The George Washington University
Choice Plus Medium Medical Plan

Effective: January 1, 2016
Group Number: 730193
TABLE OF CONTENTS

SECTION 1 - WELCOME ................................................................................................................. 1

SECTION 2 - INTRODUCTION ......................................................................................................... 4
  Eligibility ....................................................................................................................................... 4
  Cost of Coverage .......................................................................................................................... 4
  How to Enroll ................................................................................................................................ 5
  When Coverage Begins ............................................................................................................... 5
  Changing Your Coverage............................................................................................................. 6

SECTION 3 - HOW THE PLAN WORKS .......................................................................................... 8
  Accessing Benefits ....................................................................................................................... 8
  Eligible Expenses ....................................................................................................................... 11
  Annual Deductible ..................................................................................................................... 12
  Copayment .................................................................................................................................. 12
  Coinsurance ................................................................................................................................ 13
  Out-of-Pocket Maximum ......................................................................................................... 13

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION ......................... 14
  Care Management ...................................................................................................................... 14
  Prior Authorization.................................................................................................................... 14
  Covered Health Services which require Prior Authorization .............................................. 15
  Special Note Regarding Medicare............................................................................................ 17

SECTION 5 - PLAN HIGHLIGHTS ................................................................................................. 18
  Payment Terms and Features................................................................................................... 18
  Schedule of Benefits .................................................................................................................. 20

SECTION 6 - ADDITIONAL COVERAGE DETAILS ...................................................................... 28
  Ambulance Services................................................................................................................... 28
  Cancer Resource Services (CRS) ............................................................................................. 29
  Clinical Trials .............................................................................................................................. 29
  Congenital Heart Disease (CHD) Surgeries ........................................................................... 32
  Dental Services - Accident Only.............................................................................................. 33
  Diabetes Services ....................................................................................................................... 34
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>35</td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td>36</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>37</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>37</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>38</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>38</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>39</td>
</tr>
<tr>
<td>Kidney Resource Services (KRS)</td>
<td>39</td>
</tr>
<tr>
<td>Lab, X-Ray and Diagnostics - Outpatient</td>
<td>40</td>
</tr>
<tr>
<td>Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine</td>
<td>41</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>41</td>
</tr>
<tr>
<td>Neurobiological Disorders - Autism Spectrum Disorder Services</td>
<td>42</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>43</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>44</td>
</tr>
<tr>
<td>Orthognathic Surgery</td>
<td>44</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>45</td>
</tr>
<tr>
<td>Pharmaceutical Products - Outpatient</td>
<td>45</td>
</tr>
<tr>
<td>Physician Fees for Surgical and Medical Services</td>
<td>45</td>
</tr>
<tr>
<td>Physician's Office Services - Sickness and Injury</td>
<td>45</td>
</tr>
<tr>
<td>Pregnancy - Maternity Services</td>
<td>46</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>47</td>
</tr>
<tr>
<td>Private Duty Nursing - Outpatient</td>
<td>48</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>48</td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td>49</td>
</tr>
<tr>
<td>Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative</td>
<td>50</td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
</tr>
<tr>
<td>Scopnic Procedures - Outpatient Diagnostic and Therapeutic</td>
<td>52</td>
</tr>
<tr>
<td>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td>52</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>54</td>
</tr>
<tr>
<td>Surgery - Outpatient</td>
<td>55</td>
</tr>
<tr>
<td>Temporomandibular Joint (TMJ) Services</td>
<td>55</td>
</tr>
<tr>
<td>Therapeutic Treatments - Outpatient</td>
<td>56</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>57</td>
</tr>
</tbody>
</table>
Travel and Lodging .................................................................................................................... 58
Urgent Care Center Services .................................................................................................... 59
Virtual Visits ............................................................................................................................. 59
Vision Examinations ............................................................................................................... 59
Wigs ......................................................................................................................................... 59

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY ...................................................... 60
Consumer Solutions and Self-Service Tools ........................................................................ 60
Disease and Condition Management Services ..................................................................... 63
Wellness Programs .................................................................................................................. 65

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER ........................................................................................................... 66
Alternative Treatments .......................................................................................................... 66
Dental ....................................................................................................................................... 66
Devices, Appliances and Prosthetics ..................................................................................... 67
Drugs ......................................................................................................................................... 68
Experimental or Investigational or Unproven Services ...................................................... 69
Foot Care ................................................................................................................................. 69
Medical Supplies and Equipment ......................................................................................... 69
Mental Health/Substance Use Disorder .................................................................................. 70
Nutrition .................................................................................................................................... 71
Personal Care, Comfort or Convenience ............................................................................... 72
Physical Appearance .............................................................................................................. 73
Procedures and Treatments ................................................................................................. 73
Providers .................................................................................................................................... 75
Reproduction ............................................................................................................................ 75
Services Provided under Another Plan .................................................................................. 76
Transplants ............................................................................................................................... 76
Types of Care ........................................................................................................................... 76
Vision and Hearing .................................................................................................................. 77
All Other Exclusions .............................................................................................................. 77

SECTION 9 - CLAIMS PROCEDURES ............................................................................................ 79
Network Benefits ..................................................................................................................... 79
Non-Network Benefits ............................................................................................................. 79
If Your Provider Does Not File Your Claim......................................................................... 79
Health Statements ...................................................................................................................... 80
Explanation of Benefits (EOB) ............................................................................................... 81
Claim Denials and Appeals ....................................................................................................... 81
Federal External Review Program ........................................................................................... 82
Limitation of Action .................................................................................................................. 88

SECTION 10 - COORDINATION OF BENEFITS (COB) ......................................................... 90
Determining Which Plan is Primary ....................................................................................... 90
When This Plan is Secondary ............................................................................................... 91
When a Covered Person Qualifies for Medicare ................................................................... 92
Medicare Cross-Over Program ............................................................................................... 93
Right to Receive and Release Needed Information ................................................................ 94
Overpayment and Underpayment of Benefits ....................................................................... 94

SECTION 11 - SUBROGATION AND REIMBURSEMENT ....................................................... 96
Right of Recovery ...................................................................................................................... 99

SECTION 12 - WHEN COVERAGE ENDS ............................................................................ 100
Coverage for a Disabled Child ............................................................................................... 101
Extended Coverage for Total Disability ............................................................................... 101
Continuing Coverage Through COBRA ............................................................................... 102
When COBRA Ends ............................................................................................................... 106
Uniformed Services Employment and Reemployment Rights Act .................................. 106

SECTION 13 - OTHER IMPORTANT INFORMATION .......................................................... 108
Qualified Medical Child Support Orders (QMCSOs) ........................................................ 108
Your Relationship with UnitedHealthcare and The George Washington University ... 108
Relationship with Providers ................................................................................................. 109
Your Relationship with Providers ......................................................................................... 109
Interpretation of Benefits ...................................................................................................... 110
Information and Records ........................................................................................................ 110
Incentives to Providers ........................................................................................................... 111
Incentives to You ..................................................................................................................... 112
Rebates and Other Payments ................................................................................................. 112
Workers' Compensation Not Affected ................................................................................ 112
Future of the Plan .................................................................................................................. 112
Plan Document ...................................................................................................................... 112

SECTION 14 - GLOSSARY ...................................................................................................... 114

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA .................. 128

ATTACHMENT I - HEALTH CARE REFORM NOTICES .................................................... 131
Patient Protection and Affordable Care Act ("PPACA") ..................................................... 131

ATTACHMENT II – LEGAL NOTICES .................................................................................. 132
Women's Health and Cancer Rights Act of 1998 ................................................................. 132
Statement of Rights under the Newborns’ and Mothers’ Health Protection Act .......... 132

ADDENDUM - UNITEDHEALTH ALLIES .......................................................................... 133
Introduction .......................................................................................................................... 133
What is UnitedHealth Allies? ............................................................................................... 133
Selecting a Discounted Product or Service ........................................................................ 133
Visiting Your Selected Health Care Professional ............................................................... 133
Additional UnitedHealth Allies Information ...................................................................... 134

ADDENDUM - PARENTSTEPS® .......................................................................................... 135
Introduction .......................................................................................................................... 135
What is ParentSteps®?........................................................................................................... 135
Registering for ParentSteps® .............................................................................................. 135
Selecting a Contracted Provider .......................................................................................... 135
Visiting Your Selected Health Care Professional ............................................................... 136
Obtaining a Discount ............................................................................................................ 136
Speaking with a Nurse ......................................................................................................... 136
Additional ParentSteps® Information ................................................................................... 136
SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (877) 706-1739;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and

The George Washington 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 George Washington University Welfare Benefit 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; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

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

The George Washington University intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.
UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The George Washington University is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how The George Washington University Welfare Benefit Plan works. If you have questions contact GW Benefits at (571) 553-8382 or call the number on the back of your ID card.
How To Use This SPD

■ Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.

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

■ You can find copies of your SPD and any future amendments at Employer Website or request printed copies by contacting GW Benefits at (571) 553-8382.

■ Capitalized words in the SPD have special meanings and are defined in Section 14, Glossary.

■ If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, Glossary.

■ The George Washington University is also referred to as Group.

■ If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.
SECTION 2 - INTRODUCTION

What this section includes:
■ Who’s eligible for coverage under the Plan;
■ The factors that impact your cost for coverage;
■ Instructions and timeframes for enrolling yourself and your eligible Dependents;
■ When coverage begins; and
■ When you can make coverage changes under the Plan.

Eligibility
You are classified as an eligible if you are:

■ A full-time employee normally working a minimum of 40 hours/week (35 hours for Biostats employees).
■ A part-time employee normally working a minimum of 14 hours/week.

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

■ your Spouse, as defined in Section 14, Glossary (Domestic Partners are included in the definition of Spouse);
■ your or your Spouse’s child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
■ an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

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

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

Cost of Coverage
You and The George Washington University share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.
Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

**Note:** The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of The George Washington University's cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

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

You can obtain current contribution rates by calling GW Benefits at (571) 553-8382 or logging onto Employer Website.

**How to Enroll**

To enroll, call GW Benefits at (571) 553-8382 or log onto Employer Website within 30 calendar days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 calendar days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

**Important**

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact GW Benefits within 30 calendar days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

**When Coverage Begins**

Once GW Benefits receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire, unless you are hired on the 1st of the month, then coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date GW Benefits receives notice of your marriage, provided you notify GW Benefits within 30 calendar days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify GW Benefits within 30 calendar days of the birth, adoption, or placement.
If You Are Hospitalized When Your Coverage Begins

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

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

Changing Your Coverage

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

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact GW Benefits within 60 calendar days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact GW Benefits within 60 calendar days of determination of subsidy eligibility);
■ a strike or lockout involving you or your Spouse; or
■ a court or administrative order.

If you experience a family status change or qualifying life event, you must complete the steps below within 30 calendar days of the event to make changes to your benefit elections.

Changes are effective on the first of the month following completion of the following steps*:

■ Enter your qualified life event online through EasyEnroll (http://benedetails.gwu.edu).
■ Gather supporting documentation of the life event.
■ Send the documentation to the GW Benefits Administration Department.

* Please note: Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you complete the steps above within 30 calendar days of the birth, adoption, or placement.

Unless otherwise noted above, if you wish to change your elections, you must contact GW Benefits within 30 calendar days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

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

**Change in Family Status - Example**

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in The George Washington University's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under The George Washington University's medical plan outside of annual Open Enrollment.
SECTION 3 - HOW THE PLAN WORKS

What this section includes:
■ Accessing Benefits;
■ Eligible Expenses;
■ Annual Deductible;
■ Copayment;
■ Coinsurance; and
■ Out-of-Pocket Maximum.

Accessing Benefits

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

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

You can choose to receive Network Benefits or non-Network Benefits.

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

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

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

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.
You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

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

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

**Health Services from Non-Network Providers Paid as Network Benefits**

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

**Looking for a Network Provider?**

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

**Network Providers**

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

Network providers are independent practitioners and are not employees of The George Washington University or UnitedHealthcare.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the number on your ID card to request a copy.
It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

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

**Designated Facilities and Other Providers**

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

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

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

**Limitations on Selection of Providers**

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

The Plan pays Benefits for Covered Persons while traveling outside the United States. Eligible Expenses for services incurred while outside the United States are reimbursed at the non-Network benefit level and are subject to the Annual Deductible. Emergency services received outside the United States will be paid at the network benefit level subject to the Annual Deductible. If you receive treatment while traveling outside the United States, you will have to pay for the services up-front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, refer to Section 9, *Claims Procedures*. If you have any questions about Benefits while traveling abroad, please call UnitedHealthcare at the toll-free number on your ID card.

**Eligible Expenses**

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

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

**For Network Benefits**, Eligible Expenses are based on the following:

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

- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

**For Non-Network Benefits**, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
- If rates have not been negotiated, then one of the following amounts:

♦ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

♦ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

♦ When a rate is not published by CMS for the service, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

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

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

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**Don't Forget Your ID Card**

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

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**Annual Deductible**

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

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

**Copayment**

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

**Coinsurance**

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

**Coinsurance – Example**

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 85% after you meet the Annual Deductible, you are responsible for paying the other 15%. This 15% is your Coinsurance.

**Out-of-Pocket Maximum**

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

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

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Applies to the Network Out-of-Pocket Maximum?</th>
<th>Applies to the Non-Network Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Payments toward the Annual Deductible</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Charges for non-Covered Health Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>The amounts of any reductions in Benefits you incur by not notifying Personal Health Support</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
■ An overview of the Personal Health Support program; and
■ Covered Health Services which require prior authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. There are some Network Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 6, Additional Coverage Details within each Covered Health Service category.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot
bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

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

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

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

**Covered Health Services which require Prior Authorization**

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator.

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

The services that require prior authorization from the Claims Administrator are:

- ambulance – non-emergent air and ground;
- Clinical Trials;
- Congenital heart disease surgery;
- dental services - accident only;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic Testing – BRCA;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- Lab, x-ray and major diagnostics - CT, PET scans, MRI, MRA and Nuclear Medicine including diagnostic catheterization and electrophysiology implants;

- manipulative treatment as described under Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment in Section 6, Additional Coverage Details;

- maternity care that exceeds the delivery timeframes as described in Section 6, Additional Coverage Details;

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);

- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility);

- obesity surgery;

- outpatient dialysis treatments as described in under Therapeutic Treatments - Outpatient in Section 6, Additional Coverage Details;

- outpatient surgery;

- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;

- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;

- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);

- Surgery - cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, and sleep apnea surgeries and orthognathic surgeries.

- temporomandibular joint services;

- therapeutics - all outpatient therapeutics; and

- transplantation services.

Notification is required within two business days of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For prior authorization timeframes, and any reductions in Benefits that apply if you do not obtain prior authorization from the Claims Administrator or contact Personal Health Support, see Section 6, Additional Coverage Details.

**Contacting Personal Health Support is easy.**

Simply call the toll-free number on your ID card.
Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, Coordination of Benefits (COB). You are not required to obtain authorization before receiving Covered Health Services.
SECTION 5 - PLAN HIGHLIGHTS

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

Payment Terms and Features

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

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Health Services</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>$250</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Physician's Office Services - Primary Physician</td>
<td>$25</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Physician's Office Services - Specialist Physician</td>
<td>$50</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Surgery - Outpatient</td>
<td>$100</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Virtual Visits</td>
<td>$25</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$500</td>
<td>$750</td>
</tr>
<tr>
<td>Individual</td>
<td>$500</td>
<td>$750</td>
</tr>
<tr>
<td>Family (not to exceed the applicable individual amount per Covered Person)</td>
<td>$1,000</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family (not to exceed the applicable individual amount per Covered Person)</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Copays
2. Annual Deductible
3. Annual Out-of-Pocket Maximum
4. Lifetime Maximum Benefit
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 and Urgent Care Center Services, Copay does not apply when you visit a non-Network provider.

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

Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
## Schedule of Benefits

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

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td></td>
</tr>
<tr>
<td>■ Emergency Ambulance</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Non-Emergency Ambulance</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Cancer Resource Services (CRS)²</td>
<td></td>
</tr>
<tr>
<td>■ Hospital Inpatient Stay</td>
<td>85% after you pay a $250 per admission Copay</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Congenital Heart Disease (CHD) Surgeries</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Dental Services - Accident Only</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Diabetes Services</td>
<td></td>
</tr>
<tr>
<td>■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Diabetes Self-Management Items</td>
<td></td>
</tr>
<tr>
<td>■ diabetes equipment</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td>100% after you pay a $150 per visit Copay</td>
</tr>
<tr>
<td>If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>(Up to a single purchase (including repair/replacement per hearing impaired ear every 36 months))</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
</tr>
<tr>
<td>Up to 100 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>85% after you meet the Annual Deductible, or 100% when care is received on an outpatient basis</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>85% after you pay a $250 per admission Copay</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>100% after you pay a $25 per visit Copay; $50 per visit Copay if a Specialist</td>
</tr>
<tr>
<td>■ Physician's Office Services</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>received at a Hospital</td>
<td></td>
</tr>
<tr>
<td>or Alternate Facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See Section 6, <em>Additional Coverage Details</em>, for</td>
</tr>
<tr>
<td></td>
<td>limits.</td>
</tr>
<tr>
<td>Kidney Resource Services (KRS)</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>(These Benefits are for Covered Health Services provided through KRS only)</td>
<td></td>
</tr>
<tr>
<td>Lab, X-Ray and Diagnostics - Outpatient</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Preferred Network (the Preferred Network includes freestanding Facilities and GW Hospital)</td>
<td></td>
</tr>
<tr>
<td>Hospital Based Facilities</td>
<td>65% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Preferred Network (the Preferred Network includes freestanding Facilities and GW Hospital)</td>
<td></td>
</tr>
<tr>
<td>Hospital Based Facilities</td>
<td>65% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>85% after you pay a $250 per admission Copay</td>
</tr>
<tr>
<td>Inpatient</td>
<td>100% after you pay a $25 per visit Copay</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Neurobiological Disorders - Autism Spectrum Disorder Services</td>
<td>85% after you pay a $250 per admission Copay</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $25 per visit Copay</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>100% after you pay a $25 per visit Copay; $50 per visit Copay if a Specialist</td>
</tr>
<tr>
<td>Up to three visits per calendar year for diabetic management</td>
<td></td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>100% after you pay a $25 per visit Copay; $50 per visit Copay if a Specialist</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85% after you pay a $250 per admission Copay</td>
</tr>
<tr>
<td>Orthognathic Surgery</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for orthognathic surgery will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>
## Covered Health Services¹

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td><strong>Pharmaceutical Products - Outpatient</strong></td>
<td>85% after you meet the Annual Deductible When performed in the Physician’s Office setting covered under the Office visit Copay</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Physician’s Office Services - Sickness and Injury</strong></td>
<td>100% after you pay a $25 per visit Copay</td>
</tr>
<tr>
<td>- Primary Physician</td>
<td>100% after you pay a $50 per visit Copay</td>
</tr>
<tr>
<td>- Specialist Physician</td>
<td>100% after you pay a $50 per visit Copay</td>
</tr>
<tr>
<td><strong>Pregnancy – Maternity Services</strong></td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>(For Network Benefits, no Copay applies for prenatal visits after the first visit)</td>
<td></td>
</tr>
<tr>
<td>A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
</tr>
<tr>
<td>- Physician Office Services</td>
<td>100%</td>
</tr>
<tr>
<td>- Lab, X-ray or Other Preventive Tests</td>
<td>100%</td>
</tr>
<tr>
<td>- Mammography</td>
<td>100%</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Breast pumps</td>
<td>100%</td>
</tr>
<tr>
<td>Private Duty Nursing - Outpatient</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Up to 60 visits per calendar year</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>100%</td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment</td>
<td>100% after you pay a $50 per visit Copay</td>
</tr>
<tr>
<td></td>
<td>See Section 6, <em>Additional Coverage Details</em>, for visit limits</td>
</tr>
<tr>
<td>Scopic Procedures - Outpatient Diagnostic and Therapeutic</td>
<td>85% after you meet the Annual Deductible. When performed in the Physician’s Office setting covered under the Office visit Copay.</td>
</tr>
<tr>
<td>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Up to 100 days per calendar year</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>85% after you pay a $250 per admission Copay</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $25 per visit Copay</td>
</tr>
<tr>
<td></td>
<td>Inpatient</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Surgery - Outpatient</td>
<td>85% after you pay a $100 per surgical procedure Copay</td>
</tr>
<tr>
<td>Temporomandibular Joint (TMJ) Services</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Therapeutic Treatments - Outpatient</td>
<td>85% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>85% after you pay a $250 per visit Copay and after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Travel and Lodging (If services rendered by a Designated Facility)</td>
<td>For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>100% after you pay a $50 per visit Copay Lab and X-ray services associated with an Urgent Care visit are paid at 100%, not subject to Annual Deductible and Coinsurance.</td>
</tr>
<tr>
<td>Virtual Visits</td>
<td>100% after you pay a $25 per visit Copay</td>
</tr>
</tbody>
</table>

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td><strong>Vision Examinations</strong></td>
<td>100% after you pay a $25 per visit Copay; $50 per visit Copay if a Specialist</td>
</tr>
<tr>
<td></td>
<td>Up to one exam every 24 months.</td>
</tr>
<tr>
<td><strong>Wigs</strong></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Up to $350 per calendar year.</td>
</tr>
</tbody>
</table>

1In general, your Network provider must obtain prior authorization from the Claims Administrator or Personal Health Support, as described in Section 4, Personal Health Support and Prior Authorization before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization from the Claims Administrator or Personal Health Support. See Section 6, Additional Coverage Details for further information.

2These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab, X-Ray and Diagnostics – Outpatient, and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.
SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

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

This section supplements the second table in Section 5, Plan Highlights.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, Exclusions and Limitations.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, Glossary for the definition of Emergency.

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

The Plan also covers transportation provided by a licensed professional 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.

Prior Authorization Requirement

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization as soon as possible prior to the transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.
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 Section 14, 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 the Claims Administrator or a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or

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

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

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

Clinical Trials

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

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

other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with UnitedHealthcare’s medical and drug policies.

- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and

- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    - ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;

- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or

- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.

**Prior Authorization Requirement**
You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.
Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

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

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

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).
Note: The services described under Travel and Lodging are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only
Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental 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. (You may request an extension of this time period provided that you do so within 60 calendar days of the injury and if extenuating circumstances exist due to the severity of the injury.)

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

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

Dental services for final treatment to repair the damage caused by accidental injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental injury only for:

- emergency examination;
- necessary diagnostic X-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

**Prior Authorization Requirement**

For Network and non-Network Benefits please remember that you must obtain prior authorization from the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain authorization before the initial Emergency treatment.)

For Non-Network Benefits, if you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

**Diabetes Services**

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

<table>
<thead>
<tr>
<th>Covered Diabetes Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</strong></td>
</tr>
<tr>
<td><strong>Diabetic Self-Management Items</strong></td>
</tr>
<tr>
<td>blood glucose monitors;</td>
</tr>
<tr>
<td>insulin syringes with needles;</td>
</tr>
<tr>
<td>blood glucose and urine test strips;</td>
</tr>
<tr>
<td>ketone test strips and tablets; and</td>
</tr>
<tr>
<td>lancets and lancet devices.</td>
</tr>
</tbody>
</table>
Covered Diabetes Services

| Insulin pumps and Glucometers are subject to all the conditions of coverage stated under Durable Medical Equipment in this section. |

Prior Authorization Requirement

Please remember for Non-Network Benefits, you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor the Claims Administrator identifies. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under Diabetes Services in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy and Surgery – Outpatient in this section (Note: this is only covered for Network Benefits only. Non-Network services are not covered);

- braces that stabilize an injured body part, including orthotic shoes and necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and

- equipment for the treatment of chronic or acute respiratory failure or conditions.

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Benefits are provided for custom foot orthoses. Custom foot orthoses are only covered as follows:

- for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);

- when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace.

  Shoe inserts, arch supports and/or shoes (standard or custom), lifts and wedges are included under this benefit.

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

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

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

**Prior Authorization Requirement**

Please remember for Non-Network Benefits, you must obtain prior authorization if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor the Claims Administrator identifies. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

**Emergency Health Services - Outpatient**

The Plan’s Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.
If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Hospital will apply instead.

**Hearing Aids**

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

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

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

Any combination of Network Benefits and Non-Network Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 36 months.

**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 Care schedule when Skilled Care is required. Refer to Section 14, Glossary for the definition of Skilled Care.

The Claims Administrator 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 100 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.
Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before receiving services or as soon as reasonably possible. If you fail to obtain authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before receiving services. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay
Hospital Benefits are available for:

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

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under Physician Fees for Surgical and Medical Services.

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

Prior Authorization Requirement
Please remember for Non-Network Benefits for:
- for elective admissions: obtain prior authorization five business days before admission or as soon as reasonably possible;
- a non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses. In addition you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

**Infertility Services**

The Plan pays Benefits for the treatment of infertility for:

- ovulation induction;
- insemination procedures (Artificial Insemination (AI) and IntraUterine Insemination (IUI));
- in vitro fertilization (IVF);
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only; and
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must:

- have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35;
- be under age 44, if female; and
- have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

Network Benefits for infertility services are limited to $30,000 per Covered Person during the entire period you are covered under the Plan.

Only charges for the following apply toward the infertility lifetime maximum:

- surgeon;
- assistant surgeon;
- anesthesia;
- lab tests; and
- specific injections.

**Kidney Resource Services (KRS)**

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary*.
In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by the Claims Administrator or Personal Health Support; or
- call KRS toll-free at (866) 561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

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

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

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 or in a Physician’s office include, but are not limited to:

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

Benefits under this section include:

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

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

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

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

Benefits under this section include:

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

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received including cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Mental Health Services
Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
Intensive Outpatient Treatment.

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

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

**Special Mental Health Programs and Services**

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

**Prior Authorization Requirement**

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

**Neurobiological Disorders - Autism Spectrum Disorder Services**

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

**Prior Authorization Requirement**

For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

**Nutritional Counseling**

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional 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.

Some examples of such medical conditions include but are not limited to:

- coronary artery disease;
- congestive heart failure;
■ severe obstructive airway disease;
■ gout (a form of arthritis);
■ renal failure;
■ phenylketonuria (a genetic disorder diagnosed at infancy); and
■ hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to three visits per calendar year for diabetic management. This limit applies to non-preventive nutritional counseling services only.

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

**Obesity Surgery**

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

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

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

■ the surgery is performed at a Network Hospital by a Network surgeon even if there are no Network Hospitals near you.

Benefits are limited to $60,000 during the entire period you are covered under the Plan.

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

**Orthognathic Surgery**

The following are eligible for coverage as reconstructive:

■ acute traumatic injury, and post-surgical sequela;
■ cancerous or non-cancerous tumors and cysts, cancer and cancer sequela.

The following are eligible for coverage when documentation requirements are met (see below):

■ obstructive sleep apnea;
■ cleft lip/palate (for cleft lip/palate related jaw surgery);
congenital anomalies that meet the criteria for reconstructive. Depending on a patient-specific clinical review, examples might include: midface hypoplasia, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome.

- dislocation of the jaw (whether due to blunt force trauma or any other cause including yawning, eating, etc.). Please note that closed treatment of dislocation of the jaw may be done instead of an open cutting jaw surgery.

**Ostomy Supplies**

Benefits for ostomy supplies are limited to:

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

**Pharmaceutical Products - Outpatient**

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

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

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

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

**Physician Fees for Surgical and Medical Services**

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

**Physician's Office Services - Sickness and Injury**

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

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

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

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

**Prior Authorization Requirement**
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Genetic Testing, including BRCA Genetic Testing. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

**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.

### Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

### Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, Resources to Help you Stay Healthy, for details.

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

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

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
breast cancer screening and genetic testing;
- tests to support cardiovascular health;
- annual HIV counseling and screening for sexually active Covered Persons;
- annual interpersonal and domestic violence screening and counseling; and
- annual counseling on sexually transmitted infections for sexually active Covered Persons.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

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

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

- which pump is the most cost effective;
- whether the pump should be purchased or rented;
- duration of a rental; and
- timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

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 60 visits per Covered Person per calendar year.

**Prosthetic Devices**

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:
artificial arms, legs, feet and hands;

■ artificial face, eyes, ears and nose; and

■ breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998,
  Benefits include mastectomy bras and lymphedema stockings for the arm.

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

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

Benefits are available for repairs and replacement, except that:

■ there are no Benefits for repairs due to misuse, malicious damage or gross neglect; and

■ there are no Benefits for replacement due to misuse, malicious damage, gross neglect or
  for lost or stolen prosthetic devices.

Covered Health Services includes cranial band treatment including surgery that is elective in
nature. Cranial bands are covered without restrictions.

**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 Section 14, Glossary.

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

Prior Authorization Requirement
For Non-Network Benefits for:

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

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

In addition, you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).

Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment
The Plan provides short-term outpatient rehabilitation services (including habilitative services):

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- vision therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.
For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

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

**Habilitative Services**

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

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

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

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

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

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

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

Any combination of Network and Non-Network Benefits are limited to:

- 60 visits per calendar year for physical, occupational and speech therapy combined;
- 20 visits per calendar year for pulmonary rehabilitation therapy;
- 36 visits per calendar year for cardiac rehabilitation therapy;
- 60 visits per calendar year for Manipulative Treatment; and

**Prior Authorization Requirement**

Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before receiving Manipulative Treatment or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

**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.

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

**Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

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

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

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

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

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

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

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital; 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 all of the following are true:

- it must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including 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. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

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

Any combination of Network Benefits and Non-Network Benefits is limited to 100 days per calendar year.
Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission or as soon as reasonably possible.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification within two business days or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

In addition, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Substance Use Disorder Services
Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider’s office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

Special Substance Use Disorder Programs and Services
Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use
Disorder Services Benefit. The Substance Use Disorder 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 your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

### Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

### 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 certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

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

### Prior Authorization Requirement
For Non-Network Benefits for diagnostic cardiac cauterization, electrophysiology implant and sleep apnea surgeries and orthognathic surgeries you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within two business days or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

### Temporomandibular Joint (TMJ) Services
The Plan covers Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.
Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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

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

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include U.S. Food and Drug Administration (FDA)-approved TMJ implants only when all other treatment has failed.

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

Prior Authorization Requirement
Please remember for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition you must contact the Claims Administrator before admission for scheduled admission or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions).

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.

Benefits under this section include:

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

**Prior Authorization Requirement**
Please remember for Non-Network Benefits, for all outpatient therapeutic treatments, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

**Transplantation Services**

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

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

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

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

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received at a Designated Facility.

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

**Prior Authorization Requirement**
Please remember that you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. If the services are not performed at a Designated Facility, no Benefits will be paid and you will be responsible for paying all charges.

**Support in the event of serious illness**
If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.
Travel and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements related to:

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

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

Travel and Lodging Expenses

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 Section 14, Glossary. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under Physician's Office Services - Sickness and Injury earlier in this section.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

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

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

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Vision Examinations

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment); and
- one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every 24 months.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair that is the result of a medical diagnosis or condition such as alopecia or as a result of chemotherapy treatment.

Any combination of Network Benefits and Non-Network Benefits is limited to one wig per calendar year up to $350.
SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:
- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

The George Washington University believes in giving you the tools you need to be an educated health care consumer. To that end, The George Washington 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 The George Washington University are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

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

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

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

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

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

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

NurseLine is available to you at no cost.

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

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**Your child is running a fever and it's 1:00 AM. What do you do?**

Call NurseLine toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine to help answer your health questions.

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

**Note:** If you have a medical emergency, call 911 instead of logging onto [www.myuhc.com](http://www.myuhc.com).

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**Reminder Programs**

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

- mammograms for women between the ages of 51 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.
Treatment Decision Support
In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

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

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

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

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

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

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

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

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

Visit www.myuhc.com and:

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

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

**Disease and Condition Management Services**

**Diabetes Prevention and Control**
UnitedHealthcare provides two programs that identify, assess, and support members over the age of 18 living with diabetes or pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes and assist members living with diabetes in controlling their condition and from developing complications.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.
The Diabetes Control Program (DCP) is available to members living with diabetes and offers face-to-face consultations with trained local pharmacists who will review diabetes history and medication, provide diabetes management education materials and assist individuals living with diabetes with managing their condition. The goal of this program is to reduce the risk of serious health complications through medication management and ongoing monitoring for complications.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP or DCP programs. If you think you may be eligible to participate or would like additional information regarding the programs, please call the DPCA call center directly at 1-888-688-4019.

**Disease Management Services**

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

These programs offer:

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

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

**HealtheNotesSM**

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, Glossary under the definition of Covered Health Services.

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

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

Wellness Programs

Healthy Pregnancy Program

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

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

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

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.
SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, Additional Coverage Details.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 6, Additional Coverage Details, those limits are stated in the corresponding Covered Health Service category in Section 5, Plan Highlights. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, Plan Highlights. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not 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. acupuncture, except when used as anesthesia;
3. aromatherapy;
4. hypnotism;
5. massage therapy;
6. Rolfing (holistic tissue massage); and
7. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, Additional Coverage Details.

Dental

1. dental care, except as identified under Dental Services - Accident Only in Section 6, Additional Coverage Details,
Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

- extractions (including wisdom teeth);
- restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; and
- services to improve dental clinical outcomes.

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

3. dental implants, bone grafts, and other implant-related procedures;

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

4. dental braces (orthodontics);

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

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, Additional Coverage Details.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

**Devices, Appliances and Prosthetics**

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME) in Section 6, Additional Coverage Details:

Examples of excluded orthotic appliances and devices include but are not limited to, any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease, or foot orthotics.

3. the following items are excluded, even if prescribed by a Physician:
- blood pressure cuff/monitor;
- enuresis alarm;
- non-wearable external defibrillator;
- trusses; and
- ultrasonic nebulizers.

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 6, Additional Coverage Details; and

7. oral appliances for snoring.

**Drugs**

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

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

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

5. over the counter drugs and treatments;

6. certain specialty medications ordered by a Physician through CVS Caremark;

7. new Pharmaceutical Products and/or new dosage forms until the date they are reviewed;

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

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

10. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
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 Section 14, 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.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details. Routine foot care services that are not covered include:

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

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

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

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

3. treatment of flat feet.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies (except for elastic stockings). Examples of supplies that are not covered include, but are not limited to ace bandages, diabetic strips and syringes.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Section 6, Additional Coverage Details;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details; or
- diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

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

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 8, Exclusions and Limitations, the listed exclusions directly below apply to services described under Mental Health Services, Neurobiological Disorder - Autism Spectrum Disorder Services and/or Substance Use Disorder Services in Section 6, Additional Coverage Details.

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

2. Health services or supplies that do not meet the definition of a Covered Health Service - see the definition in Section 10, Glossary. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which UnitedHealthcare determines to be all of the following:

   - Medically Necessary;
   - described as a Covered Health Service in this Plan under Section 5, Plan Highlights and Section 6, Additional Coverage Details; and
   - not otherwise excluded in this Plan under Section 8, Exclusions and Limitations.

3. Mental Health Services as treatments for R, T and Z code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

4. Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep-wake disorders, feeding disorders, binge eating disorders, sexual dysfunctions, communication disorders, motor disorders, neurological disorders and other disorders with a known physical basis;

5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;

8. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

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

10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

12. gambling disorders;

13. substance-induced sexual dysfunction disorders and substance-induced sleep disorders; and

14. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

**Nutrition**

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

2. Individual and group nutritional counseling. This exclusion does not apply to nutritional counseling services that are billed as *Preventive Care Services* or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - nutritional 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.

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 majority of or unless they are specifically created to treat inborn errors of metabolism or metabolic diseases such as phenylketonuria (PKU), gastro esophageal reflux disease. 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 education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

**Personal Care, Comfort or Convenience**

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps (this exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement);
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - electric scooters;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).
Physical Appearance
1. Cosmetic Procedures, as defined in Section 14, Glossary, are excluded from coverage. Examples include:
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, 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. treatment of benign gynecomastia (abnormal breast enlargement in males); and
5. wigs except as specifically as described under Wigs in Section 6, Additional Coverage Details.

Procedures and Treatments
1. biofeedback;
2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);
3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment;
4. speech therapy to treat stuttering, stammering, or other articulation disorders;
5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism
Spectrum Disorders as identified under *Rehabilitation and Habilitative Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

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

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

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

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

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

13. sex transformation operations;

14. 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*.

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation of the jaw (whether due to blunt force trauma or any other cause including yawning, eating, etc.), post-surgical sequela, cancerous or non-cancerous tumors and cysts, cancer and cancer sequela. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea; cleft lip/palate (for cleft lip/palate related jaw surgery), Congenital anomalies that meet the criteria for reconstructive. Depending on a patient-specific clinical review, examples might include: midface hypoplasia, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome;
18. breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 6, Additional Coverage Details; and

19. outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.

Providers

Services:

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

2. a provider may perform on himself or herself;

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

4. ordered or delivered by a Christian Science practitioner;

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

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

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

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
   - prior to ordering the service; or
   - after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. the following infertility treatment-related services:
   - cryo-preservation and other forms of preservation of reproductive materials;
   - long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue;
   - Assisted Reproductive Technologies (ART), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) (in-vitro and artificial insemination are covered); and
   - donor services.

2. surrogate parenting, donor eggs, donor sperm and host uterus;
3. the reversal of voluntary sterilization;

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

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

6. parenting, pre-natal or birthing classes.

**Services Provided under Another Plan**

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

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

3. while on active military duty; 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 Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

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);

3. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and

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

**Types of Care**

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

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

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in Section 6, Additional Coverage Details;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

**Vision and Hearing**

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

2. purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. bone anchored hearing aids except when either of the following applies:
   - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

**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; or
   - record processing.

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

4. 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.

5. 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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan; 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.

6. foreign language and sign language services;

7. long term (more than 30 calendar days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - required solely for purposes of education, sports or camp, career or employment, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
   - related to judicial or administrative proceedings or orders; or
   - required to obtain or maintain a license of any type.

9. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

10. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
    - Medically Necessary;
    - described as a Covered Health Service in this SPD under Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights*; and
    - not otherwise excluded in this SPD under this Section 8, *Exclusions and Limitations.*
SECTION 9 - 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.

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 your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and 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 www.myuhc.com, calling the toll-free number on your ID card or contacting GW 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:
  - 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.

The above information should be filed with UnitedHealthcare at the address on your ID card.

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

When you assign your Benefits under the Plan to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, The George Washington University reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes The George Washington University pursuant to Refund of Overpayments in Section 10 Coordination of Benefits.

UnitedHealthcare will pay Benefits to you unless:

- the provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; and
- 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 purports to have assigned Benefits to that third party.

**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](http://www.myuhc.com). You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.
Explanation of Benefits (EOB)
You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 14, Glossary for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 15 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 15-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

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

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

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

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

UnitedHealthcare - Appeals
PO Box 30432
Salt Lake City, UT 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.
Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent 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.

Filing a Second Appeal
Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 calendar days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 calendar days after receiving the completed appeal for a pre-service denial and 30 calendar days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

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

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

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

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

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

**Standard External Review**

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

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

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

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

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

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

**Expedited External Review**

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

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

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

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

■ Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.

■ Has provided all the information and forms required so that UnitedHealthcare may process the request.

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

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

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

**Timing of Appeals Determinations**

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

■ Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services;

■ Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided; and
Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

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

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

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

### Urgent Care Request for Benefits

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

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

### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:</td>
<td>5 calendar days</td>
</tr>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>15 calendar days</td>
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</tbody>
</table>
### Pre-Service Request for Benefits

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

### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 calendar days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial claim is complete, within:</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>■ after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 calendar days after receiving the adverse benefit determination</td>
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<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 calendar days after receiving the first level appeal</td>
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<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 calendar days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>30 calendar days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

### Concurrent Care Claims

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

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

### Limitation of Action

You cannot bring any legal action against The George Washington University or the Claims Administrator to recover reimbursement until 90 calendar days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against The George Washington 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 The George Washington University or the Claims Administrator.

You cannot bring any legal action against The George Washington University or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against The George Washington University or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you
lose any rights to bring such an action against The George Washington University or the Claims Administrator.
SECTION 10 - 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 www.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; 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 allowable expense;
■ the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of 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.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is 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 do not elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

■ employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare);

■ individuals with end-stage renal disease, for a limited period of time; and

■ disabled individuals under age 65 with current employment status and their Dependents under age 65.
**Determining Your Benefit When the Plan is Secondary to Medicare**

When the Plan is secondary to Medicare, your Benefit will be determined as follows:

If you are participating in Medicare:

- If you are participating in Medicare and you go to a provider that accepts Medicare, the allowable expense will be the Medicare approved amount.

- Some providers do not participate in the Medicare program. A provider who does not participate in Medicare may still agree to take a payment from Medicare. If you go to such a provider, i.e., one who does not participate in Medicare but still agrees to take a payment from Medicare, the allowable expense will be the Medicare limiting charge. The limiting charge means the highest amount Medicare will pay a provider that does not participate in Medicare.

- Some providers choose to opt-out of Medicare. This means that the provider is not allowed to bill Medicare. If you go to a provider that opts out of Medicare, the allowable expense will be the Medicare approved amount as determined by UnitedHealthcare. UnitedHealthcare may treat the provider’s billed charges as the allowable expense for Medicare when estimating the Medicare approved amount. Any determinations by UnitedHealthcare will be final, binding, and not subject to review.

If you are Medicare eligible but do not participate in Medicare:

If you are Medicare eligible but do not participate in Medicare, your benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. Thus, the allowable expense under the Plan will be the Medicare approved amount as determined by UnitedHealthcare. UnitedHealthcare may treat the provider’s billed charges as the allowable expense for Medicare when estimating the Medicare approved amount. Any determinations by UnitedHealthcare will be final, binding, and not subject to review.

Medicare payments combined with your benefit under the Plan will not exceed 100% of the allowable expense. **You will be responsible for any charges in excess of the allowable expense.**

**Medicare Cross-Over Program**

The Plan offers a Medicare Cross-over Program for Medicare Part A claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

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

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.
You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

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

**Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare 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.

UnitedHealthcare 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 Group may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Group 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, from the provider pursuant to *Refund of Overpayments*, below.

**Refund of Overpayments**

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

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

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan 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 owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund, or if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.
SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

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

**Subrogation – Example**

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

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

**Reimbursement – Example**

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

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers’ compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.
You agree as follows:

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

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

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, 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 and no amount of associated costs, including attorneys’ fees, shall be deducted from the Plan’s recovery without the Plan’s express written consent. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any “Made-
"Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan’s subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those 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.

- The Plan’s rights to recovery will not be reduced due to your own negligence.

- Upon the Plan’s request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

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

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

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

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

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

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- The Plan and all Administrators administering the terms and conditions of the Plan’s subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan’s subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.
Right of Recovery
The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

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

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

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

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

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

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.
SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

■ Circumstances that cause coverage to end;
■ Extended coverage; and
■ How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under Extended Coverage for Total Disability below.

When your coverage ends, The George Washington 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. Please note that this does not affect coverage that is extended under Extended Coverage for Total Disability below.

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

■ the last day of the month your employment with the Group ends;
■ the date the Plan ends;
■ the last day of the month you stop making the required contributions;
■ the last day of the month you are no longer eligible;
■ the last day of the month UnitedHealthcare receives written notice from The George Washington University to end your coverage, or the date requested in the notice, if later; or
■ the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

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

■ the date your coverage ends;
■ the last day of the month you stop making the required contributions;
■ the last day of the month UnitedHealthcare receives written notice from The George Washington University to end your coverage, or the date requested in the notice, if later; or
■ the last day of the month your Dependents no longer qualify as Dependents under this Plan.
Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent:

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

Coverage for a Disabled Child

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

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to The George Washington University proof of the child's incapacity and dependency within 30 calendar days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon The George Washington University's request, that the child continues to meet these conditions.

The proof might include medical examinations at The George Washington University's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 30 calendar days, the Plan will no longer pay Benefits for that child.

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

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- as determined by the Group.
Continuing Coverage Through COBRA

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

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

<table>
<thead>
<tr>
<th>If Coverage Ends Because of the Following Qualifying Events:</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td>Your work hours are reduced</td>
<td>18 months</td>
</tr>
<tr>
<td>Your employment terminates for any reason (other than gross misconduct)</td>
<td>18 months</td>
</tr>
<tr>
<td>You or your family member become eligible for Social Security disability benefits at any time within the first 60 calendar days of losing coverage¹</td>
<td>29 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
</tbody>
</table>
If Coverage Ends Because of the Following Qualifying Events:

<table>
<thead>
<tr>
<th>Event</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You divorce (or legally separate)</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>The George Washington University files for bankruptcy under Title 11, United States Code.</td>
<td>36 months</td>
</tr>
</tbody>
</table>

You May Elect COBRA:

- For Yourself
- For Your Spouse
- For Your Child(ren)

1. Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 calendar 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 calendar days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 calendar 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.

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

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

**Getting Started**

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

You will have up to 60 calendar days from the date you receive notification or 60 calendar days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 calendar 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 calendar 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 calendar 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 calendar 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 GW Benefits with notice of the Social Security Administration's determination within 60 calendar 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-calendar 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 calendar 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
When COBRA Ends

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

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

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

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 calendar 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 calendar 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.
SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:
- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and The George Washington University;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

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

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

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

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

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

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

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

**Relationship with Providers**

The relationships between The George Washington University, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not The George Washington University's agents or employees, nor are they agents or employees of UnitedHealthcare. The George Washington University and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

The George Washington University and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, The George Washington University and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not The George Washington University's employees nor are they employees of UnitedHealthcare. The George Washington University and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. The George Washington University and UnitedHealthcare are not liable for any act or omission of any provider.

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

The George Washington University is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

**Your Relationship with Providers**

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

- are responsible for choosing your own provider;
are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;

are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;

must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and

must decide with your provider what care you should receive.

**Interpretation of Benefits**

The George Washington University and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

The George Washington University and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

**Information and Records**

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

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

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

For complete listings of your medical records or billing statements The George Washington University recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, The George Washington University and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare’s designees have the same rights to this information as does the Plan Administrator.

**Incentives to Providers**

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

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or

- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

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

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

Rebates and Other Payments

The George Washington University and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The George Washington University and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

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

The Group's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Group does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

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

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

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular
business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.
SECTION 14 - GLOSSARY

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

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

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

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 Services or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

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

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, Plan Highlights.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

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 The George Washington University. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

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

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

Coinsurance – the charge, stated as a percentage of Eligible Expenses that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works.

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

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

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; 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.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.
Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary;
- described as a Covered Health Service in this SPD under Section 5, Plan Highlights and 6, Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 2, Introduction; and
- not otherwise excluded in this SPD under Section 8, Exclusions and Limitations.

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);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under Eligibility in Section 2, Introduction. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

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

Designated Physician - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.
Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Employee has established a Domestic Partnership.

Domestic Partnership - a relationship between an Employee and one other person of the same or opposite sex. All of the following requirements apply to both persons:

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

The Employee and Domestic Partner must jointly sign an affidavit of domestic partnership provided by GW Benefits upon your request.

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

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

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

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, How the Plan Works.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy
guidelines, in UnitedHealthcare’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

■ As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).

■ As reported by generally recognized professionals or publications.

■ As used for Medicare.

■ As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, which is both of the following:

■ 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.


EOB – see Explanation of Benefits (EOB).


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

■ not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not 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 I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 6, Additional Coverage Details; and

- If you are not a participant in a qualifying Clinical Trial as described under Section 6, Additional Coverage Details, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

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


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

Home Health Agency – a program or organization authorized by law to provide health care services in the home.
Hospital – an institution, operated as required by law and that meets both of the following:

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

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

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

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

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

Intensive Outpatient Treatment – a structured outpatient mental health or substance-related and addictive disorders 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.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 calendar days or less.

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

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by The George Washington University. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.
Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

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

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

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

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

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical
Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

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

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

**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** - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, Plan Highlights to determine whether or not your Benefit plan offers Network Benefits and Section 3, How the Plan Works, for details about how Network Benefits apply.

**Non-Network Benefits** - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, Plan Highlights to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, How the Plan Works, for details about how Non-Network Benefits apply.

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

**Out-of-Pocket Maximum** – for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, Plan Highlights for the Out-of-Pocket Maximum amount. See Section 3, How the Plan Works for a description of how the Out-of-Pocket Maximum works.
Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

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

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

Pharmaceutical Product(s) – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider’s license, and not otherwise excluded under the Plan.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

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


Plan Administrator – The George Washington University or its designee.


Pregnancy - includes all of the following:

- prenatal care;
- postnatal care;
- childbirth; and
- any complications associated with the above.

Pre-implantation Genetic Diagnosis (PGD) – a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine
Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

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

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

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

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

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

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

Shared Savings Program - the Shared Savings Program provides access to discounts from 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 includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

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

**Specialist Physician** - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

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

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.
Total Disability or Totally Disabled – an Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and gender.

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

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or

- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

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 its 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.
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.
SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, Glossary. While you may not need this information for your day-to-day participation, it is information you may find important.

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

Plan Administrator – Medical Plan
Plan Administration Committee
The George Washington University
45155 Research Place, Suite 160
Ashburn, VA 20147
(571) 553-8382

Claims Administrator
UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Group. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

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:

Mary Lynn Reed, Esq.
The George Washington University
Office of the Senior Vice President and General Counsel
2100 Pennsylvania Ave., N.W., Suite 250
Washington, DC 20052
Legal process may also be served on the Plan Administrator.

**Other Administrative Information**
This section of your SPD contains information about how the Plan is administered as required by ERISA.

**Type of Administration**
The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

<table>
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<td>Employee and Group</td>
</tr>
<tr>
<td>Source of Benefits:</td>
<td>Assets of the Group</td>
</tr>
</tbody>
</table>

**Your ERISA Rights**
As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are...
called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, Claims Procedures, for details.

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

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by The George Washington University, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and The George Washington University are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare and The George Washington University are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.
ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

*Patient Protection Notices*

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.
ATTACHMENT II – LEGAL NOTICES

Women’s Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

■ All stages of reconstruction of the breast on which the mastectomy was performed;
■ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
■ Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns’ and Mothers’ Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.
ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, Glossary in the SPD.

Important

UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, Plan Highlights) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, Glossary.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at www.healthallies.com or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important

You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) calendar days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.
Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at www.healthallies.com or by calling the toll-free phone number on the back of your ID card.
ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps® program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, Glossary in the SPD.

Important

ParentSteps® is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps® will collect the provider payment from you online via the ParentSteps® website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description Section 5, Plan Highlights) when a benefit is available.

What is ParentSteps®?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, Glossary.

Registering for ParentSteps®

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps® toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps® facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see
the specific rates negotiated by ParentSteps® with each provider for select types of infertility treatment in order to make an informed decision.

**Visiting Your Selected Health Care Professional**

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps® member. ParentSteps® will validate your choice and send a validation email to you and the clinic.

**Obtaining a Discount**

If you and your provider choose a treatment in which ParentSteps® discounts apply, the provider will enter in your proposed course of treatment. ParentSteps® will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps® website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps® will notify your provider with a statement saying that treatments may begin.

**Speaking with a Nurse**

Once you have successfully registered for the ParentSteps® program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps® nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps® nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

**Additional ParentSteps® Information**

Additional information on the ParentSteps® program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).