UnitedHealthcare

Columbia University

POS 100

TWU: SSA: 2110

Effective January 1, 2010

As of April 2010

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INTRODUCTION

What this section includes:

- How To Use This SPD
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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 Medical Plan. It includes summaries of:

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

This 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 – including previously released Benefits in Brief. You are responsible for using this SPD and other resources provided to you to understand your benefits.

The rest of this description provides details about how the coverage works as well as information about who is eligible, processes and events that can affect coverage, administrative information, and your rights as a participant in the Plan. Please note that the words "you" and "your" refer to eligible covered persons enrolled in the Plan.

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

How To Use This SPD

- Please read the entire SPD and share it with your family.
- 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 Columbia University HR Benefits Service Center at 212-851-7000.

OVERVIEW OF THE MEDICAL PLANS

Columbia University offers choices of medical plans so that you can select the option that best meets the needs of you and your family.

What the Plans Cover

All the healthcare plans cover medically necessary health care services provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental illness, substance abuse or symptoms.

Only certain preventive care services are covered. The plans do not cover treatment for chronic care or conditions. All plan coverage is subject to conditions, limits and exceptions explained in the sections, "Covered Services" and "Services Not Covered". Columbia University and all its medical carriers administering the Plans, assumes no responsibility for the outcome of any covered services or supplies.

The Plans described in the following pages of this booklet are a benefit plan provided by Columbia University. These benefits are not insured with Aetna, CIGNA or UHC or any of their affiliates but are paid from Columbia University funds. Aetna, CIGNA and UHC provide certain administrative services under the Plan including claim determination, application of copays, coinsurance and limitations.

The Plans differ in how benefits are determined when you have covered expenses. A description of how each plan determines benefits follows in the sections, "Covered Services" and "Services Not Covered".

Medically Necessary Services

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

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

Ordered by a licensed physician

Supported by national medical standards of practice and is consistent with conclusions of prevailing medical research (based on well-conducted, randomized, controlled trials or well-conducted cohort studies)

Consistent with the diagnosis of the condition

Required for reasons other than the convenience of the patient or his/her physician

Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the selected Claims Administrator.

Other than experimental or educational in nature.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, illness or pregnancy does not mean

that it is a medically necessary service or supply as defined above. The definition of "medically necessary" used in this SPD relates only to benefit coverage and may differ from the way you or your doctor define medical necessity.

Claim Filing Deadline

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

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

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": 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 cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

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.

Pre-Existing Conditions

There are **no** pre-existing condition limits under the Columbia University medical plans.

Preauthorization Requirements

Certain procedures, services and/or supplies require you to obtain preauthorization from your selected medical claim administrator for you to receive the maximum benefits under the plan. You must get authorization for certain procedures and treatments before the procedure is performed or before the treatment starts; otherwise, your benefits will be subject to a significant reduction in reimbursement. See the preauthorization section in CIGNA or UHC coverage descriptions.

With all plans, you must obtain **preauthorization** before receiving certain services; otherwise, your benefits will be significantly reduced. Note that each health plan calls this process something different including "pre-certification", "prior authorization", and "Personal Health Support Notification". If you do not obtain preauthorization as required, the Plan will significantly reduce payment for all expenses related to the condition, and your additional cost will not count toward your out-of-pocket maximum. Become familiar with the specific services that require preauthorization based on whether your plan's claims administrator is CIGNA or UHC. If you have questions, call your plan's member services (phone number on your member ID card).

Overview of Point-of-Service (POS) Plans

You can select this type of benefit coverage from two POS plans – CIGNA or UHC. Each one has a network of participating hospitals, physicians and other healthcare providers who have agreed to accept lower negotiated fees for services and supplies for eligible patients. When you use providers who are in the POS network, your cost toward healthcare expenses is lower.

In-Network Services

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

Out-of-Network Services

POS plans allow you the flexibility to use providers who are not in the network - at any time. However, your cost toward your healthcare expenses is significantly higher because there are no negotiated fees. In addition, the POS plans limit the amount they will pay for any service obtained outside of the network. This maximum amount they will reimburse is known as the "Reasonable & Customary" (R&C) limit. *You are responsible for paying the full amount of any charges that exceed this limit.*

In addition, you must file claim forms with your medical carrier for each service or

supply and wait for reimbursement.

ADMINISTRATIVE AND LEGAL INFORMATION ABOUT THE PLAN

What this section includes:

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

- Your ERISA rights
- Statement of University Rights
- Plan Trustee
- Claim Administrator

Your Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group health plans protect the confidentiality of your health information. The Plan and Columbia University will not use or further disclose information that is protected by HIPAA (referred to as protected health information or "PHI") except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law.

When you enroll in the Columbia University Medical Plan, you consent to and authorize the Plan to share your claims data when appropriate. For example, a condition management program administrator (e.g. asthma management) may be notified by your health plan when your medical claims activity suggests that you or a family member may have a chronic condition. As a result, you may be contacted to participate in voluntary condition management programs.

By law, Columbia University has required all of its business associates to also observe HIPAA's privacy rules. The Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Columbia University. The Plan reserves the right to modify its practices with respect to medical information.

You have certain rights under HIPAA with respect to your protected health information, including the right to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services. If you have any questions on this issue, you should contact the HIPAA Privacy Office. To exercise you HIPAA rights under Columbia University medical plans, contact:

Privacy Officer

Columbia University HR Benefits
Studebaker 4th Floor, MC 8705
615 West 131st Street
New York, NY 10027

Email: hrprivoff@columbia.edu

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option.

The special enrollment events include:

Acquiring a new Dependent. If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan:

- Employee only;
- Spouse only;
- Employee and spouse;
- Dependent child(ren) only; Employee and Dependent child(ren);
- Employee, spouse and Dependent child(ren).

Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

Loss of eligibility for other coverage (excluding continuation coverage). If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- divorce or legal separation;
- cessation of Dependent status (such as reaching the limiting age);
- death of the Employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;

you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;

- you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.

Termination of employer contributions (excluding continuation coverage). If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

Exhaustion of COBRA or other continuation coverage. Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases:

- due to failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or
- when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual.

This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be denied enrollment. You will not be enrolled in this plan if you do not enroll within 30 days of the date you become eligible, unless you are eligible for special enrollment.

Your ERISA Rights

As a participant in the medical (including prescription drug), dental, flexible spending accounts and life insurance benefits described in this SPD, you are entitled to certain rights

and protections under the Employee Retirement Income Security Act (ERISA). You are entitled to receive a yearly summary of each plan's financial report. You may examine all the official documents related to the Plans in the Columbia University HR Benefits department. If you wish, you can obtain your own copies of Plan documents by writing to HR Benefits. You may have to pay a reasonable charge to cover the cost of postage and photocopying.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who administer the plans. These people are called "fiduciaries" and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person or organization, may terminate you or otherwise discriminate against you in any way in order to prevent you from obtaining your Plan benefits or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for a welfare benefit which is denied in whole or in part, you must receive a written explanation of the reason for the denial. For the medical, dental, life and long-term disability plans, the reason for the denial is explained in the Explanation of Benefits (EOB) or denial letter. (Please see the section Claim Review and Appeals Procedures under each Plan.) For the other plans covered under ERISA, you have the right to have the Plan Administrator review and reconsider the claim by submitting a request for appeal within 60 days of the denial. The request may be made by you or your authorized representative and should include the reason you are requesting a review of the claim, as well as any additional information that supports your claim. A review of your claim will take place no later than 120 days after receipt of your appeal. If your claim is still denied, you may file suit in a state or federal court. If you have any questions about your rights under ERISA, you may contact the nearest office of the U.S. Department of Labor.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": 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 cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable. Please review this Plan for further details on the specific coverage available to you and your Dependents.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications

resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

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.

Obtaining a Certificate of Creditable Coverage

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will automatically be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, call the toll-free customer service number on the back of your ID card.

Statement of the University's Rights

This document is not a contract or agreement for employment. Employment with Columbia University is "at-will"—nothing in this document changes your right and the University's right, to end your employment at any time and for any reason. Employment at Columbia University is not guaranteed for any period of time.

The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the claims administrators for the medical plans. As the Plan Administrator's delegates, the claims administrators have the authority to make decisions relating to benefit claims.

The University intends that the terms of the Plan described in this SPD, including those relating to coverage and benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

Although Columbia University expects to continue the Plan, it reserves the right to amend, modify or discontinue all or any part of the Plan or any plan or coverage at any time for any or all employees including active, disabled and former employees participating in the Columbia University Medical Plan. In the event of termination of the Plan, no benefits will be paid for incidents or events occurring after the date of termination.

No oral or written communication will be effective in amending The Plan unless it is by way of a formal amendment. Complete details, terms and conditions relating to each element of the plans are contained in the relevant plan documents; the specific provision and language of these documents will govern in every respect and instance.

To the extent this SPD provides a general description of the tax results that may be

applicable to coverage under the Plan, Columbia University assumes no responsibility for your own personal tax status, or for any tax consequences resulting from any claims made contrary to current tax law. Please consult your tax advisor for further information on the tax treatment of your benefits.

Plan Information

The name of the Plan is:

Columbia University Group Benefits Plan

Plan Sponsor and Administrator

Columbia University is the Plan Sponsor and Plan Administrator of the Columbia University Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
Columbia University
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

Employer Identification Plan Number (EIN): 135598093 515

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Claim Office of your selected health plan (e.g.CIGNA, UHC, etc.). The phone number is listed on your member Identification card.

The cost of the some Plans is shared by the Employee and Employer.

The Plan year is calendar and ends on 12/31.

Plan Trustees

A list of Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements. A copy is available for examination from the Plan Administrator upon written request.

Claim Administrator

The Plan Administrator delegates to your selected health plan (e.g. CIGNA, UHC, Medco, etc.) the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to your selected health plan the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

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.

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:

Columbia University
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

Legal process may also be served on the Plan Administrator.

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 Welfare Benefit Plan
Plan Number:	501
Employer ID:	13-5598093
Plan Type:	Welfare benefits plan
Plan Year:	Calendar
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and University
Source of Benefits:	Assets of the University

Eligibility For Benefit Coverage

What this section includes:

- When Your Benefits Start
- Your Eligible Dependents
- Who is Not Eligible for the Plan
- Qualified Medical Child Support Order (QMCSO)

Claim Administrator

Eligibility

If you are a full-time or part-time active Columbia University Non-Union Support Staff or member of 2110, SSA or TWU, you and your family are eligible for medical coverage under the Columbia University Medical Plan.

When Your Benefits Start

The benefits of eligible full-time and part-time Non-Union Support Staff and members of 2110, SSA and TWU are effective the first day of the month following completion of the applicable waiting period. Part-time employees must work 20 hours per week to be eligible for benefits.

In order to receive benefits, you must enroll within 31 days of your date of hire. You must select the coverage you want and whom you want to cover. If you do not enroll within 31 days of your date of hire, you will not have any medical benefit coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

Exception for Newborns

Any Dependent child born while you are covered under one of the Columbia University health plans (CIGNA, UHC, HIP) will automatically be covered on the date of his or her birth for a period of 31 days. However, ***you must enroll your newborn in your coverage no later than 31 days after the birth through the Columbia University (CU) Benefits Enrollment System at www.hr.columbia.edu/benefits or by notifying Columbia University HR Benefits Service Center.*** If you do not elect to cover your newborn child within 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Your Eligible Dependents

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

Legal Spouse

Same-sex domestic partner or civil union partner, provided your partner is:

- Is at least 18 years old
- Is not related to you by blood
- Is not legally married to another person

In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender,

- **And** meets two or more of the following requirements:
- Shares the same principal residence with you full-time and for the past 12 continuous months
- Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.
- Has power of attorney for medical purposes

Unmarried legally dependent children, including adopted children, foster children and stepchildren of your spouse or same-sex domestic partner, provided that you declare the child(ren) as dependents on your federal income tax return. Dependent children are covered:

- Until the end of the calendar year in which they turn 19;
- Over the age of 19 as long as they remain full-time students. Note coverage ends at the end of the month in which they cease to be a full-time student (e.g. graduate) or the end of the calendar year in which they turn age 26, whichever is earlier
- If a court has appointed you legal guardian (for any child from birth to age 19, or to age 26 if a full-time student
- At any age if they have a mental or physical disability provided he/she is incapable of self-sustaining employment and who chiefly depends upon you for support. You must either apply for continued coverage when you are initially eligible for benefits or prior to the end of the Plan (calendar) year in which the dependent turns age 19. Approval by your medical insurance carrier (Aetna, CIGNA, UHC or your HMO) is required. See How to Continue Coverage for a Disabled Child, below.

Eligible dependent children does not include:

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

How to Continue Coverage for a Disabled Child

Coverage for an unmarried mentally or physically disabled child who is not capable of self-sustaining employment and who depends chiefly upon you for support and maintenance may continue coverage beyond age 19:

- If you're an eligible employee when your child meets this definition, you must apply for continued coverage before the end of the calendar year in which he or she turns age 19.
- If you're a newly eligible employee and your disabled child is older than age 19 when you are electing coverage, you may apply to cover your child when your coverage begins.
- To cover a disabled child who is over age 19, you must complete and submit the required form(s) to your medical plan carrier— Aetna, CIGNA, UHC or your HMO. Forms are available from the HR Benefits Service Center at 212-851-7000.
- Your medical carrier may request that you provide proof of your child's incapacity and dependency within 31 days of the date coverage would have otherwise ended. You must supply this proof to your medical carrier within the requested timeframe or the Plan will no longer pay benefits for that child.

Who is Not Eligible for the Plan

The term "employee" in this document does not include:

Support Staff employees who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures

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

You will be required to repay all costs to the University of providing coverage and any benefits paid to you. 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 notify the Columbia University HR Benefits department *within 31 days of the change*. Examples of changes include, but are not limited to, divorce, child no longer a student, etc. Contact the Columbia University HR Benefits Service Center at 212-851-7000 to report any changes in the status of your dependents within 31 days.

Verify Student Status to Avoid Loss of Coverage

A full-time student is a student who is taking 12 or more credit hours at an accredited educational institution, or as defined as full-time by the institution. You must provide proof of your child's student status.

Each year, your selected health plan will request verification, which may include the following forms of proof of student status:

- A signed letter from the Registrar or Dean of Students
- A copy of your dependent child's current semester official class schedule
- A copy of the current term tuition bill
- School name
- Student name
- Term
- Credit Hours: 12 or more (9 or more if graduate students) or indication of full-time status.

In addition, you may be asked to provide the following information:

- Medical plan member ID (located on your ID card)
- Medical plan account number (located on your ID card)

If you do not provide all the requested information in the timeframe designated by your medical and/or dental plan, **your child's coverage will automatically be terminated.**

Proof of Eligibility

Columbia 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 license, etc. **If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.**

You Choose Who to Cover Under Your Benefits

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

- Yourself only
- Yourself and your legal spouse or yourself and your same-sex domestic partner
- Yourself and a child or children
- Family

Qualified Medical Child Support Order (QMCSO)

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

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

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

Qualified Medical Child Support Order Defined

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

- The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

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

If You and Your Spouse or Same-Sex Domestic Partner Work for the University

If you and your spouse work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

- One spouse makes the medical choice for the entire family, including eligible dependent children, if any. In this case, the other spouse must select "No Coverage."
- Each spouse can make his or her own medical choice. In this case, all eligible dependent children must be covered by one spouse or the other.

Enrollment

What this section includes:

- How to Enroll
- Annual Enrollment Opportunities
- Making Changes to Your Benefits During the Year
- Adding Your Newborn Child
- Your Cost

How to Enroll

Newly Eligible Employee

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

You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 2 weeks of your date of hire, please contact the HR Benefits Service Center at 212-851-7000.

Annual Enrollment Opportunities

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

Making Changes to Your Benefits During the Year

After your initial enrollment, or after annual Benefits Open Enrollment, you will be able to change your benefits for the remainder of the calendar year only if you experience a "qualified life status change." Columbia University healthcare benefits are governed by The Internal Revenue Service (Section 125), which limits when you can make changes to your benefit elections as well as the type of changes you are permitted to make.

Examples of a qualified life status change include:

- Marriage, divorce

- Beginning or end of a same-sex domestic partnership
- Birth, adoption, or placement for adoption
- Death of a dependent
- Dependent loses eligibility for coverage (child reaches maximum age, spouse/domestic partner loses non-University coverage from their employer)
- Change in home address that changes your provider network access
- A permanent change in the way you commute to work (applies to the Transit/Parking program)
- Spouse or eligible dependent called to military duty in the United States armed forces.
- Job promotions and/or transfers that change the benefit offerings within job grade and/or bargained benefits.

If you experience a qualified life status change, ***you must contact the Columbia University HR Benefits Service Center at 212-851-7000 within 31 days of the event.*** You may be required to provide proof (e.g., marriage certificate, birth certificate) in order to make changes to your benefit selections. Your benefit changes must be consistent with the nature of your qualified life status change.

Adding Your Newborn Child

For a newborn's hospital and medical expenses to be eligible for reimbursement, you must add your child by contacting the Columbia University HR Benefits Service Center at 212-851-7000 within 31 days of the child's birth. In addition, if you are enrolled in CIGNA POS or an HMO, you should call your plan's member services and provide the name of your newborn's PCP.

Your Cost

Your Cost for Benefit Coverage

You and Columbia University share the cost of certain coverages. Each year, the University determines its level of support for benefit coverage for you and your eligible dependents. Costs vary depending on the plan you choose, and the number of eligible dependents that you cover.

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

If you contribute toward the cost of coverage, your premium cost is regularly deducted from your University paycheck on a pre-tax basis as allowed under Internal Revenue Service Section 125. Your pre-tax "premium" for healthcare coverage is based on the plan you choose and the coverage level you select (individual vs. family, etc.)

Your Cost for Same-Sex Domestic Partner/Civil Union Partner

Federal income tax rules require that your contributions toward the coverage of a same-sex domestic partner or civil union partner be deducted from your pay on an after-tax basis. In addition, University contributions toward premiums for covering your domestic or civil union partner are taxable to you.

WHEN COVERAGE ENDS

What this section includes:

- When Your Employment Ends
- If You Become Disabled
- If You Take a Leave of Absence
- Coverage While Under Military Duty in the United States Armed Forces
- Other Events Ending Your Coverage
- COBRA Continuation Rights

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

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

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

When Your Employment Ends

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

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

When your coverage ends, 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:

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

Coverage for your eligible Dependents will end on the earliest of:

the date your coverage ends;

the last day of the month you stop making the required "premium" contributions;

the last day of the month your Dependents no longer qualify as Dependents under this Plan.

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

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

If you are separated from your job and you have 10 years of service after age 45, you may be eligible for Retiree Medical coverage sponsored by the University. You must meet any service and age requirement at the time your employment ends. Subsequent attainment of the required age after you leave the Columbia University will count toward the requirement for Columbia University Retiree Medical benefits and eligibility for medical coverage continuation under these provisions.

If you qualify for Columbia University Retiree Medical, you and your covered dependents will remain covered by your selected medical plan until the end of the month in which your employment ends or if later, the end of the month in which your severance period ends. At that point, you will move into Columbia University Retiree Medical Plan. (However, if you or your eligible dependents are eligible for Medicare due to disability or because you are age 65 or older, Medicare becomes the primary plan for the individual who is Medicare eligible.)

Contact the HR Benefits Service Center at 212-851-7000 if you think you have attained the age and service requirements.

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.

- Your coverage continues without change under the medical plan in effect when your disability begins. If your coverage requires a premium contribution (e.g. UHC POS), you must pay this premium directly to EBPA (an external administrator) in order to continue your coverage. EBPA will automatically send you premium coupons shortly after your disability begins.
- Your coverage continues consistent with your Collective Bargaining Agreement

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 HR Benefits Service Center to discuss these rules.

Please note that for certain coverages to remain in effect during your leave of absence, you must pay the monthly premium costs associated with them. You will be billed separately for these coverages by Employee Benefit Plan Administrators (EBPA), an outside vendor. The HR Benefits Service Center will notify EBPA of your leave of absence status and calculate the monthly costs for those coverages that will require payment during your leave.

EBPA will bill you for these monthly costs using a payment coupon. Payment must be remitted to EBPA at the address shown on the payment coupon. Failure to make the required premium payments will result in termination of coverage retroactive to the date for which the last contribution was received.

Coverage While on a Leave Under the Family and Medical Leave Act of 1993 (FMLA)

You're entitled by Federal law to up to 12 weeks of unpaid leave under the FMLA for specified family medical purposes, such as the birth or adoption of a child, or to care for a spouse, child, or parent who is seriously ill or for your own illness. You are entitled to continue your group health coverage under Columbia University Medical Plans during your FMLA leave period at the same rate as if you were still at work, as long as you continue to make payments. If you don't timely return to covered employment after your leave ends, you are entitled to COBRA continuation coverage.

Coverage While on Military Duty in the United States Armed Forces

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

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

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

If You Die

If you die, your surviving dependents who are covered under the Columbia University Medical Plan at the time of your death will receive:

- Medical and prescription coverage for 1 year following the date of your death, free of charge.
- COBRA benefits will then be offered following the one year period of free coverage.

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

If Your Eligible Dependent Dies

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

Other Events Ending Your Coverage

Your coverage may also end when any of the following happen. If your coverage is terminated for any of the reasons below, you will be provided written notice that coverage has ended on the date the Plan Administrator identifies in the notice.

Fraud, Misrepresentation or False Information - occurs when there has been fraud or misrepresentation, or the Employee knowingly gave their selected health plan or Columbia University false material information. Examples include false information relating to another person's eligibility or status as a Dependent. Columbia University reserves the right to demand that you pay back any reimbursement paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Material Violation – occurs when there was a material violation of the terms of the Plan.

Threatening Behavior – occurs when you have committed acts of physical or verbal abuse that pose a threat to Columbia University's staff or the staff of your selected health plan staff.

Uniformed Services Employment and Reemployment Rights Act

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

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

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

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

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

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

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

to have been incurred in, or aggravated during, the performance of military service.

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

When Coverage Ends for Your Dependents

When you drop coverage for one or more of your covered dependents through a Qualified Change in Status, coverage will end as follows:

Spouse

End of the month or 21 days (whichever is greater) following the date of your divorce, or commencement of other medical coverage (through spouse's employer, etc.).

Same-Sex Domestic Partner

End of the month or 21 days (whichever is greater) following the dissolution of the partnership or commencement of other medical coverage (through partner's employer).

Child

The coverage end date varies based upon the following situations:

Reaches Age 19: Coverage ends December 31st of the calendar year in which your child turned 19.

Full-time student over age 19 graduates: End of the month or 21 days whichever is greater following the date of graduation or the date your child is no longer a student.

Full-time student reaches age 26 (and has not yet graduated): Coverage stops the end of the month in which the child reached age 26

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

a) The date that is one year after the first day of the medically necessary leave of absence; or

b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A "medically necessary leave of absence" is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

Obtaining a Certificate of Creditable Coverage

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

COBRA Continuation Rights

Continuing Coverage through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated 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; or

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, you 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; and

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; or

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 Service Center 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 15, *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 shown above if:

you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition;

or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;

you or your covered Dependent becomes eligible for, and enrolls in, Medicare after electing COBRA;

the first required premium is not paid within 45 days;

any other monthly premium is not paid within 30 days of its due date;

the entire Plan ends; or

coverage would otherwise terminate under the Plan as described in the beginning of this section.

PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

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. A Personal Health Support Nurse is notified when you or your Provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, 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 such as:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care advocacy** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, 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 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.

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

Requirements for Notifying Personal Health Support

There are some Network Benefits for which you are responsible for notifying Personal Health Support. However, Network Providers are generally responsible for notifying Personal Health Support before they provide these services to you.

When you choose to receive certain Covered Health Services from non-Network Providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services. In many cases, your non-Network Benefits will be reduced if Personal Health Support is not notified.

The services that require Personal Health Support notification are:

- Congenital Heart Disease services;
- dental services - accident only;
- Durable Medical Equipment;
- home health care;
- hospice care;
- Hospital Inpatient Stay, including Emergency admission;
- maternity care that exceeds the delivery timeframes as described in *Additional Coverage Details*;
- Reconstructive Procedures;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services; and
- Transplantation services.

The following procedures also require that you notify Personal Health Support prior to receiving services in order for Personal Health Support to determine if they are medically necessary Covered Health Services:

- breast reduction and reconstruction (except following cancer surgery);
- vein stripping, ligation and sclerotherapy (an injection of a chemical to treat varicose veins); and
- blepharoplasty (surgery to correct aging of the eyelids).

These services will not be covered when considered to be Cosmetic Procedures, as defined in *Glossary*.

For notification timeframes, and reductions in Benefits that apply if you do not notify Personal Health Support, see *Additional Coverage Details*.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card. (888) 444-3368

Special Note Regarding Mental Health and Substance Abuse Treatment

For inpatient, intermediate or outpatient Mental Health/Substance Abuse treatment you are responsible for calling the MH/SA Administrator in advance of any service to get authorization to receive these benefits. Without prior authorization, benefits will not be aid and you will be responsible for all charges. The MH/SA phone number is on the back of your ID card.

PLAN HIGHLIGHTS

The table below provides an overview of Copays and the Plan's Annual Deductible (deductible), Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	Network	Non-Network
Copays and Coinsurance[1]		
■ Emergency Health Services	$100	$100
■ Hospital - Inpatient Stay	$250 per admission	70% after deductible
■ Physician's Office Services	$20	70% after deductible
■ Urgent Care Center Services	$20	70% after deductible
Annual Deductible (deductible)[2]		
■ Individual	Not Applicable	$575
■ Family	Not Applicable	$1,725
Annual Out-of-Pocket Maximum[2]		
■ Individual	Not Applicable	$3,500
■ Family	Not Applicable	$7,000
Lifetime Maximum Benefit	Unlimited	$1,000,000

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit a non-Network Provider.
[2]Copays do not apply toward the Annual Deductible or Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits including limits see following section *Additional Coverage Details*. Many services require pre-authorization from UHC Personal Health Services in order to receive coverage. Refer to *Personal Health Services* preceding this chart for details.

Covered Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Acupuncture Services (In lieu of anesthesia ONLY)	$20 Copay	70% after deductible
Ambulance Services - Emergency Only	100%	100%
Ambulance Services - Non-Emergency	100%	70% after deductible
Cancer Resource Services (CRS) ■ Hospital Inpatient Stay	$250 per admission	Not Covered
Congenital Heart Disease (CHD)	100%	70% after deductible
Dental Services - Accident Only (Copay is per visit)	$20 Copay	70% after deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care Diabetes Self-Management Items ■ diabetes equipment ■ diabetes supplies	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section. Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) Repair/replace once every 3 years.	$20 Copay	70% after deductible
Emergency Health Services (Copay is per visit and is waived if admitted).	$100 Copay	$100 Copay

Covered Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Home Health Care Up to 200 visits per Covered Person per calendar year combined network and non-network.	**Physician house calls,** $20 Copay per visit **All other services,** 100%	70% after deductible
Hospice Care Up to 210 days per Covered Person per calendar year combined network and non-network.	100%	70% after deductible
Hospital - Inpatient Stay When services for cardiac care are received at a Network facility designated in the UnitedHealth Premium program the Copay will be waived	$250 per admission	70% after deductible
Infertility Services ■ Physician's Office Services (Copay is per visit) ■ Outpatient services received at a Hospital or Alternate Facility See *Additional Coverage Details*, for limits.	$20 Copay 100%	70% after deductible 70% after deductible
Injections in a Physician's Office	Allergy injections with no Physician's office visit, Shots & Testing in Physician's Office Only - 100% All other services, $20 Copay	70% after deductible
Lab, X-Ray and Diagnostics - Outpatient	$20 Copay	70% after deductible

Covered Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100%	70% after deductible
Mental Health Services ■ Hospital – Inpatient (Copay is per admission) Limit 60 days per calendar year combined network and non-network. ■ Physician's Office Services (Copayment is per visit) Up to 60 visits per Covered Person per calendar year combined network and non-network.	$250 Copay $20 Copay	70% after deductible
Obesity Surgery ■ Physician's Office Services	$20 Copay	70% after deductible
■ Physician Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay ■ Lab and x-ray	100% $250 per admission 100%	70% after deductible 70% after deductible 70% after deductible
Ostomy Supplies	100%	70% after deductible
Physician Fees for Surgical and Medical Services	100%	70% after deductible
Physician's Office Services – diagnostics only (Copay is per visit)	$20 Copay	70% after deductible
Pregnancy – Maternity Services ■ Physician's Office Services (No Copay applies for prenatal visits after the first visit)	$20 Copay	70% after deductible

Covered Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Hospital - Inpatient Stay (The Copayment will not apply for a newborn child)	$250 per admission	70% after deductible
■ Physician Fees for Surgical and Medical Services	100%	70% after deductible
Preventive Care		
■ Physician Office Services	100%	Not Covered
■ Lab, X-ray or Other Preventive Tests	100%	Not Covered
Private Duty Nursing - Outpatient Up to a $5,000 maximum per Covered Person per calendar year for Network and Non-Network Benefits combined	100%	70% after deductible
Prosthetic Devices	100%	70% after deductible
Reconstructive Procedures		
■ Physician's Office Services (Copay is per visit)	$20 Copay	70% after deductible
■ Hospital - Inpatient Stay	$250 per admission	70% after deductible
■ Physician Fees for Surgical and Medical Services	100%	70% after deductible
■ Prosthetic Devices	100%	70% after deductible
■ Surgery - Outpatient	100%	70% after deductible
Rehabilitation Services - Outpatient Therapy (Copay is per visit) See *Additional Coverage Details*, for visit limits	**Inpatient therapy,** 100% **Outpatient therapy,**	70% after deductible

Covered Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
	$20 Copay	
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100%	70% after deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 120 days per Covered Person per calendar year for Network and Non-Network Benefits combined.	100%	70% after deductible
Spinal Treatment (Copay is per visit) Up to 60 visits per Covered Person per calendar year for Network and Non-Network Benefits	100% after you pay a $20 Copay	70% after deductible
Substance Use Disorder Services ■ Hospital – Inpatient (Copay is per admission) ■ Physician's Office Services (Copayment is per visit) Up to 60 visits per Covered Person per calendar year.	$250 Copay **Individual**: $20 Copay **Family:** $20 Copay	70% after deductible
Surgery - Outpatient	100%	70% after deductible
Therapeutic Treatments - Outpatient	100%	70% after deductible
Transplantation Services	100%	70% after deductible
Travel and Lodging (If services rendered by a Designated	For patient and companion(s) of patient undergoing cancer, obesity surgery, Congenital	

Covered Services	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Facility)	Heart Disease treatment or transplant procedures	
Urgent Care Center Services (Copay is per visit)	$20 Copay	70% after deductible
Wigs (limit 1 wig up to $3,000 per lifetime)	100%	70% after deductible

ADDITIONAL COVERAGE DETAILS

What this section includes:

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

This section supplements the table above *Plan Highlights*.

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

Acupuncture Services (In lieu of anesthesia only)

The Plan pays for acupuncture services for anesthesia provided that the service is performed in an office setting by a Provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: Doctor of Medicine; Doctor of Osteopathy; Chiropractor; or Acupuncturist.

Ambulance Services - Emergency Only

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

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, 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 transportation provided by licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

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

Cancer Resource Services (CRS)

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

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

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.urncrs.com.

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

- Physician's Office Services;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;

- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

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

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

Congenital Heart Disease (CHD)

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

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

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

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

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

Please remember that United Resource Networks or Personal Health Support must be notified as soon as CHD is suspected or diagnosed. If United Resource Networks or Personal Health Support is not notified, Benefits for Covered Health Services will be subject to a $500 reduction.

Note: The services described under *Travel and Lodging* are Covered Services only in connection with CHD Resource Services Program.

Cranial Banding

Cranial banding is covered in certain circumstances. To receive coverage prior authorization from UCH is required. Cranial remodeling bands (or helmets) as medically necessary orthoses for treatment of moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis (shortening of the sternocleidomastoid muscle) and sleeping positions in children when banding is initiated at 4 to 12 months of age. Call the toll-free number on the back of your ID card to request authorization.

Dental Services - Accident Only

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

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

The following services are also covered by the Plan:

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

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

- has no decay;
- has no filling on more than two surfaces;

- has no gum disease associated with bone loss;
- has no root canal therapy;
- is not a dental implant; and
- functions normally in chewing and speech.

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

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Personal Health Support can determine whether the service is a Covered Health Service.

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to: • blood glucose monitors; • insulin syringes with needles; • blood glucose and urine test strips; • ketone test strips and tablets; and • lancets and lancet devices. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.
	Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

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

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

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- wheelchairs;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- braces that stabilize an injured body part and braces to treat curvature of the spine;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

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

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every 3 calendar years. At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs.

Please remember for Non-Network Benefits, you must notify Personal Health. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, Benefits will be subject to a $500 reduction.

Emergency Health Services

If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for an Emergency Health Service, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

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

Please remember for Non-Network Benefits, you must notify Personal Health Support for precertification within 48 hours or as soon as reasonably possible if you are admitted to a Hospital as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Hospital Stay will be subject to a $500 reduction.

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*; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to *Glossary* for the definition of Skilled Care.

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

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

Please remember for Non-Network Benefits, you must notify Personal Health Support for precertification five business days before receiving services. If Personal Health Support is not notified, 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 and spiritual 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 Network and non-Network Benefits is limited to 210 days per Covered Person per calendar year.

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before receiving services. If Personal Health Support is not notified, Benefits will be subject to a $500 reduction.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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 Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Please remember for Non-Network Benefits, you must notify Personal Health Support as follows:
■ for elective admissions: five business days before admission;
■ for Emergency admissions (also termed non-elective admissions): within two business days, or as soon as is reasonably possible.
If Personal Health Support is not notified, Benefits will be subject to a $500 reduction.

Infertility Services

The Plan pays Benefits for infertility services and associated expenses including:

- diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician;
- in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);
- embryo transport;
- donor ovum and semen and related costs, including collection, preparation and storage of; and
- artificial insemination.

Any combination of Network Benefits and non-Network Benefits for infertility services is limited to a $5,000 maximum per Covered Person per calendar year.

Injections in a Physician's Office

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

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

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.

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

Mental Health Services

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

In-patient – Limit 60 days per calendar year. Services that are provided by a Hospital while you or y0our dependent is confirmed in a hospital for the treatment and e valuation of Mental Health. In-patient Mental Health Services include partial Hospitalization and Mental Health Residential Treatment Services. Partial Hospitalization sessions are series that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

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

Out-Patient – Limit 60 visits per calendar year. Services of providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your dependent is not confined in a hospital and is provided in an individual or group or Intensive Outpatient Therapy Program. Covered services include but are not limited to outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning, emotional adjustment or concerns related to chronic conditions, such as

psychosis or depression emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

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:

- you have a minimum Body Mass Index (BMI) of 40 or a BMI of 35-39.9 with at least one of the following obesity related co-morbidities:

- cardiovascular disease including stroke, myocardial infarction, stable or unstable angina pectoris, coronary artery bypass or other procedures,
- hyperlipidemia uncontrolled by pharmacotherapy,
- type 2 diabetes uncontrolled by pharmacotherapy,
- hypertension uncontrolled by pharmacotherapy,
- moderate to severe sleep apnea with a respiratory disturbance index (RDI) of 16 to 30 (moderate) or apnea-hypopnea index (AHI) >30 (severe) as documented through the completion of a laboratory based polysomnography;

- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years; and

- you are over the age of 21.

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

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

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

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

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

- Surgery - Outpatient.

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

Please remember for Non-Network Benefits, you must notify Personal Health Support as soon as the possibility of obesity surgery arises but at least five days before receiving obesity surgery services. When obesity surgery services are provided at a designated BRS facility you must notify Personal Health Support before the time a pre-surgical evaluation is performed. If Personal Health Support is not notified, Benefits will be subject to a $500 reduction.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

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.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* in this section.

Physician's Office Services

Benefits are paid by the Plan for Covered Health Services received in a Primary Physician's office for the evaluation and treatment of a Sickness or Injury.

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

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

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

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

Please remember for Non-Network Benefits, you must notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Personal Health Support is not notified, Benefits for the extended stay will be subject to a $500 reduction.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See *Resources to Help you Stay Healthy*, for details.

Preventive Care

The Plan pays for services for preventive medical care provided on an outpatient basis at a Network Physician's office, a Network Alternate Facility or a Network Hospital.

In general, the Plan pays preventive care Benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) including but not limited to; frequency, age, gender and test. Other preventive care services may be covered as well. Your Physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

Examples of Covered Health Services for preventive care include:

Covered Preventive Care Services	
Physician Office Services	• routine physical; • phenylketonuria (PKU) tests; • immunizations[1,2]; • well baby and well child care; and • routine gynecological exam including breast and pelvic

Covered Preventive Care Services	
	examination, treatment of minor infections, and PAP test[2].
Lab, X-ray or Other Preventive Tests	• mammogram; • colorectal cancer screening; • cervical cancer screening; • PSA blood test and digital rectal exam; and • bone mineral density tests.

[1]Covered childhood immunizations generally include: Diptheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles-mumps-rubella (MMR), Conjugate haemophilus influenza type B, Hepatitis B, Rotavirus vaccine, Varicella (Chicken Pox) and human papilloma virus (HPV) vaccine for ages 9-18.

[2]The HPV vaccine is limited to one complete dosage per lifetime. Women over age 18 but under age 26 who have not yet received the vaccine may receive the vaccine.

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

Private Duty Nursing - Outpatient

The Plan covers private duty nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of Network Benefits and Non-Network Benefits is limited to a $5,000 maximum per Covered Person per calendar year.

Prosthetic Devices

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

- artificial limbs;
- artificial eyes; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction.

Benefits are provided for the replacement of a type of prosthetic device once every 3 calendar years. At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

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

Reconstructive Procedures

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

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

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

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

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

Please remember that you must notify Personal Health Support for precertification five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy

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

- cognative therapy;
- physical therapy;
- occupational therapy;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy Provider, under the direction of a Physician, must perform the services.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits are limited to:

- 60 visits per calendar year for physical and occupational combined;
- 60 visits per calendar year for speech therapy;
- 60 visits per calendar year for cognative therapy;
- 60 visits per calendar year for pulmonary rehabilitation therapy; and
- 60 visits per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-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.

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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.

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:

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

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

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

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

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

Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per Covered Person per calendar year.

Please remember for Non-Network Benefits, you must notify Personal Health Support as follows:
■ for elective admissions: five business days before admission;

■ for Emergency admissions (also termed non-elective admissions): within 48 hours, or as soon as is reasonably possible.

If Personal Health Support is not notified, Benefits will be subject to a $500 reduction.

Spinal Manipulation Treatment

The Plan pays Benefits for Spinal Manipulation Treatment when provided by a network or non-network Spinal Manipulation Treatment specialist in the specialist's office. Covered Health Services include chiropractic and osteopathic manipulative therapy.

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

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

Substance Abuse Services

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

Benefits for Substance Abuse Services include:

- Substance Abuse or chemical dependency evaluations and assessment;
- diagnosis;
- treatment planning;
- detoxification (sub-acute/non-medical);
- inpatient services;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- services at a Residential Treatment Facility;
- referral services;
- medication management;
- individual, family and group therapeutic services; and
- crisis intervention.

The Mental Health/Substance Abuse Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Administrator, who is responsible for coordinating all of your care. Substance Abuse Services must be authorized and overseen by the Mental Health/Substance Abuse Administrator. Contact the Mental Health/Substance Abuse Administrator regarding Benefits for Substance Abuse Services.

- Benefits are limited to 60 days per Covered Person per calendar year for outpatient Substance Abuse Network and Non-Network Benefits.

Special Substance Abuse Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Abuse Administrator may become available to you as part of your Substance Abuse Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of Substance Abuse which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Abuse Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember that you must call the MH/SA Administrator and get authorization to receive these Benefits in advance of any treatment. Please call the mental health services phone number that appears on your ID card. Without authorization, you will be responsible for all charges and no Benefits will be paid.

Surgery - Outpatient

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

Benefits under this section include:

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

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

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Transplantation Services

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

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service – please see below.

Benefits are also available for cornea transplants that are provided by a Provider at a Hospital. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service. If a separate charge is made for a bone marrow/stem cell search, the Plan will pay up to $25,000 for all charges made in connection with the search.

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

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

Please remember for Non-Network Benefits, you must notify United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Personal Health Support is not notified, Benefits will be subject to a $500 reduction.

Travel and Lodging

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

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

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

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

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

- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

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

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

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel, and lodging expenses reimbursed under this Plan in connection with all cancer treatments and transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis for loss of hair resulting from chemotherapy, treatment of a malignancy or accidental injury. Limited to one wig or other scalp hair prostheses up to $3,000 per lifetime.

RESOURCES TO HELP YOU STAY HEALTHY

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

- **myuhc.com**;
- Optum® NurseLine℠/Connect24;
- Live Nurse Chat;
- Cancer Management;
- Disease Management Services;
- Healthy Pregnancy Program; and
- UnitedHealth Premium℠ Program.

Columbia University believes in giving you the tools you need to 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; and
- navigate the complexities of the health care system.

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

www.myuhc.com

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

Health Information

With **myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;

- search for Network Providers available in your Plan through the online Provider directory;
- access all of the content and wellness topics from NurseLine/Connect24 including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Self-Service Tools

Visit **myuhc.com** and:

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

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

Health Assessment

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

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

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

Health Improvement Plan

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

Online coaching is available for:

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

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

Optum® NurseLine℠/Connect24

NurseLine/Connect24 is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Columbia University has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine/Connect24 gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages. There are also 590 messages available in Spanish.

NurseLine/Connect24 is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine/Connect24.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine/Connect24 toll-free at the number on your ID card, any time, 24 hours a day, seven days a week. You can count on NurseLine/Connect24 to help answer your health questions.

Live Nurse Chat

With NurseLine/Connect24, you also have access to nurses online. To use this service, log onto **myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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

Live Events on myuhc.com

Periodically, **myuhc.com** hosts live events with leading health care professionals. After viewing a presentation, you can chat online with the experts. Topics include:

- weight control;
- parenting;
- heart disease;
- relationships; and
- depression.

For details, or to participate in a live event, log onto **myuhc.com**.

Want to learn more about a condition or treatment?
Log on to **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.

Cancer Management

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

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

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

Healthy Pregnancy Program

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

- maternity nurses on duty 24 hours a day;
- a free copy of *The Healthy Pregnancy Guide*;
- a phone call from a maternity nurse halfway through your Pregnancy, to see how things are going;
- a phone call from a nurse approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more; and
- a copy of an available publication, for example, *Healthy Baby Book*, which focuses on the first two years of life.

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

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

Disease Management Services

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

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;

- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

- education about the specific disease and condition,
- medication management and compliance,
- reinforcement of on-line behavior modification program goals,
- preparation and support for upcoming Physician visits,
- review of psychosocial services and community resources,
- caregiver status and in-home safety.

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

UnitedHealth Premium℠ Program

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

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

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

EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

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

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

When Benefits are limited within any of the Covered Health Services categories described in *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in *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 *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 limiting 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."

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing (holistic tissue massage);
6. acupuncture, except in lieu of anesthesia, as identified under *Acupuncture Services* in Section 6, *Additional Coverage Details*; and
7. other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health.

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; and

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, except as identified under *Dental Services - Accident Only* in *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 *Additional Coverage Details*.

2. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature, including oral appliances;

3. preventive dental care;

4. diagnosis or treatment of the teeth or gums. Examples include:

   - extractions (except for wisdom teeth when extraction is covered as a Network Benefit);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

5. dental implants and braces;

6. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

7. treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Drugs

1. prescription drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications;

3. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

4. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

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

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

Foot Care

1. routine foot care, except when needed for severe systemic disease. Routine foot care services that are not covered include:

   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics.

Jawbone Surgery (Exclusion applies to non-Network Benefits only)

- diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite), except as treatment of obstructive sleep apnea; and
- upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, tumor or cancer.

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, except for ostomy bags and related supplies. Examples of supplies that are not covered include, but are not limited to:

   - elastic stockings and ace bandages; and
   - tubings, nasal cannulas, connectors and masks that are not used in connection with DME; and

3. orthotic appliances and devices.

Mental Health/Substance Abuse

The Mental Health/Substance Abuse Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

- inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Abuse (MH/SA) Administrator;
- services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective;
- treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Mental Health/Substance Abuse Administrator;
- services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuses that , in the reasonable judgment of the Mental Health/Substance Abuse Administrator, are any of the following:

- not consistent with generally accepted standards of medical practice for the treatment of such conditions;
- not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;

- typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective;
- not consistent with the Mental Health/Substance Abuse Administrator's level of care guidelines or best practices as modified from time to time; or
- not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, Substance Abuse or condition based on generally accepted standards of medical practice and benchmarks.

- Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
- treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MH/SA Administrator;
- educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
- tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
- learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
- psychosurgery (lobotomy)
- Substance Abuse Services for the treatment of nicotine or caffeine use;
- intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders;
- routine use of psychological testing without specific authorization; and
- pastoral counseling.

Nutrition and Health Education

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups;

3. food of any kind. Foods that are not covered include:

    - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded;
    - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
    - oral vitamins and minerals;
    - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
    - other dietary and electrolyte supplements;

4. health club memberships and programs, and spa treatments; and

5. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures, as defined in the *Glossary*, are excluded from coverage. Examples include:

    - liposuction;
    - pharmacological regimens;
    - nutritional procedures or treatments;
    - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
    - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. wigs regardless of the reason for the hair loss except for loss of hair resulting from chemotherapy, treatment of a malignancy or accidental injury;

5. treatments for hair loss;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. varicose vein treatment of the lower extremities, when it is considered cosmetic; and

8. treatment of benign gynecomastia (abnormal breast enlargement in males).

Pregnancy and Infertility

1. surrogate parenting;

2. the reversal of voluntary sterilization;

3. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

4. contraceptive supplies and services; except IUDs.

5. services provided by a doula (labor aide); and

6. parenting, pre-natal or birthing classes.

Providers

Services:

1. performed by a Provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a Provider may perform on himself or herself;

3. performed by a Provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license;

6. foreign language and sign language interpreters;

7. provided at a diagnostic facility (Hospital or free-standing) without a written order from a Provider;

8. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

9. ordered by a Provider affiliated with a diagnostic facility (Hospital or free-standing), when that Provider is not actively involved in your medical care:

- prior to ordering the service; or
- after the service is received.

This exclusion does not apply to mammography testing.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants,

   - except as identified under *Transplantation Services* in *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
   - determined by Personal Health Support not to be proven procedures for the involved diagnoses; and
   - not consistent with the diagnosis of the condition;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

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

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*.

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices; and

3 purchase cost of eyeglasses, contact lenses, or hearing aids;

4. fitting charges for hearing aids, assistive devices, amplifiers, eyeglasses, and contact lenses;

5. eye exercise therapy other than as a treatment for strabismus (misalignment of the eyes); and

6. 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.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms;
   - record processing; or
   - services, supplies or equipment that are advertised by the Provider as free;

3. charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;

4. charges prohibited by federal anti-kickback or self-referral statutes;

5. chelation therapy, except to treat heavy metal poisoning;

6. Custodial Care as defined in Section 14, *Glossary*, or services provided by a personal care assistant;

7. diagnostic tests that are:

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

8. Domiciliary Care, as defined in Section 14, *Glossary*;

9. growth hormone therapy;

10. expenses for health services and supplies:

    - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;

- that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country;
- 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; or
- that exceed Eligible Expenses or any specified limitation in this SPD;
- for which a non-Network Provider waives the Copay, Annual Deductible or Coinsurance amounts;

11. 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;

12. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - required solely for purposes of career, education, sports or camp, employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

13. private duty nursing received on an inpatient basis;

14. respite care;

15. rest cures;

16. sex transformation operations;

17. speech therapy to treat stuttering, stammering, or other articulation disorders;

18. Spinal Manipulation Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;

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

20. the following treatments for obesity:

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

21. treatment of hyperhidrosis (excessive sweating).

CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.
- Claim Filing Deadline
- Explanation of Benefits (EOB)
- If Your Claim is Denied
- How to Appeal a Denied Claim

Network Benefits

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

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

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-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 and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

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

- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the Provider of the service(s);
- a diagnosis from the Physician;
- the date of service;

- an itemized bill from the Provider that includes:

- the Current Procedural Terminology (CPT) codes;
- a description of, and the charge for, each service;
- the date the Sickness or Injury began; and
- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

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

UnitedHealthcare will pay Benefits to you unless:

- the Provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make a written request for the non-Network Provider to be paid directly at the time you submit your claim.

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

Claim Filing Deadline

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

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

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 **myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call 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 or post-service claim as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

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

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

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

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

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care;
- pre-service; or
- post-service claim.

Review of an Appeal

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; and
- 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.

Voluntary Second-Level Appeal
If, after exhausting the first level of appeal, you are not satisfied with the final determination, you may choose to request a voluntary second-level appeal through Columbia University. This only applies if the claim denial is based on:

- clinical reasons; or
- the exclusions for Experimental or Investigational Services or Unproven Services.

The voluntary second-level appeal is not available if the claim denial is based on explicit benefit exclusions or defined benefit limits.
For request of a voluntary second-level appeal, please call Columbia University Benefits Service Center at (212) 851-7000

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

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

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving notice
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
• if the initial claim is complete, within:	**72 hours**
• after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care claim appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care claim.

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your claim is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
• if the initial claim is complete, within:	**15 days**
• after receiving the completed claim (if the initial claim is incomplete), within:	**15 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

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** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
• 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 the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. 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 claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against 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 our final decision on your appeal or you lose any rights to bring such an action against Columbia University or the Claims Administrator.

MEDICAL CLAIM REVIEW AND APPEALS PROCEDURES

The claim review and appeals procedures followed by Aetna, CIGNA and United Healthcare (UHC) are explained in this section.

Claim Categories There are four categories of medical claims for purposes of insurance claim processing. The type of claim affects the timing for the review and appeal process as explained in this section. The four categories are:

- *Urgent care claim*—An urgent care claim decision is one where, if the insurance company fails to make a determination quickly could seriously jeopardize your life, health or ability to regain maximum function, or in the opinion of your physician, could subject you to severe pain that could not be managed without the requested treatment.

- *Pre-service claim*—A pre-service claim is a claim that is filed prior to obtaining care or treatment.

- *Concurrent claim*—A concurrent claim involves an ongoing course of treatment or number of treatments.

- *Post-service claim*—A post service claim is a claim that is filed after obtaining treatment. (Note: A post-service claim is never an urgent care claim.)

Claim Review

The amount of time it takes to make a decision on a claim will depend on the type of claim.

Type of Claim Timing

Post-service claims (for claims filed after the service has been received)	• Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) • Notice that more information is needed must be given within 30 days • You have 45 days to submit any additional information needed to process the claim*
Pre-service claims (for services requiring precertification of services)	• Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) • Notice that more information is needed must be given within five days • You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	• Decision made within 72 hours • Notice that more information is needed must be given within 24 hours • You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	• Decision made within 24 hours for urgent care treatment • Decision made sufficiently in advance for all other claims

*Time period allowed to make a decision is suspended pending receipt of additional information.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim including the expedited review procedures for urgent care claims;
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure; and
- A description of any internal rules, guidelines or protocols relied upon in arriving at the decision. It should also contain an explanation of any decision based on medical necessity or experimental exclusions.

If you disagree with the decision about your claim, you have the right to appeal. Appeal procedures differ between Aetna, CIGNA and UHC. Refer to the appeal procedures that follow for the medical plan you are enrolled in.

UHC's Appeal Procedures

If your plan is administered by UHC, to appeal the denial of a claim, you must submit a request for an appeal in writing to UHC within 180 days after receiving notice of the denial of your claim. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Mail your appeal to:

United HealthCare Appeals

P.O. Box 740800

Atlanta, GA 30374-0800

If you are unable to write, you may ask UHC to register your appeal by calling the toll-free number on your UHC plan ID card.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the claims administrator provide you, free of charge, copies of all documents, records and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the claims administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision and who is not subordinate to the person involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional who was not involved in the initial decision and who is not subordinate to the person involved in the initial decision.

UHC will respond in writing with a decision within 15 calendar days after receiving an appeal for a preservice or concurrent coverage determination, and within 30 calendar days after receiving an appeal for a post-service coverage determination.

For an urgent care claim, you may request, either orally or in writing, that the appeal process be expedited if:

- The time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services, or

- Your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

UHC, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, all necessary information shall be transmitted between the parties in the most expeditious method, including, but not limited to, by telephone or facsimile, UHC will respond orally with a decision within 72 hours, followed up in writing.

If you are not fully satisfied with UHC's decision, you may request an independent review.

See the section, Voluntary Appeal to the Plan Administrator, that follows.

Unless you request a voluntary appeal to the Plan Administrator, no civil action can be brought challenging the denial of the claim on appeal more than six months following the date on which the written response to your appeal is sent to you.

COORDINATION OF BENEFITS (COB)

What this section includes:

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

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

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

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

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

Determining Which Plan is Primary

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

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an Employee pays benefits before a plan that covers the person as a Dependent;

- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- the parents are married or living together whether or not they have ever been married and not legally separated; or
- a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

- the parent with custody of the child; then
- the Spouse of the parent with custody of the child; then
- the parent not having custody of the child; then
- the Spouse of the parent not having custody of the child;

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

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

Determining Primary and Secondary Plan – Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

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

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

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

Determining the Allowable Expense When This Plan is Secondary

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

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

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

Right to Receive and Release Needed Information

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

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

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, Columbia University may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. Columbia University may have other rights in addition to the right to reduce future Benefits.

SUBROGATION AND REIMBURSEMENT

What this section includes:
- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

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

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

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

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

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

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

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

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid. Subrogation applies when the Plan has paid on your behalf Benefits for a

Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- Columbia University in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:

- underinsured or uninsured motorist insurance;
- medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
- workers' compensation coverage; or
- any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.

- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- the Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- complying with the terms of this section;
- providing any relevant information requested;
- signing and/or delivering documents at its request;
- appearing at medical examinations and legal proceedings, such as depositions or hearings; and
- obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party.
- in case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

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.

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.

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

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

An Alternate Facility may also provide Mental Health or Substance Abuse Treatment Service on an outpatient basis or inpatient basis (for example a residential treatment facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits that are subject to deductible in that calendar year. The Deductible is shown in the first table in Section 5*, Plan Highlights*. (Note: POS 90 Plan has in-network deductible)

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; and
- access to specialized Network facilities and Physicians for obesity surgery services.

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

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

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Columbia University. The CRS program provides:

- specialized consulting services to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating specific forms of cancer – even the most rare and complex conditions; and
- guidance for the patient on the prescribed plan of care and the potential side effects of radiation and chemotherapy.

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 percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Columbia University.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth. (what if it is after 12 months?)

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);

- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

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

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

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

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

Covered Health Services – those health services and supplies that are:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Abuse, or their symptoms;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

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

CRS – see Cancer Resource Services (CRS).

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

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

DME – see Durable Medical Equipment (DME).

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

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

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

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

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

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

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

For:	Eligible Expenses are Based On:
Network Benefits	Contracted rates with the Provider
Non-Network Benefits	• negotiated rates agreed to by the non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.
	• the following: 1. selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area; 2. fee(s) that are negotiated with the Provider; • 70% of the billed charge; or • A fee schedule that the Claims Administrator develops. These provisions do not apply if you receive Covered Health Services from a non-Network Provider in an Emergency. In that case, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

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

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Abuse which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

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

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* 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 – Columbia University.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

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

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

Exceptions:

If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

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; and
- the reason(s) why the service or supply was not covered by the Plan.

Full-time Student – a person who is enrolled in and attending, full-time, a recognized course of study or training at:

- an accredited high school;
- an accredited college or university; or
- a licensed vocational, technical, automotive, or beautician school, or similar training school.

The educational institution determines what constitutes Full-time Student status. You continue to be a Full-time Student during periods of regular vacation established by the institution. You are no longer a Full-time Student as of the last day of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

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

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, Substance Abuse, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

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

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

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

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

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

Intermediate Care – Mental Health or Substance Abuse treatment that encompasses the following:

- care at a Residential Treatment Facility;
- care at a Partial Hospitalization/Day Treatment program; or
- care through an Intensive Outpatient Treatment Program.

Lifetime Maximum Benefit – the most the Plan will pay for Benefits during the entire period you are enrolled in this Plan or any other medical plan offered by Columbia University. The Lifetime Maximum Benefit is shown in the first table in Section 5, *Plan Highlights*.

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.

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 and Substance Abuse (MH/SA) Treatment – treatment for the following:

- any diagnosis which is identified in the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, including a psychological and/or physiological dependence on alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- any diagnosis where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

Mental Health/Substance Abuse (MH/SA) Administrator – the organization or individual designated by Columbia University who provides or arranges Mental Health and Substance Abuse Treatment under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, unless they are listed in Section 8, *Exclusions*.

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 Network; however, this does not include those Providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network Provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network Providers. Refer to Section 5, *Plan Highlights* for details about how non-Network Benefits apply.

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.

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

Personal Health Support – programs provided by UnitedHealthcare 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.

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 Medical Plan.

Plan Administrator – Columbia University or its designee.

Plan Sponsor – Columbia University.

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

Provider – a health care professional or facility operating as required by law.

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

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

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

3. room and board;
4. evaluation and diagnosis;
5. counseling; and
6. referral and orientation to specialized community resources.

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

Retired Employee – an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program Providers and the Shared Savings Program Providers are not Network Providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program Providers will be paid at the non-Network

Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network Providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the Provider, in addition to any required Annual Deductible.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or Substance Abuse, regardless of the cause or origin of the Mental Illness or Substance Abuse.

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, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

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

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.

Spinal Manipulation Treatment – detection or correction, by manual or mechanical means, of bone or joint dislocation(s) (subluxation) in the body to remove nerve interference or its effects. The nerve interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

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

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

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

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

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

7. If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
8. It must be performed by a Physician and in a facility with demonstrated experience and expertise.
9. The Covered Person must consent to the procedure acknowledging that UnitedHealthcare does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
10. At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare to conclude that the service is promising but unproven.
11. The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

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

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