifts and wedges; and
8. shoe orthotics.

Medical Supplies and Appliances

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
   - elastic stockings, ace bandages, diabetic strips, and syringes; and
   - urinary catheters.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Additional Coverage Details;
- Sheath-protection for endoscopy;
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Additional Coverage Details; or
- diabetic supplies for which Benefits are provided as described under Diabetes Services in Additional Coverage Details.

3. tubings, nasal cannulas, connectors and masks that are not used in connection with DME.
4. orthotic appliances that straighten or re-shape a body part (including some types of braces). Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics or any orthotic braces available over-the-counter.
5. cranial banding, except as described under Durable Medical Equipment in Additional Coverage Details;
6. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in Additional Coverage Details.

**Mental Health/Substance Use Disorder**

Exclusions listed directly below apply to services described under Mental Health Services, and/or Substance Use Disorder Services in Additional Coverage Details.

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

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

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

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

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

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

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

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

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

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

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

12. psychosurgery (lobotomy);

13. Substance Use Disorder services for the treatment of nicotine or caffeine use;

14. routine use of psychological testing without specific authorization,

15. pastoral counseling, and

16. Wilderness Treatment Programs.
**Nutrition and Health Education**

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;
2. nutritional counseling for either individuals or groups;
3. food of any kind. Foods that are not covered include:
   - enteral readings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements;
4. health club memberships and programs, and spa treatments; and
5. health education classes unless offered by UHC or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

**Physical Appearance**

1. Cosmetic Procedures, as defined in the Glossary, are excluded from coverage. Examples include:
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;
4. wigs regardless of the reason for the hair loss, except as shown under Durable Medical Equipment in Additional Coverage Details;
5. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
6. varicose vein treatment of the lower extremities, when it is considered cosmetic; and
7. treatment of benign gynecomastia (abnormal breast enlargement in males).

**Pregnancy and Infertility**

Health services and associated expenses for infertility treatments including, but not limited to:

1. surrogate parenting;
2. the reversal of voluntary sterilization;
3. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
4. services provided by a doula (labor aide); and
5. parenting, pre-natal or birthing classes.

**Providers**

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
   - prior to ordering the service; or
   - after the service is received.

This exclusion does not apply to mammography testing.

**Services Provided under Another Plan**

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Coordination of Benefits (COB);
2. under workers’ compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

**Transplants**

1. health services for organ and tissue transplants,
   - except as identified under Transplantation Services in Additional Coverage Details;
   - determined by Personal Health Support not to be proven procedures for the involved diagnoses; and
   - not consistent with the diagnosis of the condition;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and
3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient’s benefit plan).

**Travel**

1. health services provided in a foreign country, unless required as Emergency Health Services; and
2. travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in Additional Coverage Details. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Additional Coverage Details.

**Treatment of Gender Identity Disorder**
1. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
2. sperm preservation in advance of hormone treatment or gender surgery;
3. cryopreservation of fertilized embryos;
4. voice modification surgery;
5. facial feminization surgery, including but not limited to: facial bone reduction, face “lift”, facial hair removal and certain facial plastic procedures; and
6. treatment received outside the United States.

**Vision and Hearing**
1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
2. purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices;
3. eye exercise or vision therapy other than as a treatment for strabismus (misalignment of the eyes);
4. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy; and
5. routine hearing care for adults, except coverage is allowed for one exam every 24 months.
6. Routine vision care for adults, except coverage is allowed for one exam every 12 months.

**All Other Exclusions**
1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
   ♦ missed appointments;
   ♦ room or facility reservations;
   ♦ completion of claim forms;
   ♦ record processing; or
   ♦ services, supplies or equipment that are advertised by the Provider as free;
3. charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;
4. charges prohibited by federal anti-kickback or self-referral statutes;
5. chelation therapy, except to treat heavy metal poisoning;
6. Custodial Care as defined in the Glossary, or services provided by a personal care assistant;
7. diagnostic tests that are:
   ♦ delivered in other than a Physician’s office or health care facility; and
   ♦ self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests
8. Domiciliary Care, as defined in the Glossary;
9. growth hormone therapy;
10. expenses for health services and supplies:
that do not meet the definition of a Covered Health Service in the Glossary;
that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
that exceed Eligible Expenses or any specified limitation in this Benefit Summary;
for which an Out-of-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;
11. foreign language and sign language services;
12. Services related to a non-Covered Health Service. However, This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.
For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
13. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded;
14. Private Duty Nursing received on an inpatient basis;
15. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in Additional Coverage Details;
16. rest cures;
17. speech therapy to treat stuttering, stammering, or other articulation disorders;
18. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly or is needed following the placement of a cochlear implant as identified under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment in Additional Coverage Details;
19. Spinal Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;
20. long term (more than 30 days ) storage of blood, umbilical cord, reproductive materials or other material for use in a Covered Health Service, except if needed for an imminent surgery;
21. the following treatments for obesity:
   ♦ non-surgical treatment, even if for morbid obesity; and
   ♦ surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in Additional Coverage Details
22. treatment of hyperhidrosis (excessive sweating).
23. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
24. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   ♦ required solely for purposes of education, sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration;
   ♦ conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details;
   ♦ related to judicial or administrative proceedings or orders; or
   ♦ required to obtain or maintain a license of any type.

25. Applied Behavior Analysis (ABA).

Claims and Appeals Procedures

What this section includes:
- How In-Network and Out-of-Network claims work
- What to do if your claim is denied, in whole or in part
- Claim Filing Deadline
- Health Statements
- Explanation of Benefits (EOB)
- If Your Claim is Denied
- How to Appeal a Denied Claim

In-Network Benefits
In general, if you receive Covered Health Services from a Network Provider, UHC will pay the Physician or facility directly. If a Network Provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the Provider or call UHC at the phone number on the back of your ID card for assistance.

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

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

If Your Provider Does Not File Your Claim
You can obtain a claim form by visiting www.myuhc.com or calling the toll-free number on your ID card. You can also contact the Columbia Benefits Service Center at (212) 851-7000 or go to www.hr.columbia.edu/benefits. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
• the patient’s name, age and relationship to the Employee;
• the number as shown on your ID card;
• the name, address and tax identification number of the Provider of the service(s);
• a diagnosis from the Physician;
• the date of service;
• an itemized bill from the Provider that includes:
  ♦ the Current Procedural Terminology (CPT) codes;
  ♦ a description of, and the charge for, each service;
  ♦ the date the Sickness or Injury began; and
  ♦ a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

After UHC has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-Network Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UHC will pay Benefits to you unless:

• the Provider notifies UHC that you have provided signed authorization to assign Benefits directly to that Provider; or
• you make a written request for the out-of-network Provider to be paid directly at the time you submit your claim.

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

**Claim Filing Deadline**

This Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, Injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

You have 12 months to submit a claim to the Claims Administrator for a covered service under the Plan. While most in-network providers automatically submit claims on behalf of the patient, there are many situations when this does not occur. If you receive services from an out-of-network provider, you are responsible for submitting your claim to the Claims Administrator for a covered service within the 12 months from the date of service.

**Health Statements**

Each month in which UHC processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family’s medical costs by providing claims information in easy-to-understand terms.
If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

**Explanation of Benefits (EOB)**

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

**Claim Denials and Appeals**

**If Your Claim is Denied**

If a claim for Benefits is denied in part or in whole, you may call UHC at the number on your ID card before requesting a formal appeal. If UHC cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

**How to Appeal a Denied Claim**

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your appeal.

Please note that the Columbia Benefits Service Center cannot serve as your authorized representative for purposes of filing a claim or appeal under the Plan.

You or your enrolled Dependent may send a written request for an appeal to:

UnitedHealthcare - Appeals  
P.O. Box 740800  
Atlanta, Georgia 30374-0800

For Urgent Care claims that have been denied, you or your Provider can call UHC at the toll-free number on your ID card to request an appeal.

You have the right to submit written comments, documents, records, and other information in connection with your appeal. Your authorized representative also may make such written submissions on your behalf. Please note that the Columbia Benefits Service Center cannot serve as your authorized representative for this purpose.
Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care;
- pre-service; or
- post-service claim.

Review of an Appeal
UHC will conduct a full and fair review of your appeal. The appeal will be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination, nor the subordinate of such individual; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process, if the adverse benefit determination which you are appealing is based in whole or in part on a medical judgment.

Once the review is complete, if UHC upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial as well as a general explanation of your right to have the claims denial reviewed through the Plan’s external review program and/or by a court of competent jurisdiction.

Federal External Review Program
If, after exhausting your internal appeals, you are not satisfied with the determination made by UHC, you may be entitled to request an external review of UHC's determination. The process is available at no charge to you.

You may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UHC’s decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative’s name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.
An external review will be performed by an Independent Review Organization (IRO). UHC has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

**Timing of Appeals Determinations**

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- **Urgent Care request for Benefits** - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, Glossary;
- **Pre-Service request for Benefits** - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UHC before non-Urgent Care is provided; and
- **Post-Service** - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UHC are required to follow.

### Urgent Care Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is incomplete, UHC must notify you within:</td>
<td>24 hours</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits to UHC within:</td>
<td>48 hours after receiving notice of additional information required</td>
</tr>
<tr>
<td>UHC must notify you of the benefit determination within:</td>
<td>72 hours</td>
</tr>
<tr>
<td>If UHC denies your request for Benefits, you must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UHC must notify you of the appeal decision within:</td>
<td>72 hours after receiving the appeal</td>
</tr>
</tbody>
</table>

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

### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is filed improperly, UHC must notify you within:</td>
<td>5 days</td>
</tr>
</tbody>
</table>
### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is incomplete, UHC must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits information to UHC within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UHC must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>if the initial request for Benefits is complete, within:</td>
<td>15 days</td>
</tr>
<tr>
<td>after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UHC must notify you of the first level appeal decision within:</td>
<td>15 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UHC must notify you of the second level appeal decision within:</td>
<td>15 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UHC must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UHC within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UHC must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
</tbody>
</table>
### Post-Service Claims

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<thead>
<tr>
<th>Type of Claim or Appeal</th>
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<tr>
<td>UHC must notify you of the first level appeal decision within:</td>
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</tr>
<tr>
<td>UHC must notify you of the second level appeal decision within:</td>
<td>30 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

### Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UHC will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

### Limitation of Action

You cannot bring any legal action against the University or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the University or the Claims Administrator, you must do so within one year from the date of the final denial of your claim on appeal or you lose any rights to bring such an action against the University or the Claims Administrator.

You cannot bring any legal action against the University or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the University or the Claims Administrator you must do so within one year from the date of the final denial of your claim on appeal or you lose any rights to bring such an action against the University or the Claims Administrator.

### Coordination of Benefits (COB)

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

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

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

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

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

- this Plan will always be secondary to medical payment coverage or personal Injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an Employee pays benefits before a plan that covers the person as a Dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
the parent not having custody of the child; then
- the Spouse of the parent not having custody of the child;

- plans for active Employees pay before plans covering laid-off or retired Employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

**Determining Primary and Secondary Plan – Examples**

Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

**When This Plan is Secondary**

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

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

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

**Determining the Allowable Expense When This Plan is Secondary**

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

**What is an allowable expense?**

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

**When a Covered Person Qualifies for Medicare**

**Determining Which Plan is Primary**

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:
• Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
• individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary
If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. In all cases where a participant is Medicare eligible, the Medicare approved amount is the allowable expense for purposes of this Plan, and in no event will Medicare payments, combined with Plan Benefits, exceed 100% of the allowable expense.

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

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

Overpayment and Underpayment of Benefits
If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UHC should have paid. If this occurs, the Plan may pay the other plan the amount owed.

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

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

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

• all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
• all or some of the payment the University made exceeded the Benefits under the Plan; or
• all or some of the payment was made in error.

The refund equals the amount the University paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the University get the refund when requested.
If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the University may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. The University may have other rights in addition to the right to reduce future Benefits.

**SUBROGATION AND REIMBURSEMENT**

*What this section includes:*
- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.
- The Plan has a right to subrogation and reimbursement, as defined below.

**Right of Recovery**
The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

**Right to Subrogation**
The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

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

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

**Third Parties**

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- UHC in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

**Subrogation and Reimbursement Provisions**

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim you may have against a third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.
- the Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys’ fees. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.
- regardless of whether you have been fully compensated or made whole, the Plan may collect from you, your representative or a third-party payor the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan’s subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;

responding to requests for information about any accident or injuries;

appearing at medical examinations and legal proceedings, such as depositions or hearings; and

obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.

- the Plan's rights will not be reduced due to your own negligence.

- the Plan may file suit in your name and take appropriate action to assert its rights under this section. Even if it files suit in your name, the Plan is not required to pay you part of any recovery it may obtain from a third party to the extent the recovery does not exceed the Benefits the Plan has provided for a Sickness or Injury caused by a third party and the costs the Plan incurs in obtaining the recovery. Notwithstanding anything to the contrary in this document, even if it files in your name, the Plan is not required to seek a recovery from the third-party in excess of the Benefits the Plan has provided for a Sickness or Injury caused by a third party and the costs the Plan incurs in obtaining the recovery.

- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or offset from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

- if any claim is made that any part of the Plan’s subrogation, reimbursement and/or offset provisions are ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of these provisions.

**Subrogation – Example**

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver’s insurance carrier to recover the cost of those Benefits.
It is a federal crime punishable by prison to defraud an ERISA-governed plan. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an ERISA-governed plan, submits an application or files a claim containing a false or deceptive statement is guilty of fraud.

**Glossary**

*What this section includes:*
- Definitions of terms used throughout this Benefit Summary.

Many of the terms used throughout this Benefit Summary may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Summary, but it does not describe the Benefits provided by the Plan.

**Addendum** – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this Benefit Summary and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Benefit Summary and/or Amendments to the Benefit Summary, the Addendum shall be controlling.

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

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

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

**Amendment** – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the Amendment is specifically changing. Notwithstanding anything to the contrary in this Benefit Summary, the Plan Sponsor reserves the right, in its sole discretion, to amend, modify or terminate the terms of the Plan, including, but not limited to, the removal of a particular coverage or benefit provided under the Plan.

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

**Assisted Reproductive Technology** (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- in vitro fertilization (IVF);
- gamete intrafallopian transfer (GIFT);
- pronuclear stage tubal transfer (PROST);
- tubal embryo transfer (TET); and
- zygote intrafallopian transfer (ZIFT).

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

**Bariatric Resource Services (BRS)** – a program administered by UHC or its affiliates made available to you by the University. The BRS program provides:
- specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options; and
- access to specialized Network facilities and Physicians for obesity surgery services.

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

**Body Mass Index (BMI)** – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

**Cancer Resource Services (CRS)** – a program administered by UHC or its affiliates made available to you by the University. The CRS program provides:
- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

**CHD** – see Congenital Heart Disease (CHD).

**Claims Administrator** – UnitedHealthcare, also known as UnitedHealthcare Service LLC, (“UHC”) and its affiliates, who provide certain claim administration services for the Plan.

**Clinical Trial** – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

**COBRA** – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

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

**Congenital Anomaly** – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

**Congenital Heart Disease (CHD)** – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:
- be passed from a parent to a child (inherited);
• develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
• have no known cause.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

**Cosmetic Procedures** – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

**Cost-Effective** – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

**Covered Health Services** – those health services, including services or supplies, which UHC determines to be:

• Medically Necessary
• included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
• provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility*; and
• not identified the *Exclusions*.

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

**CRS** – see Cancer Resource Services (CRS).

**Custodial Care** – services that do not require special skills or training and that:

• provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
• are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
• do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Deductible** – see Annual Deductible.

**Dependent** – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

**Dependent Child(ren)** – legally dependent children, including adopted children, foster and stepchildren of your spouse or same-sex Domestic Partner.
Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specific diseases or conditions. A Designated Facility may or may not be located within your geographic area.

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

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same sex with whom you have established a Domestic Partnership as described below.

A Domestic Partnership is a relationship between an Employee and one other person of the same sex. Both persons must:

• not be so closely related that marriage would otherwise be prohibited;
• not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
• be at least 18 years old;
• live together and share the common necessities of life;
• be mentally competent to enter into a contract; and
• be financially interdependent.

The Employee and Domestic Partner must jointly sign an affidavit of Domestic Partnership. Contact Human Resources for more information.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

• used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
• not disposable;
• not of use to a person in the absence of a Sickness, Injury or their symptoms;
• durable enough to withstand repeated use;
• not implantable within the body; and
• appropriate for use, and primarily used, within the home.

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

<table>
<thead>
<tr>
<th>For Services Provided by a:</th>
<th>Eligible Expenses are Based On:</th>
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<tbody>
<tr>
<td>In-Network Provider</td>
<td>Contracted rates with the provider</td>
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<tr>
<td>For Services Provided by a:</td>
<td>Eligible Expenses are Based On:</td>
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<tr>
<td>Out-of-Network Provider</td>
<td>Negotiated rates agreed to by the Out-of-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator.</td>
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<td>If rates have not been negotiated, then one of the following amounts:</td>
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<td>♦ 190 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or</td>
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<td></td>
<td>♦ When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:</td>
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<tr>
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<td>• For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare’s website at <a href="http://www.myuhc.com">www.myuhc.com</a> for information regarding the vendor that provides the applicable gap fill relative value scale information.</td>
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<td></td>
<td>• For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by <em>RJ Health Systems, Thomson Reuters</em> (published in its Red Book), or the Claims Administrator based on an internally developed pharmaceutical pricing resource.</td>
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For Services Provided by a:

- When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50 percent of the provider's billed charge, except that certain Eligible Expenses for mental health and Substance Use Disorder Services are based on 80 percent of the billed charge.

- For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. Theses updates are typically implemented within 30 to 90 days after CMS updates its data.

These provisions do not apply if you receive Covered Health Services from an Out-of-Network provider in an Emergency. In that case, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

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

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines. An example of these reimbursement policy guidelines are the guidelines for multiple surgical procedures. Current multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.

- Covered Expenses for any subsequent procedure performed in addition to a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

You may request a copy of the guidelines related to your claim from the Claims Administrator.

**IMPORTANT NOTICE**

Out-of-Network Physicians and providers may bill you for any difference between the Physician’s or provider’s billed charges and the Eligible Expense described above.

**Emergency** – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:
• arises suddenly; and
• in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

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

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under Eligibility. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Columbia University in the City of New York (“the University”).

EOB – see Explanation of Benefits (EOB).


Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UHC makes a determination regarding coverage in a particular case, are determined to be any of the following:

• not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
• subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
• the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

• Clinical trials for which Benefits are available as described under Clinical Trials in Section 6, Additional Coverage Details.
• If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UHC may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UHC must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UHC to you, your Physician, or another health care professional that explains:

• the Benefits provided (if any);
• the allowable reimbursement amounts;
• Deductibles;
• Coinsurance;
• any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

**Gender Identity Disorder** – Characterized by the following diagnostic criteria:
- a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex);
- persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that gender;
- the disturbance is not concurrent with a physical inter-gender condition;
- the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning;
- the transsexual identity has been present persistently for at least two years; and
- the disorder is not a symptom of another mental disorder or a chromosomal abnormality.

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

**Health Statement(s)** – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

**Home Health Agency** – a program or organization authorized by law to provide health care services in the home.

**Hospital** – an institution, operated as required by law, which is:
- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

**Injury** – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility** – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

**Intercottent Care** – skilled nursing care that is provided or needed either:
- fewer than seven days each week; or
• fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

**Manipulative Treatment** – the therapeutic application of chiropractic and/or Manipulative Treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medicaid** – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

• in accordance with Generally Accepted Standards of Medical Practice;
• clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
• not mainly for your convenience or that of your doctor or other health care provider; and
• not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

**Generally Accepted Standards of Medical Practice** are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator’s sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the **Generally Accepted Standards of Medical Practice** scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

**Medicare** – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.
**Mental Health Services** – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder (MH/SUD) Administrator** – the organization or individual designated by the University who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

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

**In-Network** – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the In-Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator’s affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator’s ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be an In-Network provider for only some products. In this case, the provider will be an In-Network provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** – description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to *Plan Highlights* for details about how Network Benefits apply.

**Out-of-Network Benefits** – description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to *Plan Highlights* for details about how Out-of-Network Benefits apply.

**Open Enrollment** – the period of time, determined by the University, during which eligible Employees may enroll themselves and their Dependents under the Plan. The University determines the period of time that is the Open Enrollment period.

**Out-of-Pocket Maximum** – the maximum amount you pay every calendar year. Refer to *Plan Highlights* for the Out-of-Pocket Maximum amount. See *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

**Partial Hospitalization/Day Treatment** – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Personal Health Support** – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

**Personal Health Support Nurse** – the primary nurse that UHC may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

**Physician** – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.
Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.


Plan Administrator – Columbia University in the City of New York or its designee.

Plan Sponsor – Columbia University in the City of New York.

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

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

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:

  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.
**Semi-private Room** – a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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

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

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

**Skilled Care** – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

**Skilled Nursing Facility** – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

**Spouse** – an individual to whom you are legally married or a Domestic Partner as defined in this section.

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

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

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn’t offer the intensity and structure needed to assist the Covered Person with recovery; or
supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

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

**Unproven Services** – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UHC has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UHC issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com](http://www.myuhc.com).

**Please note:**

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UHC may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UHC must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

- UHC may, in its discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that UHC does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow UHC to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UHC’s discretion. Other apparently similar promising but unproven services may not qualify.
**Urgent Care** – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

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

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