Summary Plan Description

Columbia University
Officer Pre-65 Retiree Choice Plus 100, 90 and 80 Plans

Effective: January 1, 2026
Group Number: 712790

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Delegate: 1-888-265-9945.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374.
- Online assistance: **www.myuhc.com**.

Columbia University is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Columbia University Retiree Medical Life Insurance Benefits Plan. It includes summaries of:

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

This SPD 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 SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, Substance Use, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Columbia University intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Columbia University is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Columbia University Plan works. If you have questions contact the Columbia University Benefit Service Center (BSC) at 212-851-7000or call the number on your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at **www.hr.columbia.edu** or request printed copies by contacting the number on your ID card.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Columbia University is also referred to as University.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.
- Eligibility

Eligibility

Contact the Columbia Benefits Service Center at 212-851-7000 if you think you have attained the age and service requirements for Officer 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. Before you can begin participating in the Columbia University Retiree Medical Plan, you must make your coverage selection under that Plan on the Health Plan Election Form for Retired Officers and agree to make the required contributions to obtain the elected coverage.

You are eligible to enroll in the Plan if you separate from service and have attained age 55 years of age with 10 or more years of benefits eligible service after the age of 45. You must choose to participate in the Plan and must be enrolled in an active Columbia medical plan at retirement. If you elect not to participate, you will forfeit future enrollment.

If you and your dependents are under age 65 and separate from service as an Officer with the required 10 or more years of benefits eligible service, you and any eligible dependents are eligible for the pre-65 Choice Plus 80, 90 or 100 coverages under, and subject to the terms of, the Columbia University Retiree Medical and Life Insurance Benefits Plan. In addition, if you become disabled and begin receiving benefits under the Columbia University Long Term Disability (LTD) program will be eligible to participate in this Plan when the LTD benefit terminates, provided that you had 10 years of service when you first began to receive LTD benefits. However, you must be under age 65 when your Long Term Disability Benefits terminate to be eligible for the pre-65 Choice Plus 80, 90 or 100 coverages under the Columbia University Retiree Medical Plan.

If you qualify for and elect to participate in the Columbia University Retiree Medical and Life Insurance Benefits Plan, you and your covered dependents will remain covered by your selected active medical plan until the end of the month in which you retired. Please note that if you retire on the last day of the month your active medical plan will end on the same day. At that point, if you are under age 65, you will be eligible to elect a Columbia University pre-65 Choice Plus 80, 90 or 100 coverage provided through, and subject to the terms of, the Columbia University Retiree Medical Plan.

Effective January 1, 2023, retirees who reach age 65 and over, may be offered supplemental medical coverage through VIA Benefits. Please contact VIA Benefits 3 months prior to age 65, at 833-945-1109 to inquire about the retirement benefits options. For more information about VIA Benefits, please visit https://humanresources.columbia.edu/content/via-benefits for information about VIA Benefits for information.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse as of the date your retiree medical benefits commence, as defined in Section 14, *Glossary*.
- Your or your Spouse's child who is under age 19 and/or a Full-Time student under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Columbia University, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Columbia University, only one parent may enroll your child as a Dependent.

Note: The only qualifying Domestic Partnerships will include those whose coverage was effective on or before January 1, 2023 or, in limited circumstances, in instances where an employee can demonstrate that the employee or their domestic partner reside in a country or jurisdiction where their marriage is prohibited and/or persecuted, or can demonstrate an equally compelling reason for an exception to the policy, as determined at the sole discretion of the plan administrator.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Who is Not Eligible for the Plan

You are not eligible to participate in the Plan if you retire from any of the following positions:

- Officers whose appointments are incidental to their educational program at the University.
- Officers who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures.
- Officers whose terms of employment are subject to a collective bargaining agreement unless the agreement specifically provides for their participation in the medical plan.
- 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 for Covering Only Eligible Dependents

- You are responsible for ensuring that only your eligible Dependents are enrolled in the medical plan. A Retiree 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 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 or a child reaching the limiting age under the Plan, etc. Contact the Columbia Benefits Service Center at 212-851-7000 or hrbenefits@columbia.edu to begin the status change process.

Proof of Eligibility

The University 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.***

Cost of Coverage

Your Cost for Benefit Coverage

The University provides a fixed-dollar contribution (subsidy) for a retiree of any age and for a spouse and or eligible dependent of any age to support the cost of Columbia University's Retiree Medical Plan health coverage. The costs vary depending if you are also covering your spouse or if you are covering your children. The cost for your children is the same regardless of how many eligible children are covered. Information about your cost is provided with your enrollment materials when you are newly retired 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 savings or checking account on record with the Direct Billing Plan Administrator or paid directly by you, whichever the case may be based on your election at enrollment. Your "premium" for healthcare coverage is based on the Plan coverage you select.

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 for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Note: **For Employees with Domestic Partner relationships enrolled in the Plan on or before January, 1, 2023:** The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Columbia University's cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Columbia University reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Columbia Benefit Service Center (CUBSC) at 212-851-7000 or logging onto **www.hr.columbia.edu/find-out-about/benefits/officers-health-welfare/officers-health-welfare-medical-benefits.**

How to Enroll

If you separate from your position as an Officer and are eligible to participate in the Plan, the Benefits Service Center will enroll you according to the Plan selected on the election form. Coverage will be effective as of the first day of the month following your retirement date.

After your initial enrollment, you have the opportunity to make changes each fall during the Benefits Open Enrollment period. If you are enrolled in retiree medical benefits, 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.

Please contact the Columbia Benefits Service Center at 212-851-7000 or hrbenefits@columbia.edu with any questions you have regarding enrollment under the Plan.

Important
If you wish to change your benefit elections following your birth, adoption of a child, placement for adoption of a child or other Qualified Life Status Change, you must log into CUBES with your UNI and password at www.hr.columbia.edu within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once the Benefits Department receives your properly completed Health Plan Election Form for Retired Officers coverage will begin on the first day of the month following your retirement date. Coverage for your Dependents will start on the date your coverage begins, provided they were eligible prior to your retirement. Coverage for eligible children are available if they are under age 26 and only if a Full-Time student.

Coverage for a Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify the Benefits Department within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the Qualified Life Status Change, provided you notify the Columbia Benefit Service Center (CUBSC) at 212-851-7000 within 31 days of the birth, adoption, or placement.

If you do not wish to change your benefit election due to the birth of a newborn, the automatic coverage for the newborn will terminate immediately following day 31 after birth. You will need to wait until the next annual Open Enrollment to change your election if coverage has not been selected within 31 days.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. In-Network Benefits are available only if you receive Covered Health Services from In-Network providers.

Use Your Prior Health Care Coverage

If you have prior coverage that extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. Benefits for that particular condition or disability are subject to your prior coverage.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered qualified life status changes for purposes of the Plan:

- Your divorce, legal separation or annulment.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact United Healthcare at the number on your ID card within 60 days of the date of termination of subsidy eligibility).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact the Columbia Benefit Service Center (CUBSC) at 212-851-7000 within 60 days of the date of determination of subsidy eligibility).
- A strike or lockout involving you or your Spouse.
- A court or administrative order.
- Unless otherwise noted above, if you wish to change your elections, you must complete a Health Plan Election Form for Retired Officers and submit it to the Benefits Service Center for review and processing within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take

advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 and only if a Full-Time student who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Qualified Life Status Change- Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Columbia University's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this Qualified Life Status Change, Jane can elect family medical coverage under Columbia University's medical plan outside of annual Open Enrollment.

Participation beyond Normal Retirement Age

If you work beyond the Plan's normal retirement age of 65, you may continue to participate in the Plan in the same manner as any other active Participant. The Plan's normal retirement age of 65 does not affect "Retiree" status under other Retiree programs.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

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

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

You can choose to receive In-Network Benefits or Out-of-Network Benefits.

In-Network Benefits apply to Covered Health Services that are provided by an In-Network Physician or other In-Network provider.

Out-of-Network Benefits apply to Covered Health Services that are provided by an Out-of-Network Physician or other Out-of-Network provider, or Covered Health Services that are provided at an Out-of-Network facility.

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

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

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

Ground Ambulance transport provided by an Out-of-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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

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

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

Health Services from Out-of-Network Providers Paid as In-Network Benefits

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

Looking for an In-Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's In-Network. While In-Network status may change from time to time, **www.myuhc.com** has the most current source of In-Network information. Use **www.myuhc.com** to search for Physicians available in your Plan. You can also go to http://columbia.welcometouhc.com/home to search for In-Network providers.

In-Network Providers

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

In-Network providers are independent practitioners and are not employees of UnitedHealthcare.

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

Before obtaining services you should always verify the In-Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy. If you receive a Covered Health

Service from an Out-of-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was an In-Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for In-Network Benefits.

It is possible that you might not be able to obtain services from a particular In-Network provider. The In-Network of providers is subject to change. Or you might find that a particular In-Network provider may not be accepting new patients. If a provider is no longer In-Network or is otherwise not available to you, you must choose another In-Network provider to get In-Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to out-of-network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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

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

Designated Providers

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

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

You or your In-Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from an Out-of-Network provider (regardless of whether it is a Designated Provider) or other

Out-of-Network provider, In-Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

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

Eligible Expenses

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

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For In-Network Benefits for Covered Health Services provided by an In-Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain In-Network facilities on a non-Emergency basis from out-of-network Physicians**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain In-Network facilities on a non-Emergency basis from out-of-network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below,** you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by an Out-of-Network provider,** you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by an Out-of-Network provider**, you are not responsible, and the out-of-network

provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

In-Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from an In-Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from an out-of-network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

When Covered Health Services are received from an Out-of-Network provider as described below, Eligible Expenses are determined as follows:

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

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

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that

arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an Out-of-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

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

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

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

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

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

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

When Covered Health Services are received from an Out-of-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan. The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of

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

Advocacy Services Through Naviguard

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

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

Annual Deductible

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

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

Eligible Expenses charged by Out-of-Network providers apply toward the In-Network individual and family Deductibles.

Copayment

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

Coinsurance

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

Out-of-Pocket Maximum

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

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

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

Plan Features	Applies to the In-Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services 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.

UnitedHealthcare 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.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare 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. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support 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. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Personal Health Support 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

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

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In-Network Primary Physician and other In-Network providers are responsible for obtaining prior authorization before they provide these services to you.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed in Section 6, *Additional Coverage Details* have been prior authorized as required. Before receiving these services from an In-Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are In-Network providers and that they have obtained the required prior authorization. In-Network facilities and In-Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on 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 an In-Network facility or refers you to other In-Network providers.

To obtain prior authorization, call the number on 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.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

In-Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

When you choose to receive certain Covered Health Services from Out-of-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Out-of-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

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.

Plan Features	In-Network			Out-of-Network
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Copays In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.				
■ Dental Services-Accident Only.	$30	$30	$30	Not Applicable
■ Emergency Health Services.	$150	$150	$150	$150
■ Hospital - Inpatient Stay.	$500	Not Applicable	Not Applicable	Not Applicable
■ Physician's Office Services.	$30	$30	$30	Not Applicable
■ Physician's Office Services - Specialist.	$30	$30	$30	Not Applicable
■ Rehabilitation Services.	$30	$30	$30	Not Applicable
■ Urgent Care Center Services.	$30	$30	$30	Not Applicable
■ Virtual Care Services.	$30	$30	$30	Not Applicable
Copays do not apply toward the Annual Deductible. Copays apply toward the Out-of-Pocket Maximum.				
Annual Deductible **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$200 per Individual.	$400 per Individual.	$600 per Individual.	$850 per Individual.

Plan Features	In-Network			Out-of-Network
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Annual Out-of-Pocket Maximum ■ Individual (single coverage). ■ Family (not to exceed the applicable Individual amount for all Covered Persons in a family). The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.	$4,750 $9,500	$3,250 $6,500	$3,750 $7,500	$5,250 $10,500
Lifetime Maximum Benefit 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. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and Substance Use services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).	Unlimited			

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary*.

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Acupuncture Services	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible
Ambulance Services - Emergency Only Eligible Expenses for ground and Air Ambulance transport provided by an Out-of-Network provider will be determined as described in Section 3, *How the Plan Works*.	*Air Ambulance* 100% *Ground Ambulance* 100%	*Air Ambulance* 100% *Ground Ambulance* 100%	*Air Ambulance* 100% *Ground Ambulance* 100%	*Air Ambulance* Same as In-Network *Ground Ambulance* Same as In-Network
Ambulance Services - Non-Emergency Ground or **Air Ambulance**, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance transport provided by an Out-of-Network provider will be determined as described in Section 3, *How the Plan Works*.	*Air Ambulance* 100% after you meet the Annual Deductible *Ground Ambulance* 100% after you meet the Annual Deductible	*Air Ambulance* 90% after you meet the Annual Deductible *Ground Ambulance* 90% after you meet the Annual Deductible	*Air Ambulance* 80%after you meet the Annual Deductible *Ground Ambulance* 80% after you meet the Annual Deductible	*Air Ambulance* Same as In-Network *Ground Ambulance* 60% after you meet the Annual Deductible
Cellular and Gene Therapy	Depending upon where the Covered Health Service is provided, Benefits will be the same			Out-of-Network Benefits are not available.

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Services must be received at a Designated Provider.	as those stated under each Covered Health Service category in this section.			
Clinical Trials Depending upon the Covered Health service, Benefit limits are the same as those stated under the specific Benefit category in this section. Benefits are available when the Covered Health Services are provided by either In-Network or Out-of-Network providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.			
Congenital Heart Disease (CHD) Surgeries Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.				
■ Inpatient Facility.	100% after you pay a Copayment of $500 per Inpatient Stay	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Inpatient Professional Services.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Dental Services – Wisdom teeth	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	Out-of-Network Benefits are not available
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	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.			
Diabetes Self-Management Items ■ Diabetic Supplies - Office	100% after you pay a Copayment of $30 per item	100% after you pay a Copayment of $30 per item	100% after you pay a Copayment of $30 per item	60% after you meet the Annual Deductible
- All Other Facilities	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetic Durable Medical Equipment (DME)	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.			
Durable Medical Equipment (DME) ■ Office	100%	100%	100%	60% after you meet the Annual Deductible
■ All Other Facilities. See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Emergency Health Services – Outpatient (Emergency and non-emergency services) If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency and non-emergency Health Services provided by an Out-of-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	100% after you pay a Copayment of $150 per visit	100% after you pay a Copayment of $150 per visit	100% after you pay a Copayment of $150 per visit	Same as In-Network
Enteral Nutrition	100%			60% after you meet the Annual Deductible
Fertility Preservation for Iatrogenic Infertility See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Fertility Services For Benefits, services must be received by an In-Network Provider and performed by an In-Network Provider. See Section 6, *Additional Coverage Details*, for limits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.			Out-of-Network Benefits are not available

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Gender Affirmation Surgery For Benefits, services must be received by an In-Network Provider and performed by an In-Network Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.			Out-of-Network Benefits are not available
Hearing Aid	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hearing Aid Exam	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible
Home Health Care See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	100% after you pay a Copayment of $500 per Inpatient Stay	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Injections in a Physician's Office				
■ Allergy Injections – Office[2]	100%	100%	100%	60% after you meet the Annual Deductible
■ Allergy Injections – All Other Facilities	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
■ Injections Other Than Allergy	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray, Minor and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine and Other Diagnostics Testing - Outpatient				
■ Office	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient Hospital[3]	100% after you pay a $150 Copay	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ All Other Outpatient Facilities	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
	The first diagnostic mammogram or breast ultrasound of the year is covered at 100%. Subsequent diagnostic mammograms and/or breast ultrasounds are reimbursed at 100% after you	The first diagnostic mammogram or breast ultrasound of the year is covered at 100%. Subsequent diagnostic mammograms and/or breast ultrasounds are reimbursed at 90% after you	The first diagnostic mammogram or breast ultrasound of the year is covered at 100%. Subsequent diagnostic mammograms and/or breast ultrasounds are reimbursed at 80% after you	

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
	meet the Annual Deductible and/or any required Copay depending on where care is received.	meet the Annual Deductible.	meet the Annual Deductible.	
	The first diagnostic breast MRI of the year is covered at 100%. Subsequent diagnostic breast MRIs are reimbursed at 100% after you meet the Annual Deductible and/or any required Copay depending on where care is received.	The first diagnostic breast MRI of the year is covered at 100%. Subsequent diagnostic breast MRIs are reimbursed at 90% after you meet the Annual Deductible.	The first diagnostic breast MRI of the year is covered at 100%. Subsequent diagnostic breast MRIs are reimbursed at 80% after you meet the Annual Deductible.	
	The first diagnostic colonoscopy of the year is covered at 100%. Subsequent diagnostic colonoscopies are reimbursed	The first diagnostic colonoscopy of the year is covered at 100%. Subsequent diagnostic colonoscopies are reimbursed	The first diagnostic colonoscopy of the year is covered at 100%. Subsequent diagnostic colonoscopies are reimbursed	

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
	at 100% after you meet the Annual Deductible and/or any required Copay depending on where care is received.	at 90% after you meet the Annual Deductible.	at 80% after you meet the Annual Deductible.	
Mental Health Services				
■ Inpatient Facility.	100% after you pay a Copayment of $500 per Inpatient Stay	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Inpatient Professional Services.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Office Visit.	100% after you pay a $30 Copayment per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	70% after you meet the Annual Deductible
■ All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs	100%	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services				
■ Inpatient Facility.	100% after you pay a Copayment of	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
	$500 per Inpatient Stay			
■ Inpatient Professional Services	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Office Visit	100% after you pay a $30 Copayment per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	70% after you meet the Annual Deductible
■ All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs	100%	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Intensive Behavioral Therapy	100%	90%	80%	70% after you meet the Annual Deductible
Non-Preventive Nutritional Counseling See Section 6, *Additional Coverage Details*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Obesity Surgery Obesity surgery must be received by a Designated Provider and performed by a Designated Provider. See Section 6, *Additional Coverage Details* for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.			Out-of-Network Benefits are not available.
Orthognathic Surgery	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	Out-of-Network Benefits are not available
Ostomy Supplies ■ Office Setting.	100%	100%	100%	60% after you meet the Annual Deductible
■ Outpatient Setting. See Section 6, *Additional Coverage Details* for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by an Out-of-Network Physician in certain In-Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by an In-Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*. ■ Primary Physician	100% after you meet the	90% after you meet the	80% after you meet the	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
	Annual Deductible	Annual Deductible	Annual Deductible	
■ Specialist Physician.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury ■ Home Visits	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ All Other Services	100% after you pay a Copayment $30 per visit	100% after you pay a Copayment $30 per visit	100% after you pay a Copayment $30 per visit	60% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. No Copayment applies for prenatal visits after the first visit.	Benefits will be the same as those stated under each Covered Health Service category in this section.			
Preimplantation Genetic Testing (PGT) and Related Services See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Preventive Care Services ■ Physician Office Services.	100%	100%	100%	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
■ Lab, X-ray or Other Preventive Tests.	100%	100%	100%	60% after you meet the Annual Deductible
■ Breast Pumps)	100%	100%	100%	60% after you meet the Annual Deductible
■ Breast Ultrasound – Preventive.	100%	100%	100%	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.			
Rehabilitation Services - Outpatient Therapy See Section 6, *Additional Coverage Details*, for visit limits.	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic ■ Office	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
■ Outpatient Hospital[3]	100% after you pay a $150 Copay	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ All Other Outpatient Facilities	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance Use Services ■ Inpatient Facility.	100% after you pay a Copayment of $500 per Inpatient Stay	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Inpatient Professional Services.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Office Visit	100% after you pay a $30 Copayment per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	70% after you meet the Annual Deductible
■ All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs	100%	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Surgery - Outpatient				
■ Surgery – Outpatient Facility.	100% after you pay a Copayment of $150	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Surgery – Outpatient Professional Services.	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Physician's Office Visit	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.			
Therapeutic Treatments - Outpatient	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible For dialysis services, Out-of-Network Benefits are not available.
Transplantation Services For Network Benefits, transplantation services must be received by a Designated Provider or an In-Network Provider. The Claims Administrator does not require that cornea transplants be performed by a Designated Provider in order for you to receive Network Benefits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.			

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Urgent Care Center Services				
■ Outpatient Facility/Office Visit.	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	100% of eligible expenses after you pay a Copayment of $30 per visit
■ Lab, Radiology, and All Other Services	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urinary Catheters				
■ Office Visit	100%			60% after you meet the Annual Deductible
■ All Other Services	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Virtual Care Services In-Network Benefits are available only when services are delivered through a Designated Virtual In-Network Provider. You can find a Designated Virtual In-Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	100% after you pay a Copayment of $30 per visit	Out-of-Network Benefits are not available
Vision Examinations See Section 6, *Additional Coverage Details*, for limits.	100% after you pay a Copayment of $10 per visit	100% after you pay a Copayment of $10 per visit	100% after you pay a Copayment of $10 per visit	60% after you meet the Annual Deductible

Covered Health Services[1] **Please Note: Be sure to check Prior Authorization for Covered Health Services listed in Section 6, *Additional Coverage Details.***	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***			
	In-Network			**Out-of-Network**
	Choice Plus 100 Plan	**Choice Plus 90 Plan**	**Choice Plus 80 Plan**	**All Plans**
Wigs				
■ Office Visit	100%	100%	100%	60% after you meet the Annual Deductible
■ All Other Services	100% after you meet the Annual Deductible	90% after you meet the Annual Deductible	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 6, Additional Coverage Details.

[2]If your provider bills for an Office visit in addition to the Covered Health Service provided, then an Office visit copay of $30 will apply.

[3]For the Choice Plus 100 Plan only: Hospital-based outpatient radiology and laboratory services performed at certain New York-Presbyterian (NYP) locations are exempt from the $150 Copay. Call the number on your ID card for locations where the $0 (Zero) Copay applies.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 5, *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 obtain prior authorization from the Claims Administrator as required. 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 Section 8, *Exclusions and Limitations*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Acupuncture Services

The Plan pays for acupuncture services for all diagnoses and in lieu of anesthesia, provided that the service is performed by a provider who is one of the following, practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body.

Any combination of Network and Out-of-Network Benefits are limited to 20 treatments per calendar year.

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

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 Section 14, *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, UnitedHealthcare 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 non-Emergency transportation provided by a licensed professional ambulance (either ground or Air Ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From an Out-of-Network Hospital to an In-Network Hospital.

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

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), please remember that you must obtain prior authorization as soon as possible prior to transport.

If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

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

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare'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.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*

- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

    - ♦ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- 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.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of Fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

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

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

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).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a provider that is not a Designated Provider, 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.
- Surgery - Outpatient.

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

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.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. For Out-of-Network Benefits, if you do not obtain prior authorization as required, Benefits will be subject to a $500 reduction.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Dental Services - Accident Only

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

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

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

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

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.
- Functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Please Note: Dental-Related General Anesthesia and Facility Charges: 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 UnitedHealthcare specific medical criteria for dental-related general anesthesia in an inpatient or outpatient hospital. Note: there is no coverage for anesthesia in conjunction with any type of cosmetic surgery.

Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps is are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
- Blood glucose meters, including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

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.
- 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 unless the pump that is prescribed by the prescribing physician determines to be the most clinically appropriate insulin pump for the patient. Benefits are provided for a single unit of DME (example: one insulin pump)

and for repairs of that unit. Replacement of a Continuous Positive airway Pressure device (CPAP) and/or Bi-level Positive Airway Pressure device (BiPAP) can be a purchase or rental based on the member's choice and is not limited by the most cost effective method.

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).
- Cranial Orthotics (Helmets) custom molded, when prescribed by a Physician.
- 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.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

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

Please Note: The use of a cranial orthotic device is covered 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, as determined by the Claim Administrator. The use of a cranial orthotic device is covered as consolidation treatment following craniofacial surgery when prescribed by the treating neurosurgeon.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase these devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for dedicated speech generating 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 for repair/replacement are limited to once every two years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every two calendar years. Replacement of a Continuous Positive airway Pressure device (CPAP) and/or Bi-level Positive Airway Pressure device (BiPAP) can be a purchase or rental based on the member's choice and is not limited by the most cost effective method.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the 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. Replacement of a Continuous Positive airway Pressure device (CPAP) and/or Bi-level Positive Airway Pressure device (BiPAP) can be a purchase or rental based on the member's choice and is not limited by the most cost effective method. Requests for repairs may be made at any time and are not subject to the two year timeline for replacement.

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.

In-Network Benefits will be paid for an Emergency admission to an Out-of-Network Hospital as long as the Claims Administrator 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. The Claims Administrator may elect to transfer you to an In-Network Hospital as soon as it is medically appropriate to do so. 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 an In-Network Hospital, In-Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in an Out-of-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 48 hours or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be

provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Benefits are also available when a planned medical treatment due to a diagnosis of Gender Dysphoria is likely to produce Infertility/sterility. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Injections in a Physician's Office* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. This Benefit limit also includes services as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services*.

Fertility Services

Covered Health Services **must** be received by an **In-Network Provider** in order for you to receive Benefits.

Services for the treatment of Fertility/infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- ICSI - (intracytoplasmic sperm injection).

- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Cryopreservation and storage of embryos for 12 months. Long-term storage costs (anything longer than 12 months) are not covered.
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the SPD. Benefits for diagnostic tests are described under, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits*.

Additional Benefits

Donor Coverage: The plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. Administrative service fees that a donor bank may charge are also reimbursable under the plan. The Plan will not pay for charges associated with compensation to the donor.

Criteria to be eligible for Benefits

To be eligible for the Infertility/Fertility Services Benefit:

- You must use an In-Network Provider in order for you to receive Benefits.
- You have Infertility that is not related to voluntary sterilization or failed reversal of a voluntary sterilization.
- Dependent children are eligible for Infertility/Fertility benefit if above eligibility criteria are met. Dependent children are eligible for fertility preservation when planned cancer or other medical treatment is likely to produce infertility/sterility.

Any combination of Network Benefits and Out-of-Network Benefits are limited to $30,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. Treatment for the diagnosis and treatment of the underlying cause of Infertility does not apply to the lifetime maximum.

There are separate limits under the Plan for medical services and for *Outpatient Prescription Drugs*. The *Outpatient Prescription Drugs* infertility lifetime limit is $30,000 and is noted in the separate *Prescription Drugs Summary Plan Description*.

Only charges for the following apply toward the Infertility/Fertility Services lifetime maximum as described above:

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

Fertility and Maternal Support Services.

Fertility and Maternal Support Services are provided by Maven. Maven provides free virtual support for preconception and fertility, pregnancy, postpartum, adoption, surrogacy, and returning to work after parental leave. Maven is available to all Columbia University medical plan participants and their covered dependents.

Use Maven for:

On-demand video appointments with top-rated practitioners: Unlimited coaching and education appointments and messaging with Maven OB-GYNs, mental health specialists, prenatal nutritionists, lactation consultants, career coaches, and many others.

Your own Care Advocate: Personalized, one-on-one support to help answer questions about your benefits, get connected to the right Maven practitioners for your needs, and for referrals to in-person support when you need it.

Holistic fertility support: Expert navigation, referrals to best-in-class practitioners, and preferred pricing at select clinics to support fertility treatments.

Easy Reimbursement: Through Maven Wallet, an easy-to-use digital tool that helps manage your out-of-pocket costs related to adoption and surrogacy.

A library of expert content, tailored to your experience: Trustworthy content tailored to you on topics like prenatal health, postpartum depression, and returning to work with confidence, and empowering virtual classes led by Maven practitioners.

Maven Milk: Maven Milk helps moms and new parents transition back to work and get breast milk home to baby - easily, reliably, and safely. Maven Milk offers simple breast milk shipping and convenient domestic and international travel kits for Columbia employees on University travel. Learn more about Maven Milk offering at: https://humanresources.columbia.edu/content/maven-milk.

Visit mavenclinic.com/join/columbia for more information and to register for this program.

Family Building Benefit (FBB)

Columbia University offers employees a Family Building Benefit (FBB). Information on available resources are available through the FBB that are not Covered Health Services under the benefit plan. Please visit Columbia University Benefits Web site at https://humanresources.columbia.edu/womens-health / for more information about the FBB program.

Gender Affirmation Surgery

Gender affirmation surgery benefits for Covered Persons 19 years or older with a diagnosis of Gender Dysphoria limited to the following services performed by an In-Network provider:

- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation of vagina)
  - Voice modification surgery
  - Vulvectomy (removal of vulva)

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

The Covered Person must provide documentation of the following for breast surgeries listed above:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 19 years or older.
    If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for **genital surgeries** listed above:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 19 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

In addition, the following services are covered for transmasculine, transfeminine or gender diverse members 19 years or older with a diagnosis of Gender Dysphoria:

- Breast enlargement, including augmentation mammoplasty and breast implants.
- Chest binders for chest masculinization.
- Facial feminization or masculinization procedures limited to:
  - Forehead contouring
  - Rhinoplasty
  - Mandible reconstruction
  - Trachea shave
  - Blepharoplasty
  - Brow lift
  - Cheek augmentation
  - Face lift or liposuction (only as needed in conjunction with facial feminization or masculinization procedures).
- Mastopexy.
- Pectoral implants for chest masculinization.
- Voice therapy - Feminizing or masculinizing speech therapy or voice therapy provided by a licensed therapy provider, under the direction of a Physician (when required by state law).

Fertility Preservation - when planned medical treatment due to a diagnosis of Gender Dysphoria is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, and embryo cryopreservation. Benefits are not available for embryo transfer. Long-term storage costs (anything longer than 12 months) are not covered.

Gender Transformation services are available to Covered Persons 19 years or older. Services must be received by an In-Network Provider in order for you to receive benefits.

Note: Puberty suppression hormone therapy and associated lab services for the purposes of monitoring hormone therapy are not covered.

Hearing Aids and Hearing Aid Exam

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of In-Network and Out-of-Network Benefits for hearing aids are limited to a single purchase (including repair/replacement) per hearing impaired ear every 2 calendar years.

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 Section 14, *Glossary*.

- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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

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

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization for nutritional foods, Private Duty Nursing and skilled nursing, from the Claims Administrator five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, 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 Benefits and Out-of-Network Benefits is limited to 6 months per lifetime per Covered Person during the entire period you are covered under the Plan.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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).
- 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 - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Out-of-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $500 reduction.

In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.

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

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

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

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

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.
- Mammography.

Benefits under this section include:

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

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.

Prior Authorization Requirement
For Out-of-Network Benefits for Genetic Testing and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

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.
- 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

The Mental Health Services Delegate (the Delegate) administers Benefits for Mental Health services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Services, you can contact the Delegate at the telephone number on your ID card.

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Benefits for Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents are covered medical and behavioral treatments.

Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Mental Health Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing and transcranial magnetic stimulation.

If you do not obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Neurobiological Disorders - Autism Spectrum Disorder Services

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

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

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the *Enhanced Autism Spectrum Disorders* benefit below.

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing and Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

If you do not obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Non-Preventive Nutritional Counseling

The Plan covers non-preventive nutritional counseling services for mental health and Substance Use and medical diagnosis that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

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

For adults:

- You have a minimum Body Mass Index (BMI) of 40; or
- You have a minimum BMI of 35-39.9 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

For adolescents:

- You must have a BMI over 35 or 120% of the 95th percentile and a co-morbidity; or
- You must have a BMI over 40 or 140% of the 95th percentile.
- You have documentation from a Physician of a diagnosis of morbid obesity within the last 2 years.
- Completion of a preoperative evaluation that includes a detailed weight history along with dietary and physical activity patterns.

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

- You have enrolled in the Bariatric Resource Services (BRS) program.
- The surgery is performed at a Bariatric Resource Service (BRS) Designated Provider by an In-Network surgeon even if there are no BRS Designated Provider near you.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 14, *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 1-888-936-7246.

Note: The services described under *Complex Medical Conditions Travel and Lodging* are Covered Health Services only in connection with obesity-related services received by a Designated Provider.

See *Bariatric Resource Services (BRS)* in Section 7*, Clinical Programs and Resources* for more information on the BRS program.

Orthognathic Surgery

Orthognathic surgery is covered in the following situation:

- A jaw deformity resulting from facial trauma or cancer; or
- A skeletal anomaly of 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 impairment determined to be due to the jaw deformity.
  - Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Orthognathic surgery is not a Covered Health Service because it is considered unproven treatment due to a lack of evidence of improved functional clinical outcomes in peer reviewed, published medical literature, for the following symptoms:

- Myofascial, neck head and shoulder pain;
- Irritation of head/neck muscles;
- Popping/clicking of temporomandibular joint(s);
- Potential for development or exacerbation of temporomandibular joint dysfunction; and
- Teeth grinding.

Treatment of malocclusion is dental and therefore not a covered health service.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

- Urinary catheters.
- Sheaths for protection for when endoscopy is performed.

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

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals.

- Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury such as, but not limited to, pink eye, cataracts, macular degeneration.

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

Facility charges are not considered Covered Health Services for office based surgery.

Please note: Travel immunizations are a covered benefit.

Please Note
Your Physician does not have a copy of your SPD, 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.
- 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.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Preimplantation Genetic Testing (PGT-M, PGT-SR and PGT-A) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- **Embryo biopsy for Pre-implantation Genetic Testing for Aneuploidy (PGT-A)** used to select embryos for transfer in order to increase the chance for conception.
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This Benefit limit also includes services as described under *Fertility Preservation for Iatrogenic Infertility*.

Benefits for Assisted Reproductive Technology (ART) for related services as described under *Infertility Services* do not include the Preimplantation genetic testing for the specific genetic disorder.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services 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*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

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

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

Benefits are only available if breast pumps are obtained from an In-Network DME provider or an In-Network Physician.

For questions about your preventive care Benefits under this Plan call the number on 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 external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

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

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will 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 available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every two calendar years.

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

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceeds $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be subject to a $500 reduction.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic

function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

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

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *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.

Prior Authorization Requirement
For Out-of-Network Benefits for:

- A scheduled reconstructive procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled reconstructive procedure is performed.
- A non-scheduled reconstructive procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided, Benefits will be subject to a $500 reduction.

In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

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

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

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

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

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from developmental delays, Injury, stroke, Autism, cancer, Congenital Anomaly, treatment of swallowing dysfunction and/oral function for feeding, or is needed following the placement of a cochlear implant.

Please note: For occupational, physical and speech therapy, autism and developmental delays are covered diagnosis. Members will not be denied primary or secondary coverages for early intervention services if they are also eligible for state benefits.

Habilitative Services

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

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

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

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

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

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

The Plan may require the following be provided:

- medical records.
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

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*.

Benefits are limited to:

- 60 visits per calendar year for physical and occupational therapy combined. Visit limits do not apply to members with a behavioral diagnosis.
- 60 visits per calendar year for speech therapy. Visit limits do not apply to members with a behavioral diagnosis.
- 60 visits per calendar year for pulmonary rehabilitation therapy.

- 60 visits per calendar year for cardiac rehabilitation therapy.
- 60 visits per calendar year for cognitive rehabilitation therapy.
- 60 visits per calendar year for Manipulative Treatment.
- 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 diagnostic endoscopy.

Benefits under this section include:

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

Benefits for other Physician services are described 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.

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

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:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- 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*.

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

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

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

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

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

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

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

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

Prior Authorization Requirement
Please remember for Out-of-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $500 reduction.

In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Substance Use Services

The Substance Use Services Delegate (the Delegate) administers Benefits for Substance Use Services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Services, you can contact the Delegate at the telephone number on your ID card.

Substance Use Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Benefits for Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents are covered medical and behavioral treatments.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Substance-Related and Addictive Disorders Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing.

If you do not obtain prior authorization as required, 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 as defined under *Glossary* Section 14 or in a Physician's office (office based facility charges are not included).

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

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

Benefits under this section include:

- The facility charge except for office based surgery.
- The charge for supplies and equipment.
- 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*.

Facility charges are not considered Covered Health Services for office based surgery. This means that if you receive otherwise Covered Health Services for office-based surgery, any associated facility charges will not be payable by the Plan.

Prior Authorization Requirement
For Out-of-Network Benefits for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within 48 hours or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Temporomandibular Joint Dysfunction (TMJ)

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

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

Arthrocentesis for temporomandibular joint (TMJ) disorder 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 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 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 when 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

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

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Please note: Appliances and orthodontic treatment are excluded.

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.

Benefits under this section include:

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

Prior Authorization Requirement
For Out-of-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization from the Claims Administrator, as required, Benefits will be subject to a $500 reduction.

Transplantation Services

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

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

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

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received by a Designated Provider, In-Network provider that is not a Designated Provider or an Out-of-Network provider.

Benefits are also available for cornea transplants. The Claims Administrator does not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.

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

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). For Out-of-Network Benefits, if you do not obtain prior authorization as required, Benefits will be subject to a $500 reduction.

In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare 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 Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services*.

Urinary Catheters

Benefits are provided for external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Care Services

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility every 12 months.

The first pair of lenses post cataract surgery is covered.

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for temporary loss of hair resulting from chemotherapy, treatment of a malignancy or permanent loss of hair from an accidental injury.

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to one (1) wig every three calendar years.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

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

- Consumer Solutions and Self-Service Tools.
- Disease Management Services.
- Complex Medical Conditions Programs and Services.
- Women's Health/Reproductive

Columbia University believes in giving you tools to help you be an educated health care consumer. To that end, Columbia 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.
- 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 more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Columbia 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, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women between the ages of 40 and 68.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women between the ages of 20 and 64.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support

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

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

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

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

UnitedHealth Premium® Designation Program

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

For details on the UnitedHealth Premium® designation program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

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

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 In-Network providers available in your Plan through the online provider directory.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

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

Visit **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.
- 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 Management Services

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, 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 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.
- 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 In-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 your ID card.

Complex Medical Conditions Programs and Services

Bariatric Resource Services (BRS)

Your Plan offers Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Employees and Enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Obesity Surgery* in Section 6, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions* Travel and Lodging Assistance Program.

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program*.

Cancer Support Program

UnitedHealthcare provides a program that identifies and supports a Covered Person who has cancer. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies 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 your ID card or call the program directly at 1-866 936-6002.

Comprehensive Kidney Solution (CKS) program

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Kidney Resource Services (KRS) program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high

blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions* Travel and Lodging Assistance Program.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Complex Medical Conditions Travel and Lodging Assistance Program*, refer to the provision below.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below

Your Plan Sponsor may provide you with Travel and Lodging assistance for certain Covered Health Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the requisite distance from your home address to the facility is at least 50 miles. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the number on your ID card.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Covered Person and a travel companion, provided the Covered Person is not covered by Medicare, as follows:

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider. The 50 mile radius requirement does not apply to services related to Bariatric Resource Services.
- Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

Lodging

- A per diem rate, up to $50.00 per day, for the Covered Person or the caregiver if the Covered Person is in the Hospital.

- A per diem, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

  Examples of items that are not covered:

  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

Transportation

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

Women's Health/Reproductive

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

Plan Benefits for Covered Health Services are described in Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights*, under the *Schedule of Benefits*, unless the service is excluded in Section 8, *Exclusions and Limitations*.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit **www.myuhc.com** for additional information. Scan the QR code on www.myuhc.com to download the much app.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: 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 Section 6, *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.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits 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 SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

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 reimbursements.

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the *National Center for Complementary 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 Section 6, *Additional Coverage Details*.

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. Non-Hospital beds and comfort beds.
11. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
12. Home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services or dental anesthesia for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

   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 Section 6, *Additional Coverage Details*.

2. Preventive care, diagnosis, treatment of the teeth or gums. Examples include:

   - Extractions, restoration and replacement of teeth. This exclusion does not apply to removal of wisdom teeth.
   - Medical or surgical treatments of dental conditions.

- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. Dental implants and braces.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the separate *Prescription Drugs* SPD for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain specialty medications ordered by a Physician through OptumRx.

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

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

8. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

10. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

11. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

12. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another *Pharmaceutical Product*, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

13. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

   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*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.
   - Cutting or removal of corns and calluses;
   - Nail trimming or cutting; and
   - Debriding (removal of dead skin or underlying tissue).

   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.

2. Treatment of flat feet.

3. Shoe inserts.

4. Arch supports.

5. Shoes (standard or custom), lifts and wedges.

6. Shoe orthotics.

Gender Affirmation Surgery

1. The following Gender Affirmation Surgery-related services and Cosmetic Procedures:

   - Abdominoplasty.
   - Breast lift.
   - Body contouring, such as lipoplasty.
   - Calf implants.
   - Injection of fillers or neurotoxins.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction, except as described under Gender Affirmation Surgery in Section 6, *Additional Coverage Details*.
   - Skin resurfacing, chemical peel, dermabrasion.

2. Reconstructive surgery following gender affirmation surgery to reverse natural signs of aging.

3. Reconstructive surgery following gender affirmation surgery if the member is not satisfied with the surgical result but the member's physician does not opine that a subsequent surgery is mandated for the physical health of safety of the member.

4. Reversal of gender affirmation surgery.

5. Puberty suppression hormone therapy and associated lab services for the purposes of monitoring hormone therapy are not covered.

6. Services performed by an Out-of-Network Provider.

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 and syringes.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.
   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in *Additional Coverage Details*;
   - Urinary catheters for which Benefits are provided as described under *Urinary Catheters* in Section 6, *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. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

6. 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, as determined by the claim Administrator.

7. Powered and non-powered exoskeleton devices.

8. Over-the-counter continuous glucose monitors.

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. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
2. Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to Benefits provided under *Non-Preventive Nutritional Counseling* as described in Section 6, *Additional Coverage Details*.
3. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in Section 6, *Additional Coverage Details*. Infant formula available over the counter is always excluded.
4. Health club memberships and programs, and spa treatments.
5. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes
6. Nutritional procedures or treatments.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure.

   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prosthesis except for temporary loss of hair resulting from chemotherapy, treatment of a malignancy or permanent loss of hair from an accidental injury, in which case the Plan covers up to a maximum of one (1) wig every three calendar years.

6. Treatments for hair loss.

7. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.

8. Varicose vein treatment of the lower extremities, when it is considered cosmetic.

9. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition.

5. Speech therapy to treat stuttering, stammering, or other articulation disorders.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. The following treatments for obesity:

- Non-surgical treatment of obesity, even if for morbid obesity.
- Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*.

12. Obesity surgery that is not received by a Designated Provider.

13. Medical and surgical treatment of excessive sweating (hyperhidrosis).

14. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations except as described under *TMJ* in Section 6, *Additional Coverage Details*.

15. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*. This exclusion does not apply to breast reduction surgery for treatment of gender dysphoria.

16. Congenital Heart Disease surgery that is not received by a Designated Provider.

17. Intracellular micronutrient testing.

18. Cellular and Gene Therapy services not received from a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a freestanding or Hospital-based diagnostic facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

6. Facility charges for office based surgery.

Reproduction

Please note: Information on available resources are available through Columbia University's Family Building Benefit (FBB) that are not Covered Health Services under the benefit plan. Please visit Columbia University Benefits Web site at https://humanresources.columbia.edu/ for more information about the FBB program.

1. The following infertility treatment-related services:

   - Cryopreservation and other forms of preservation of reproductive materials except as described under Infertility Services. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described in Section 6, *Additional Coverage Details*.
   - Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
   - Donor services and Non-medical costs of oocyte or sperm donation (e.g., donor agency fees).This exclusion does not apply to covered services as described under *Fertility Services,* in section 6, *Additional Coverage Details*. The Plan will not pay for charges associated with compensation to the donor.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:

   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation. This exclusion does not apply to covered services as described under *Fertility Services,* in section 6, *Additional Coverage Details*.

4. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

5. The reversal of voluntary sterilization.

6. Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

7. Fertility treatment following unsuccessful reversal of voluntary sterilization.

8. Fertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

9. Fertility Services not received from an In-Network Provider.

10. Elective fertility preservation.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *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.
4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

5. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

Transplants

1. Health services for organ and tissue transplants,

    - except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details*.
    - determined by Personal Health Support not to be proven procedures for the involved diagnoses.
    - not consistent with the diagnosis of the condition.

2. Health services for transplants involving animal organs.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 7, *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services

received from a Designated Provider or other In-Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses, except for first pair of lenses post cataract surgery as described in Section 6, *Vision Care*.

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.

5. Over-the-counter hearing aids.

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
   - 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 Section 14, *Glossary*, or maintenance care.

7. Services of personal care aides.

8. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

9. Domiciliary Care, as defined in Section 14, *Glossary*.

10. Growth hormone therapy.

11. Expenses for health services and supplies:

    - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, 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 SPD.

12. Foreign language and sign language services.

13. Long term (more than 30 days) storage of blood, umbilical cord or other material.

14. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this SPD under Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights*.
    - Not otherwise excluded in this SPD under this Section 8, *Exclusions and Limitations*.

      This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.

15. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. 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.

16. 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.

17. Private Duty Nursing Inpatient.

18. Respite care. This exclusion does not apply to respite care for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*.

19. Rest cures.

20. Speech therapy to treat stuttering, stammering, or other articulation disorders.

21. Manipulative Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies.

22. Storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery.

23. The following treatments for obesity:

    - Non-surgical treatment, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*.

24. Treatment of hyperhidrosis (excessive sweating).

25. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

26. In the event an Out-of-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

27. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).

28. Independent living services.

29. Assisted living services.

30. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individual with Disabilities Education Act*.

31. Transitional Living services (including recovery residences).

32. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and 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 unless Medically Necessary.
- Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS 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.

In-Network Benefits

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

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to an In-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 UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting the Columbia Benefit Service Center (BSC) at (212) 851-7000 or going to the CU Benefits Enrollment System at 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.

- 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.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare 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.

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment

recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 10: Coordination of Benefits*.

Eligible Expenses due to an Out-of-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

Health Statements

Each month in which UnitedHealthcare 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 UnitedHealthcare 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 www.myuhc.com. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Out-of-Network Claims
All claim forms for Out-of-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare 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.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

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

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare 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. Please note that the Columbia Benefits Service Center (BSC) 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 request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim. Review of an Appeal

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.

- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare 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 the rules established by the *U.S. Department of Labor*.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare'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.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare 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.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.

- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the *IRO*'s request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for 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.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**30 days** after receiving the appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare must notify you of the appeal decision within:	**60 days** after receiving the appeal

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 request for Benefits 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. UnitedHealthcare 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 request for Benefits 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 request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Columbia 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 Columbia University or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Columbia University or the Claims Administrator.

You cannot bring any legal action against Columbia 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 Columbia University or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Columbia University or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.
- 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. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The Plan covering the Custodial Parent.
b) The Plan covering the Custodial Parent's spouse.
c) The Plan covering the non-Custodial Parent.
d) The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

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

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Service under this plan

When the provider is an In-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's in-network rate. When the provider is an in-network provider for the Primary Plan and an Out-of-Network provider for this Plan, the Allowable Expense is the Primary Plan's in-network rate. When the provider is an Out-of-Network provider for the Primary Plan and an In-Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is an Out-of-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As 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 (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, 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.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use Medicare's Allowable Expense or Medicare's limiting charge for covered services as the Allowable Expense for both the Plan and Medicare.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

Right to Receive and Release Needed Information?

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

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

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan 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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

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

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

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

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a

person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

- Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.
- If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:
- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

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

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

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.

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 coverage ends, Columbia 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:
- The end of the month if your retirement falls on any day of the month.
- The end of the month if your retirement date is on the end of the month.
- The date the Plan ends.
- The last day of the month you stop making the required "premium" contributions.
- The date you are no longer eligible.
- The date UnitedHealthcare receives written notice from Columbia University to end your coverage, or the date requested in the notice, if later.
- The date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:
- The date your coverage ends.
- The date you stop making the required contributions.
- The date UnitedHealthcare receives written notice from Columbia University to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependent child no longer qualifies as a Dependent under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and Columbia University find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Columbia University has the right to demand that you pay back all Benefits Columbia University paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

If You Die

If you die, your surviving Dependents who are covered under the Plan at the time of your death would have the option of maintaining coverage under the Columbia University Retiree Medical and Life Plan. However, your eligible Dependent may have additional rights to continuation coverage under COBRA in the event of your death (See "General Notice of COBRA Continuation Rights" below).

You and your spouse and Dependents must be enrolled in a Columbia medical plan at the time of your death to be eligible.

Please contact the Benefits Service Center additional eligibility details at 212 851-7000.

When Your Employment Ends: Are You Eligible for Retiree Medical Benefits?

If you qualify for and elect to participate in the Columbia University Retiree Medical and Life Insurance Benefits Plan, and your retirement date is in any day of the month, you and your covered dependents will remain covered by your selected active medical plan until the end of the month. If your retirement date falls on the last day of a month, coverage will end on that day. At that point, if you are under age 65, you may be eligible to elect a Columbia University pre-65 Choice Plus 80, 90 or 100 coverage provided through, and subject to the terms of, the Columbia University Retiree Medical Plan.

For more information on eligibility, please refer to Section 2, Eligibility, on page 4.

If you and or your eligible spouse are under age 65, you will be eligible for the Columbia University Pre-65 Retiree Medical Plans until the end of the month immediately before your or your spouse's 65th birthday. Then you may be eligible to enroll in a supplemental plan through Via Benefits effective the first of the month in which you turn 65.

Contact the Columbia Benefits Service Center (BSC) at 212-851-7000 if you think you have attained the age and service requirements for Officer Retiree Medical Benefits. The Columbia Benefits Service Center (BSC) will confirm your retirement eligibility. You then are responsible for communicating to your department administrator your effective date of retirement. Before you can begin participating in the Columbia University Retiree Medical and Life Insurance Benefits Plan, you must make your coverage selection under that Plan on the Health Election Form for Retired Officers and agree to make the required contributions to obtain the elected coverage.

The retiree medical benefits that may apply to you are discussed in further detail under the Columbia University Retiree Medical Plan Benefit Summary. If you are considering retirement, you may request a copy of the applicable Benefit Summary by contacting the Columbia Benefits Service Center (BSC) at 212-851-7000.

If You Become Disabled

If you become disabled, your medical coverage can continue based on the type of disability and the length of your disability.

- If you receive salary continuance: Any "premium" contributions you make for University benefits will continue on a before-tax basis. Your coverage continues without change under the medical plan in effect when your disability began.
- If you receive temporary disability benefits: Any contributions you make for University benefits will be on an after-tax basis. Coverage continues under the medical plan in effect when your disability began.
- If you receive Long Term Disability benefits: Any "premium" contributions you make for University benefits will be on an after-tax basis.

Coverage continues for the remainder of the calendar year under the medical plan in effect when your long term disability began. For the next two calendar years, coverage will continue under the University long term disability program. Medicare coverage generally becomes available if you have been entitled to Social Security benefits for two years. You must enroll for Medicare when available. For additional information about the need to apply for Medicare, please contact the Columbia Benefits Service Center (BSC) at 212-851-7000. For Medicare information, please contact 1-800-Medicare (1-800-633-4227).

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 (BSC) 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 (BSC) 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. After 6 months of leave, you will be charged the full premium rate, that is, your regular contribution plus the Columbia portion of the premium.

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.

Family and Medical Leave Act (FMLA) or Non-FMLA Leave of Absence

During FMLA (Family and Medical Leave Act of 1993) or other employer approved non-FMLA leave of absence, the Plan Sponsor will maintain the Employee's and his/her

Enrolled Dependents' coverage under the Plan under the same conditions as if the Employee had been continuously employed during the leave of absence period. To continue coverage during an unpaid leave of absence, the Employee remains responsible for his/her share of the contribution and for making such contributions on a timely basis. Coverage may terminate if the Employee fails to make such contributions. If the Employee fails to return from a leave of absence, the Employee and his/her Enrolled Dependents may be eligible for COBRA continuation coverage. Please contact the Plan Sponsor for more information.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to UnitedHealthcare proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon UnitedHealthcare's request, that the child continues to meet these conditions.

The proof might include medical examinations at Columbia University's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Columbia University is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- An Employee.

- An Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law.
- An Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Columbia University files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Benefits Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

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 payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (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.

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.
- 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.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and Columbia University.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Columbia University

In order to make choices about your health care coverage and treatment, Columbia University believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Columbia University and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Columbia University and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Columbia University and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Columbia University, UnitedHealthcare and In-Network providers are solely contractual relationships between independent contractors.

Although In-Network providers may be Columbia University's agents or employees that does not change the relationship for the purposes of the benefit plan.

In-Network Providers are not agents or employees of UnitedHealthcare.

Columbia University and any of its employees are not agents or employees of In-Network providers. Although they may be employees of Columbia University, that does not change the relationship for the purposes of the benefit plan.

UnitedHealthcare and any of its employees are not agents or employees of In-Network providers.

Although Columbia University does provide health care services or supplies and practice medicine through their onsite clinic, that does not change the relationship for purposes of the benefit plan.

UnitedHealthcare does not provide health care services or supplies, nor do they practice medicine.

Instead, Columbia University and UnitedHealthcare arrange for health care providers to participate in an In-Network and administer payment of Benefits. In-Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Although In-Network Providers may be Columbia University's employees, that does not change the relationship for the purposes of the benefit plan.

In-Network Providers are not employees of UnitedHealthcare.

Columbia University and UnitedHealthcare do not have any other relationship with In-Network providers such as principal-agent or joint venture. Columbia University and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Columbia University is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.

- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq*., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes In-Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Columbia University is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

Columbia University and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, Summary of Material Modifications (SMMs) and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Columbia University and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Columbia University may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Columbia University does so in any particular case shall not in any way be deemed to require Columbia University to do so in other similar cases.

Information and Records

Columbia University and UnitedHealthcare 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. Columbia University and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Columbia University and UnitedHealthcare will keep this information confidential. Columbia University and UnitedHealthcare 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 Columbia University and UnitedHealthcare with all information or copies of records relating to the services provided to you including provider billing and provider payment records. Columbia University and UnitedHealthcare 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. Columbia University and UnitedHealthcare agree that such information and records will be considered confidential.

Columbia University and UnitedHealthcare 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 Columbia University is required to do by law or regulation. During and after the term of the Plan, Columbia University and UnitedHealthcare 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 Columbia University 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 UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, Columbia University and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's 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 UnitedHealthcare 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.
- A practice called capitation which is when a group of In-Network providers receives a monthly payment from UnitedHealthcare 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.
- Bundled payments - certain In-Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The In-Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific In-Network providers. From time to time, the payment method may change. If you have questions about whether your In-Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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, surveys, discount programs, administrative programs, and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but Columbia 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 your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

Columbia University and UnitedHealthcare 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. Columbia University and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the University expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The University's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the University does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and University decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the University and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be

responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, Out-of-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your Out-of-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer

to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD 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 SPD, 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 SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility). Providers who are licensed to perform office based surgery do not meet the definition of Alternate Facility for the purposes of the plan.

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.

Ancillary Services – items and services provided by out-of-network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and

Provided by an Out-of-Network Physician when no other Network Physician is available.

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 Section 5, *Plan Highlights*.

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

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association.*

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Columbia University. The BRS program provides:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options.
- Access to specialized In-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.

BMI - see Body Mass Index (BMI).

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

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Columbia 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.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as UnitedHealthcare Service LLC.) 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 charge, stated as a percentage of Eligible Expenses, or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *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.
- 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 charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

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

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and 6, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions and Limitations*.

Covered Person - either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Dispensing Entity - a pharmacy, provider, or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual In-Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services through live audio with video technology or audio only.

DME - see Durable Medical Equipment (DME).

Domestic Partnerships: The only qualifying Domestic Partnerships will include those whose coverage was effective on or before January 1, 2023 or, in limited circumstances, in instances where an employee can demonstrate that the employee or their domestic partner reside in a country or jurisdiction where their marriage is prohibited and/or persecuted, or can demonstrate an equally compelling reason for an exception to the policy, as determined at the sole discretion of the plan administrator.

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:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare or as required by law as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. UnitedHealthcare develops the reimbursement policy guidelines, in its discretion, following evaluation and validation of all provider billings generally in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Services include items and services otherwise covered under the Plan when provided by an Out-of-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Emergency Health Services include Covered Health Services for medical, Mental Health and Substance Use conditions.

Employee - a full-time or part-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. 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 – The Trustees of Columbia University in the City of New York

EOB - see Explanation of Benefits (EOB).

ERISA - see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, Substance Use or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;

  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator 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, the Claims Administrator 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 UnitedHealthcare 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.
- The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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 and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, Substance Use, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

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

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. 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.

In-Network Benefits - for Benefit Plans that have an In-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by In-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers In-Network Benefits and Section 3, *How the Plan Works*, for details about how In-Network Benefits apply.

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

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

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Programs(s) - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance Use Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.

- Fewer than eight hours each day for periods of 21 days or less.

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

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

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

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

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

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

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

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

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Delegate - the organization or individual designated by Columbia University who provides or arranges Mental Health Services and Substance Use Services.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Columbia University. The NRS program provides guided access to an In-Network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

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

Out-of-Network Benefits - for Benefit Plans that have an Out-of-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Out-of-Network Benefits and Section 3, *How the Plan Works*, for details about how Out-of-Network Benefits apply.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment/High Intensity Outpatient - a structured ambulatory program that may be a freestanding 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 UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

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 - The Columbia University Pre-65 Retiree Choice Plus 100, 90 and 80 Medical Plans.

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

Plan Sponsor - Columbia University.

Pre-65 Retiree – an Employee who retires while covered under the Plan.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Preimplantation Genetic Testing (PGT) - A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-A – for aneuploidy (formerly PGS)

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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:

- Services exceed the scope of Intermittent Care in the home.
- 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.
- 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.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by out-of-network providers.

- Out-of-network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain In-Network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain In-Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an Out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment – A program of Mental Health Services or Substance Use Services that 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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

Residential Treatment Facility- a Hospital or facility, licensed and operated as required by law, that provides Residential Treatment.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private

Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or Substance Use Services.

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.
- They are not Custodial Care, as defined in this section.

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

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse - an individual to whom you are legally married as defined in this section.

Substance Use - services for the diagnosis and treatment of substance use that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance Use Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM) Criteria*, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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. Please note: these living arrangements are also known as supportive housing (including recovery residences).

Unproven Services – health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical or behavior health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-designed system reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case control studies cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com and liveandworkwell.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) the Claims Administrator 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, the Claims Administrator must first establish that

there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - an entity that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under *ERISA*.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by *ERISA* as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Columbia University is the Plan Sponsor and Plan Administrator of the Columbia University in the City of New York Group Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator - Medical Plan
Trustees of the Columbia University in the City of New York
615 West 131st Street
4th Floor
New York, NY 10027
(212) 851-7000

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the University. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

UnitedHealthcare Service LLC.
150 Motor Parkway
Suite 220
Hauppauge, NY 11788

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - Medical Plan
The Trustees of Columbia University In the City of New York
615 West 131st Street
4th Floor
New York, NY 10027
(212) 851-7000

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Columbia University in the City of New York Group Benefits Plan
Plan Number:	515
Employer ID:	13-5598093
Plan Type:	Welfare benefits plan
Plan Year:	January 1 - December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and the University
Source of Benefits:	Assets of the University

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided under *How to Appeal a Denied Claim* in Section 9, *Claims Procedures*.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, *ERISA* imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under *ERISA*.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the *Employee Benefits Security Administration* at 1-866-444-3272.

The Plan's Benefits are administered by Columbia University, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Columbia University are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by an In-Network or Out-of-Network provider UnitedHealthcare and Columbia University are neither liable nor responsible for the treatment, services or supplies provided by In-Network or Out-of-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's In-Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's In-Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

ATTACHMENT III – NONDISCRIMINATION

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service LLC on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to help you communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

We also provide reasonable modifications for persons with disabilities.

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator identified below.

Claims Administrator Civil Rights Coordinator
UnitedHealthcare Service LLC Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a complaint, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human Services, Office for Civil Rights.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.