

BENEFIT PLAN

**Prepared Exclusively for
University of Chicago Medical Center
Employees**

University of Chicago Health Plan

**What Your Plan
Covers and How
Benefits are Paid**



**University of Chicago Health Plan
(applicable to UCMC Employees)**

Booklet

Prepared exclusively for:

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Third Party Administrative Services provided by Aetna Life Insurance Company

Welcome

Thank you for choosing **the University of Chicago Health Plan (UCHP) administered by AETNA.**

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer's self-funded health benefit plan for in-network coverage.

This booklet will tell you about your **covered benefits** – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

Each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer's self-funded health benefit plan for in-network coverage.

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Schedule of benefits

Issued with your booklet-

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean **Aetna** when we are describing administrative services provided by **Aetna** as Third Party Administrator for UCHP.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**.

What your plan does – covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network coverage for medical and pharmacy benefits. This plan provides coverage for hearing.

What your plan doesn't do – exclusions

Your plan does not pay for benefits that are not covered under the terms of the plan. These are Exclusions and are described more in greater detail later in the document.

Many health care services and supplies are eligible for coverage under your plan in the *Eligible health services under your plan* section. However, some of those health care services and supplies have exclusions. For example, **physician care** is an eligible health service, but **physician care** for cosmetic surgery is never covered. This is an example of an exclusion.

The *What your plan doesn't cover - some eligible health service exclusions* section of this document also provides additional information.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- Generally will pay only when you get care from **providers** in our UCHP network of doctors, **hospitals**, and other **providers**.
- There is no coverage when you use a **network provider unless authorized by the plan**.

1. Eligible health services

Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

So what are **eligible health services**? They are health care services that meet these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *plan doesn't cover – some eligible health service exclusions* section. (We refer to this section as the "exclusions" section.)
- They are not beyond any limits in the schedule of benefits.

2. Providers

UCHP's network of doctors, **hospitals** and other health care **providers** are there to give you the care you need. You can find **network UCHP providers** (PCP's only) and see important information about them most easily on the UCHP online **provider directory**. Just log into your Aetna Navigator® secure member website at www.aetna.com or <http://www.aetna.com/dse/custom/uchp>.

You choose a UCHP **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other UCHP **providers** when you need specialized care. You have to access care through your **PCP**. You may not go directly to UCHP network **specialists** and **providers** for **eligible health services**. Your **PCP** will provide you with an order to a participating UCHP **specialist**, so choose a **PCP** as soon as you can.

For more information about the network and the role of your **PCP**, see the *Who provides the care* section.

3. Service area

UCHP generally pays for **eligible health services** only within a specific geographic area, called a **service area**. There are some exceptions, such as for **emergency services** and urgent care. See the *Who provides the care* section.

4. Paying for eligible health services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**, and
- You get your care from:
 - Your **PCP**, or
 - Another **network provider** after you get an order (also can be referred to as a script) from your **PCP**, and
- Your provider **pre-certifies** the **eligible health service** when required.

You will find details on **medical necessity**, **physician order** and **precertification** requirements in the *Medical necessity, physician order and precertification requirements* section. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

5. Disagreements

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an “external review organization” or ERO for short will make the final decision for us.

For more information see the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. You can contact us by logging onto your Aetna Navigator® secure member website at www.aetna.com.

Register for Aetna Navigator®, our secure internet access to reliable health information, tools and resources. Aetna Navigator® online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

- Calling **Aetna** UCHP Member Services at the toll-free number on your ID card
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT06156

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your Aetna Navigator® secure member website at www.aetna.com.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

Your Employer decides and tells us who is eligible for health care coverage. **Please contact your Employer for complete eligibility and coverage requirements.**

When you can join the plan

As an employee you can enroll yourself and your dependents if you live or work in the UCHP **service area**:

- Once each Plan Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are referred to in this booklet as your “dependents”.)

- Your spouse, same-gender domestic partner (Registered with your Employer on or before December 31, 2016 and remain enrolled in the Plan without interruption) or Civil Union Partner (CU Partner) as defined under Illinois law
- Your dependent children – your own or those of your spouse, domestic partner (Registered with your Employer on or before December 31, 2016 and remain enrolled in the Plan without interruption), or CU Partner
 - The children must be under 26 years of age, and they include:
 - Your natural children
 - Your stepchildren
 - Your legally adopted children
 - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you)
 - Returning military dependents who are age 30 or younger and are not married

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year within 31-days of the qualified life event:

- A spouse, domestic partner (registered with your Employer on or before December 31, 2016 and remain enrolled in the Plan without interruption) or CU Partner - If you marry or enter into an Civil Union, you can add your spouse or CU Partner to your plan.
 - Your Employer must receive your completed enrollment information not more than 31 days after the date of marriage/partnership.
- A newborn child - Newborns are covered for their entire newborn confinement until discharged. The newborn will be covered from birth, until discharge, regardless of how long the confinement lasts.
 - **To keep your newborn covered, your Employer must receive your completed enrollment information within 31 days of birth.**
 - You must still enroll your newborn within 31 days of birth even when coverage will not change your current family tier (does not require payment of an additional contribution)

- for the covered dependent)
- **If you miss this deadline, your newborn will not have health benefits after the first 31 days until the beginning of the next plan year (after the next annual open enrollment period).**
- An adopted child - A child that you, or that you and your spouse, domestic partner or CU Partner adopts is covered on your plan for the first 31 days after the adoption is complete.
 - To keep your adopted child covered, your Employer must receive your completed enrollment information within 31 days after the adoption.
 - **If you miss this deadline, your adopted child will not have health benefits after the first 31 days until the beginning of the next plan year (after the next annual open enrollment period).**
- A stepchild - You may put a child of your spouse or CU Partner on your plan.
 - You must complete your enrollment information and send it to your Employer within 31 days after the date of your marriage /partnership with your stepchild's parent.
 - **If you miss this deadline, your stepchild will not have health benefits after the first 31 days until the beginning of the next plan year (after the next annual open enrollment period).**

Notification of change in status

It is important that you notify your Employer of any changes in your benefit status. This will help your Employer effectively maintain your benefit status. Please notify your Employer as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other group health plan of any covered dependent

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
 - You were covered by another group health plan, and now that other coverage has ended.
 - You had COBRA, and now that coverage has ended because the maximum period of COBRA coverage has expired.
 - You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your contribution for coverage under this plan.
- When a court orders that you cover a current spouse or a minor child on your health plan.

Your Employer or the party they designate must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage begins on the date your Employer tells us. This will be the effective date on the enrollment information sent to us to enroll you and your eligible dependents in the plan.

Claims will not be paid under UCHP for expenses incurred in connection with any hospital stay that began before the date you or your dependents became covered.

Medical necessity and authorization requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services**. See the *Eligible health services under your plan* and *exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible health services** only if the general requirement is met:

- The **eligible health service** is **medically necessary**.

This section addresses the **medical necessity** and **authorization** requirements.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**." That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

Physician Order/Precertification

You need a **physician order** from your **PCP** for most **eligible health services** and in some cases **precertification from the plan**. If you do not have a **physician order or precertification** when required, we won't pay the **provider** and you will have to pay for services. Refer to the *What the plan pays and what you pay* section.

In some situations, your **PCP** may refer you to a **non-designated UCHP network provider**. If your **PCP** obtains precertification before treatment begins, you will pay the cost sharing that apply to **designated network providers** listed on the schedule of benefits. You may not seek care outside of the UCHP network without precertification from the plan requested by your **PCP**.

Certain **prescription drugs** are covered under the medical plan when they are given to you by your doctor or health care facility and not obtained at a **pharmacy**. The following **precertification** information applies to these **prescription drugs** only if you obtain the service at a facility outside of the UCHP network:

For certain drugs, your **prescriber** or your pharmacist needs to get approval from us before we will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a **medically necessary** need for the drug. For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Sometimes you or your prescriber may seek a medical exception to get health care services for drugs not covered or for which health care services are denied through precertification and/or step therapy. You or your prescriber can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic** surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exclusions in the *exclusions* section, and about the limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**
Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
 - Preventive counseling visits and/or risk factor reduction intervention
 - Nutritional counseling
 - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- **Misuse of alcohol and/or drugs**
Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
 - Preventive counseling visits
 - Risk factor reduction intervention
 - A structured assessment
- **Use of tobacco products**
Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
 - Preventive counseling visits
 - Treatment visits
 - Class visits;
 - **Tobacco cessation prescription and over-the-counter drugs**
 - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**

Eligible health services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a UCHP network OB, GYN or OB/GYN without a **physician order**.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting at a UCM facility. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include obtaining **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump in medically necessary situations.
- The buying of:
 - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once per pregnancy

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. Including the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician, PCP, OB, GYN, or OB/GYN** on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

Voluntary sterilization

Eligible health services include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs and supplies*
- *Treatment of basic infertility*

Physicians and other health professionals

Physician services

Eligible health services include services by your **physician** to treat an **illness** or **injury**. You can get those services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility approved by the UCHP Aetna plan

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery**
- Your surgeon who you visit before and after the **surgery**
- Another surgeon who you go to for a second opinion before the **surgery**

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician** services and not for a separate fee for facilities.

Alternative to physician office visits

Walk-in clinic/urgent care – eligible health services include health care services provided at Ingalls Quick Care (Crestwood location only) or any CVS Minute Clinic for unscheduled, non-medical emergency illnesses and injuries.

Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the University of Chicago Physician Group (UCPG)
- Operating and recovery rooms
- Intensive or special care units of a **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy

- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient surgery performed in a **surgery center** or a **hospital's** outpatient department.

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician or PCP** services and not for a separate fee for facilities.

Home health care and skilled behavioral health services in the home

Eligible health services include home health care services and skilled behavioral health services provided by a **home health agency** in the home, but only when all of the following criteria are met:

Home health care services	Skilled behavioral health services in the home
<ul style="list-style-type: none"> • You are homebound. • Your physician orders them. 	<ul style="list-style-type: none"> • You are homebound. • Your physician orders them.
<ul style="list-style-type: none"> • The services take the place of your needing to stay in a hospital or a skilled nursing facility, or needing to receive the same services outside your home. 	<ul style="list-style-type: none"> • The services take the place of your needing to stay in a hospital or a residential treatment facility, or needing to receive the same services outside your home.
<ul style="list-style-type: none"> • The services are part of a home health care plan. 	<ul style="list-style-type: none"> • The services are part of an active treatment plan of care.

<ul style="list-style-type: none"> The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy. 	<ul style="list-style-type: none"> The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.
<ul style="list-style-type: none"> If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement. 	
<ul style="list-style-type: none"> Home health aide services are provided under the supervision of a registered nurse. 	
<ul style="list-style-type: none"> Medical social services are provided by or supervised by a physician or social worker. 	

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

Home health care services do not include **custodial care** or applied behavior analysis.

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of hospice care services that are eligible for coverage include:

- Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
 - Physical and occupational therapy
 - Medical supplies
 - Outpatient **prescription drugs**
 - Psychological counseling
 - Dietary counseling

Outpatient skilled nursing care

Eligible health services include services provided by an **R.N.**, **L.P.N.**, or nursing agency for outpatient skilled nursing care. This is care by a visiting **R.N.**, or **L.P.N.** to perform specific skilled nursing tasks.

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**

Emergency services and walk-in/urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or a non-medically emergent illness or injury (**urgent condition**).

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when **Aetna** and the attending **physician** determine that you are medically able to travel or to be transported to a UCHP **network provider** if you need more care.

As it applies to in-network coverage, you are covered for follow-up care only when your **PCP** provides or coordinates it.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your **PCP** but only if a delay will not harm your health.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits and the *exclusion- Emergency services* sections for specific plan details.

In case of an urgent condition

Urgent condition within the service area

If you need care for an **urgent condition** while within the **service area**, you should first seek care through your **PCP**. If your **PCP** is not reasonably available to provide services, you may access urgent care from the University of Chicago Medical Center, Ingalls Quick Care (Crestwood location ONLY) or a CVS Minute Clinic.

Urgent condition outside the service area

You are covered for urgent care obtained from a facility outside of the **service area** if you are temporarily absent from the **service area** and getting the health care service cannot be delayed until you return to the **service area**.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition**, the plan may not cover your expenses.

Specific conditions

Autism spectrum disorder

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of Autism Spectrum Disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover early intensive behavioral interventions such as Applied Behavior Analysis. Applied Behavior Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the services and supplies needed for circumcision by a **provider**.

Mental health treatment

Eligible health services include the treatment of **mental disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital or residential treatment facility**, including:
 - **Partial hospitalization treatment** provided in a facility or program for mental health

- treatment provided under the direction of a **physician**.
- **Intensive Outpatient Program** provided in a facility or program for mental health treatment provided under the direction of a **physician**.
- Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor.
- Other outpatient mental health treatment such as:
 - Electro-convulsive therapy (ECT)
 - Mental health injectables
 - Transcranial magnetic stimulation (TMS)
 - Substance use disorder injectables

Eligible health services also include skilled behavioral health services provided in the home, but only when all of the following criteria are met:

- You are homebound.
- Your **physician** orders them.
- The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or needing to receive the same services outside your home.
- The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.

Substance related disorders treatment

Eligible health services include the treatment of **substance abuse** provided by a **hospital, psychiatric hospital, residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

As used here, "medical complications" include, but are not limited to, **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**, including:
 - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**.
 - **Intensive Outpatient Program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**.
 - Ambulatory detoxifications which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.
 - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor.
 - Other outpatient substance abuse treatment such as:
 - Outpatient monitoring of injectable therapy

Obesity surgery

Eligible health services include obesity surgery, which is also known as “weight loss surgery.” Obesity surgery is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI)**. To determine whether you qualify for obesity surgery, your doctor will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a **BMI** less than 35.

Your doctor must request approval in advance of your obesity surgery. The plan will cover charges made by a UCHP **network provider** for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam

Health care services include one obesity surgical procedure. However, **eligible health services** also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may only go to a UCHP **network** facility that performs obesity surgeries.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
 - Surgery needed to:
 - Treat a fracture, dislocation, or wound.
 - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
 - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
 - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:
 - Natural teeth damaged, lost, or removed as a result of an accident or injury.
 - Other body tissues of the mouth fractured or cut due to **injury**.
- Crowns, dentures, bridges, or in-mouth appliances only for:
 - The first denture or fixed bridgework to replace lost teeth due to injury.
 - The first crown needed to repair each damaged tooth.
 - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.
- Treatment must begin within ninety (90) days of accident/injury and accident/injury must have occurred after coverage began.
- Coverage under this plan is always secondary to benefits provided through another coverage a member may have.

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part.
 - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Transplant services

Eligible health services include organ transplant services provided by a **physician** and **hospital**.

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities

If the University of Chicago Medical Center is not able to perform the transplant you can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need
- A **Non-IOE facility** requested by a UCHP network Provider

The National Medical Excellence Program® will coordinate:

- All solid organ and bone marrow transplants
- Other specialized care you need and requested by your UCHP provider.

Advanced reproductive technology

Eligible health services include Assisted Reproductive Technology (ART) services. ART services are medical procedures or treatments performed to help a woman achieve pregnancy.

ART services

ART services include:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Cryopreserved embryo transfers (Frozen Embryo Transfers (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery

You are eligible for ART services if:

- You are covered under this plan as an employee or as a covered dependent who is the employee's legal spouse/domestic partner (registered with your Employer on or before December 31, 2016)/CU Partner, referred to as "your partner" and over the age of 18. Dependent children are covered under this plan for ART services only in the case of fertility preservation due to planned cancer treatment



- that will render the individual infertile.
- There exists a condition that:

Is demonstrated to cause the disease of **infertility**.

Has been recognized by your **physician** or **infertility specialist** and documented in your or your partner's medical records.

- You or your partner has not had a voluntary sterilization (tubal ligation, hysterectomy and vasectomy) with or without surgical reversal, regardless of post reversal results.
- You or your partner does not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- You or your partner has not had **infertility** that resulted from gender reassignment surgery (female to male or male to female).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have exhausted the comprehensive **infertility** services benefits or have clinical need to move on to ART procedures.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers

Your un-medicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

You are	Number of months of unprotected timed sexual intercourse:	Number of donor artificial insemination cycles: Self paid/not paid for by plan	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female under 35 years of age with a male partner	A. 12 months or more or 	B. At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.
A female under 35 years of age without a male partner	Does not apply	At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.
A female 35 years of age or older with a male partner	A. 6 months or more or 	B. At least 6 cycles of donor insemination	6 months	<p>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</p> <p>If you are age 40 and older, must be less than 19 mIU/mL in all prior tests prior to age 40 to use your own eggs, embryos or donor eggs or embryos.</p>
A female 35 years of age or older without a male partner	Does not apply	At least 6 cycles of donor insemination	6 months	If you are less than age 40 , must be less than 19 mIU/mL in your

				<p>most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</p> <p>If you are age 40 and older, must be less than 19 mIU/mL in all prior tests prior to age 40 to use your own eggs, embryos or donor eggs or embryos.</p>
A male of any age with a female partner under 35 years of age	12 months or more	Does not apply	Does not apply	Does not apply
A male of any age with a female partner 35 years of age or older	6 months or more	Does not apply	Does not apply	Does not apply

Fertility preservation

Only cancer patients are eligible for fertility preservation. Fertility preservation involves the creation of embryos or the retrieval of eggs and sperm that are frozen for future use. Along with the eligibility requirements above, you are eligible for fertility preservation benefits if:

- You, your partner or dependent child has a diagnosis of cancer and you are planning cancer treatment that is demonstrated to result in **infertility**. Planned cancer treatments include:
 - Bilateral orchiectomy (removal of both testicles).
 - Bilateral oophorectomy (removal of both ovaries).
 - Hysterectomy (removal of the uterus).
 - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**.
- The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

You are	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female under 35 years of age	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.
A female 35 years of age or older	6 months	If you are less than age 40 , must be less than 19 mIU/mL in your most recent lab test.
		If you are age 40 and older , must be less than 19 mIU/mL in all prior tests performed prior to age 40.

Eligible health services for fertility preservation will be paid on the same basis as ART services benefits for individuals who are **infertile** and not diagnosed with cancer.

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators with expertise in all areas of **infertility** who can help:

- Enroll in the **infertility** program.
- Assist you with **precertification** of **eligible health services**.
- Coordinate **precertification** for ART services and fertility preservation services when these services are **eligible health services**. Your UCHP **provider** should obtain **precertification** for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are **eligible health services**.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your **provider** will request approval from us in advance for your ART services and fertility preservation services. We will cover charges made by an ART specialist for the following ART services:

- Any combination of the following ART services:
 - In vitro fertilization (IVF)*
 - Zygote intrafallopian transfer (ZIFT)
 - Gamete intrafallopian transfer (GIFT)
 - Cryopreserved embryo transfers (Frozen Embryo Transfers (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with obtaining the spouse's/domestic partner's/CU Partner's sperm for ART services, when the spouse/domestic partner/CU Partner is also covered under this plan.
- The procedures are done while not confined in a **hospital** or any other facility as an inpatient.
- Cryo-preservation (freezing) or storage of sperm, eggs or embryos when in active course of infertility treatment under the plan.

A "cycle" is an attempt at a particular type of **infertility** treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, "one" cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to individuals who meet the criteria for ESET, as determined by our NIU and for whom the initial ESET cycle did not result in a documented fetal heartbeat. **Eligible health services** for ESET will be paid on the same basis as any other ART services benefit.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds \$500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

Eligible health services for chemotherapy depends on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in his/her office
- A home care **provider** in your home

Infusion therapy is the parenteral (i.e. intravenous) administration of prescribed medications or solutions.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

- Purchased by your **provider**, and
- Injected or infused by your **provider** in an outpatient setting such as:
 - A free-standing outpatient facility
 - The outpatient department of a **hospital**
 - A **physician** in his/her office
 - A home care **provider** in your home
- And, listed on our **specialty prescription drug** list as covered under this booklet.

You can access the list of **specialty prescription drugs** by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Outpatient radiation therapy

Eligible health services include the following radiology services provided by a **health professional**:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility or physician's office**, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing facility, or physician's office**, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.

Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital, skilled nursing facility, or hospice facility**
- A **home health care agency**
- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness, injury or surgical procedure**.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
 - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness, injury or surgical procedure**, or
 - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:

- Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury** or **surgical procedure**, or
- Improve delays in speech function development caused by a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation associated with physical rehabilitation, but only when:
 - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital, skilled nursing facility, or hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
 - Develop any impaired function, or
 - Relearn skills to significantly develop your ability to perform the activities of daily living.
- Speech therapy is covered provided the therapy is expected to:
 - Develop speech function as a result of delayed development (Speech function is the ability to express thoughts, speak words and form sentences).

Other services

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Ambulance service

Eligible health services include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From a **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one **hospital** to another and
 - The first **hospital** cannot provide the **emergency services** you need, and
 - The two conditions above are met.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. UCHP will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

UCHP only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the *exclusions* section.

Hearing exams

Eligible health services include hearing care that includes hearing exams.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects.

Coverage includes:

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instructions and other services (such as attachment or insertion) so you can properly use the device

Outpatient prescription drugs and supplies – pharmacy benefit

The plan covers outpatient prescription drugs through a separate pharmacy benefits administrator (PBM). The plan's PBM is CVS Health and the information provided in this section is specific to the plan's outpatient prescription pharmacy benefit only.

Covered Drugs and Supplies:

Benefits are available for:

- Drugs, unless otherwise excluded by plan, which under the applicable state or federal law, may only be dispensed upon the written prescription of a physician or other lawful provider;
- Compounded medication of which at least one ingredient is a prescription drug;
- Preventive contraceptives, including birth control pills, patches, vaginal rings and emergency contraceptives;
- Preventive care drugs and supplements including over-the-counter drugs and supplements as required by the Affordable Care Act (ACA) guidelines;
- Risk reducing breast cancer drugs for women with increased risk of breast cancer and low risk for adverse medication side effects;
- Drugs used for the treatment of infertility (**covered by UCHP at 75% of cost with remaining cost covered by You**);
- Drugs used for the treatment of impotence covered to benefit maximum of 6 syringes or tablets per 30 days;
- Growth hormones;
- Tobacco cessation FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products;
- Diabetic supplies are covered at no copayment or cost share, including test strips, lancets, lancet devices, alcohol wipes, needles, syringes and glucose monitors.

Benefits for these drugs will be provided when:

- You have a prescription by your physician, dentist or podiatrist; and
- You fill the prescription at UCMC's DCAM Pharmacy, Ingalls Pharmacies, CVS Caremark retail pharmacy or through CVS Caremark's Mail Order Prescription Program, subject to the applicable pharmacy copayments. Prescriptions filled at other CVS Caremark contracted pharmacies are subject to additional restrictions and increased costs to you.
- Prior authorization is obtained for those drugs that require it per CVS Caremark's prior authorization program.

Exclusions: What your plan doesn't cover

We already told you about the many health care services and supplies that are eligible for coverage under UCHP in the *Eligible health services under your plan* section. And we told you there, that some of those health care services and supplies have exclusions. For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

In this section we tell you about the exclusions. We've grouped them to make it easier for you to find what you want.

- Under "General exclusions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exclusions, in "Exclusions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exclusions may apply in your situation.

Note that these exclusions are for health services not identified as eligible health services found under the *Eligible health services under your plan* section.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exclusions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

Cosmetic services and plastic surgery

- Any treatment, **surgery (cosmetic or plastic)**, service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons.

Counseling

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications

- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care

Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, job training and job hardening programs.
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Services such as speech therapy eligible under the Individuals with Disabilities in Education Act (IDEA).

Examinations/Immunizations

Any health examinations/immunizations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered

under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs).

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care

- Services and supplies for:
 - The treatment of calluses, bunions, toenails, hammertoes, fallen arches
 - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
 - Supplies including ankle braces, guards, protectors, creams, ointments and other equipment
 - Routine pedicure services, such as routine cutting of nails, when there is no **illness** or **injury** in the nails

Growth/Height care

- A treatment, device, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth.

Hearing aids

Jaw joint disorder

- Non-surgical treatment of Temporomandibular joint disorder (TMJ)
- Temporomandibular joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function.

Medical Record Copying Costs

- Costs associated with the interpretation of foreign medical records. It is your responsibility to have all foreign medical records transcribed into English before submitting to plan.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
 - Sheaths
 - Bags
 - Elastic garments
 - Support hose
 - Bandages

- Bedpans
- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck brace
- Compresses
- Other devices not intended for reuse by another patient

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient prescription or non-prescription drugs and medicines, including:

- Over-the-counter contraceptive devices (including but not limited to condoms);
- Any drugs used for aging therapy or cosmetic usage
- Anorectics (any drug used for the purpose of weight loss)
- CNS stimulants prescription medication for less than 30 days
- Dietary supplements
- Any drug used for hair growth/stimulant
- Tobacco cessation drugs
- Experimental drugs

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party.

Pregnancy Charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies.

Services provided by a family member

- Services provided by a spouse, CU Partner or domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient **prescription drugs** or supplies received outside of the United States. They are not covered even if they are covered in the United States under this booklet.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire. Including:
 - **Surgery, prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ

- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your strength, physical condition, endurance, or physical performance.

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Therapies and tests

- Full body CT scan
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF) <https://www.uspreventiveservicestaskforce.org/>

This also includes:

- Counseling
- Hypnosis and other therapies
- Medications
- Nicotine patches
- Gum

Vision Care

- Vision care services and supplies, including:
 - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
 - Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors
 - Eyeglasses or contact lenses

Wilderness Treatment Programs

- Wilderness treatment programs (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Additional exclusions for specific types of care

– except as provided in the *Eligible health services under your plan*

Physicians and other health professionals

There are no additional exclusions specific to **physicians** and other **health professionals**.

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital**
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Services are not for Applied Behavior Analysis
- Hospice care Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
 - Sitter or companion services for either you or other family members
 - Transportation
 - Maintenance of the house

Private duty nursing (See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

Specific conditions

Family planning services - other

- Reversal of voluntary sterilization procedures including related follow-up care

- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related prenatal care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):
 - Dementias and amnesias without behavioral disturbances
 - Antisocial or dissocial personality disorder
 - Specific delays in development (learning disorders, academic underachievement)
 - Intellectual disability
 - Wilderness Treatment Program or any such related or similar program
 - School and/or education service.

Substance related disorders treatment

- Alcoholism or drug abuse rehabilitation treatment on an inpatient or outpatient basis

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person and has other coverage
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Treatment of infertility

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists
- All charges associated with:
 - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
 - Thawing of cryopreserved eggs, embryos or sperm
 - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
 - Obtaining sperm for ART services from males who are not covered under this plan.
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- ART services are not provided for out-of-network care

Specific therapies and tests

- Chiropractic, Acupuncture and acupuncture therapy Outpatient infusion therapy Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

- **Specialty prescription drugs** and medicines provided by our employer or through a third party vendor contract with your employer.

Short-term rehabilitation services

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
 - Autism Spectrum Disorder
 - Down syndrome
 - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

Habilitation therapy services

Physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
 - Down syndrome
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.

Other services

Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**
- **Non-emergency transportation unless otherwise authorized**

Clinical trial therapies (experimental or investigational)

- UCHP does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)*

section.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition
- Prosthetic devices Services covered under any other benefit
- Other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Spinal manipulation

- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body.
- Other physical treatment of any condition caused by or related to neuromusculoskeletal disorders of the spine, including manipulation of the spine.

Who provides the care

Just as the starting point for coverage under UCHP is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about UCHP **network providers**.

Network providers

UCHP contracts with UCM providers (including UCMC, UCPG, Ingalls and Ingalls Provider Group) **and select non-UCM providers** in the **service area** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use the UCHP **network providers** for **eligible health services**. There are three exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section.
- **Urgent care** – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section.
- **Network provider not reasonably available** – You can get **eligible health services** under your plan that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. Your PCP must request access to the **out-of-network provider** in advance and UCHP must agree the service cannot be rendered through the UCHP network. Your **PCP** will coordinate this out-of-network care.

You must select a UCHP **PCP** from the **directory** through your Aetna Navigator® secure member website at www.aetna.com or <http://www.aetna.com/dse/custom/uchp>.

You will not have to submit claims for treatment received from **network providers**. Your **network provider** will take care of that for you. And we will directly pay the **network provider** for what the plan owes.

Your PCP

For you to receive the network level of benefits **eligible health services** must be accessed through your **PCP's** office. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your plan:

- General practitioner
- Family physician
- Internist
- Pediatrician

How do you choose your PCP?

You can choose a UCHP **PCP** from the list of **PCPs** in our UCHP **directory**. See the *Who provides the care, Network providers* section. You will need to elect a PCP after receiving your member ID card.

Each covered family member is required to select their own **PCP**. You may each select your own **PCP**. You must select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What will your PCP do for you?

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Your **PCP** can also:

- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a **hospital stay** or a **stay** in another facility.

Your **PCP** will give you an **order** to see other UCHP **network providers**.

How do I change my PCP?

You may change your **PCP** at any time to another UCHP provider. You can call us at the toll-free number on your ID card or log on to your Aetna Navigator® secure member website at www.aetna.com to make a change.

What happens if I do not select a PCP?

Because having a **PCP** is so important, we may choose one for you. If your provider leaves the UCHP network, we will assign you to another **PCP** within the provider office, if you do not elect a new one.

Your **eligible health services** will be limited to care provided by direct access UCHP **network providers** and **emergency services**.

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the UCHP network.
- You are already a member of **UCHP** and your **provider** stops being in the UCHP network.

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee and your provider is a non-designated network provider	If you are a new enrollee and your non-designated network provider stops participation with us
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your provider should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.
How claim is paid	Your claim will be paid at the designated network provider cost sharing level.	Your claim will not be covered. This date is based on the date the provider terminated their participation with UCHP .

	If you are a new enrollee and your provider is not contracted with Aetna
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.
How claim is paid	Your claim will to the non-designated network provider is not covered.

If you are pregnant and have entered your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

What the plan pays and what you pay

Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **copayments/payment percentage**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an **eligible health service**.

The general rule

When you get **eligible health services**:

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/payment percentage**.

And then

- The plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and referral requirements* section.
- When you get an **eligible health service** without a **physician order or precertification** when your plan requires a **physician order or precertification**. See the *Medical necessity, physician order and precertification requirements* section.

- Usually, when you get an **eligible health service** from someone who is not a UCHP **provider**. See the *Who provides the care* section.

In all these cases, the **provider** may require you to pay the entire charge. And any amount you pay will not count towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your copayment/ payment percentage works

Your **copayment/ payment percentage** is the amount you pay for **eligible health services**. Your schedule of benefits shows you which **copayments/ payment percentage** you need to pay for specific **eligible health services**.

You will pay the **PCP copayment/ payment percentage** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **copayments/payment percentage** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, UCHP will pay for **covered benefits** for the remainder of that **Plan Year**.

Important note:

See the schedule of benefits for any **copayments/ payment percentage, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

Claim decisions and appeals procedures

In the previous section, we explained how you and the plan share responsibility for paying for your **eligible health services**.

When a claim comes in, you will receive a decision on how you and the plan will split the expense. We also explain what you can do if you think we got it wrong.

Claims are processed in the order in which they are received.

Claim procedures

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> ☐ You should notify and request a claim form from your employer. ☐ The claim form will provide instructions on how to complete and where to send the form(s). 	<ul style="list-style-type: none"> • Within 15 working days of your request. • If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of medical expense. It must detail the nature and extent of the medical expense within 90 days of your receiving services.
Proof of loss (claim)	<ul style="list-style-type: none"> • A completed claim form and any additional information required by your employer. 	<ul style="list-style-type: none"> ☐ No later than 90 days after you have incurred expenses for covered benefits. • We won't void or reduce your claim if you can't send us notice and proof of medical expense within the required time. But you must send us notice and proof as soon as reasonably possible. ☐ Proof of medical expense may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	<ul style="list-style-type: none"> • Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of medical expense. 	<ul style="list-style-type: none"> • Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. You can request a claim form from us and we will review that claim for payment to the **provider**.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim

A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**/payment percentage and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital**.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days

				for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*We must receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the **recognized charge** with a **provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

Aetna will handle all first level appeals. You can appeal by sending a written appeal to Member Services at the address on the notice of adverse benefit determination. Or you can call Member Services at the number on your ID card. You need to include:

- Your name
- The employer’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. Your second level of appeal will be handled by Aetna if it is related to an urgent care claim or a concurrent care claim. Second level appeals to Aetna must be presented within 60 calendar days from the date you receive the notice of the first appeal decision. Aetna will notify you in our first level appeal decision that your appeal is eligible for a second level appeal to your employer if the appeal does not involve urgent or concurrent care.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

For final adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this *COB* section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section when we talk about a “plan” through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist.
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan is covering you as an employee.	The plan is covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: <ul style="list-style-type: none">• Online: Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans.• By phone: Call the toll-free Member Services number on	

	your ID card.	
COB rules for dependent children		
Child of: <ul style="list-style-type: none"> Parents who are married or have a partnership (domestic or Civil Union) 	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none"> Parents separated or divorced With court-order 	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other parent’s plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse’s plan is primary.
Child of: <ul style="list-style-type: none"> Parents separated or divorced & court-order states both parents are responsible for coverage or have joint custody 	Primary and secondary coverage is based on the birthday rule. The plan of the parent whose birthday (month and day only) falls earlier in the calendar year. If same birthdays--the plan that has covered a parent longer is primary	
Child of: <ul style="list-style-type: none"> Parents separated or divorced and there is no court-order 	The order of benefit payments is: <ul style="list-style-type: none"> The plan of the custodial parent pays first The plan of the spouse of the custodial parent (if any) pays second The plan of the noncustodial parents pays next The plan of the spouse of the noncustodial parent (if any) pays last 	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a dependent of a former employee.	A plan that covers the person as a dependent of a former employee is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or the dependent of an employee is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or the dependent of an employee.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	<p>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan.</p> <p>The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</p>

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it
- Dropped it, or
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, the plan may pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	Primary plan	Secondary plan
The employer has 20 or more employees	Your plan	Medicare
If you have Medicare because of:		

End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and the employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate the amount we would pay if there were no Medicare coverage. If the Medicare payment is equal to or more than what we would pay, we make no payment. If Medicare paid less than what we would pay, we pay the difference between our payment and the Medicare payment.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the toll-free Member Services number on your ID card.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid, or
- Any other plan that is responsible under these COB rules.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued.
- You voluntarily stop your coverage.
- You are no longer eligible for coverage, including when you move out of the service area.
- Your employment ends.
- You do not make any required contributions.
- We end your coverage.
- You become covered under another medical plan offered by your employer.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependents coverage?

We will give you 31 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on either the date you stop active work, or the day before the first contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents at the end of the period defined by your employer following the date on which you no longer meet the eligibility requirements.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a “qualifying event”. COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/Group health plan notification requirements		
Notice	Requirement	Deadline
General notice – employer or Aetna	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	Your active employment ends for reasons other than gross misconduct Your working hours are reduced You become entitled to benefits under Medicare You die	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer or Aetna	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – employer or Aetna	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice – employer or Aetna	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period.	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the employer if: <ul style="list-style-type: none"> ☐ You divorce or legally separate and are no longer responsible for dependent coverage ☐ Your covered dependent children no longer qualify as a dependent under the plan 	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the employer if: <ul style="list-style-type: none"> • The Social Security Administration determines that you or a covered dependent qualify for disability status 	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary’s status change to non-disabled	Notify the employer if: <ul style="list-style-type: none"> • The Social Security Administration decides that the beneficiary is no longer disabled 	Within 30 days of the Social Security Administration’s decision
Enrollment in COBRA	Notify the employer if: <ul style="list-style-type: none"> • You are electing COBRA 	60 days from the qualifying event. You will lose your right to elect, if you do not: <ul style="list-style-type: none"> ☐ Respond within the 60 days ☐ And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
<ul style="list-style-type: none">You dieYou divorce or legally separate and are no longer responsible for dependent coverageYou become entitled to benefits under MedicareYour covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. The employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due for each of the additional eleven (11) months will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the employer within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the preexisting conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

To request an extension of coverage, just call the toll-free Member Services number on your ID card.

How can you extend coverage if you are totally disabled when coverage ends?

Your coverage may be extended if you or your dependents are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension.

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Additional information

We gathered a number of provisions here.

Administrative information

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group health plan. This document may have amendments too. Under certain circumstances, we or the employer or the law may change your plan.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen.

Legal action

No legal action may be taken by you against **UCHP** for any expense or bill until you complete the appeal process. See the *Claim decisions and appeals procedures* section. And you cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians**, dentists and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Intentional deception

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.

- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an Aetna appeal.
- You have the right to a third party review conducted by an independent external review organization.

Financial information

Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** or facility under this plan. This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this plan.

Financial sanctions exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Recovery of overpayments

We sometimes pay you or your provider too much for **eligible health services** or pay for something that this plan doesn't cover or have paid in error. If we do, the plan has a right to require the return of the overpayment on a request from the party we paid – you or your provider. The plan also has the right to reduce the amount of the overpayment from any future benefit payment to on behalf of that person or another person in his or her family covered under the plan.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited

to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Glossary

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance

A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider

An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices.

Body mass index

This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Copay/Copayments

The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Custodial care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it prescribed by a **physician** or given by trained medical personnel.

Deductible

The amount you pay for **eligible health services** per Plan Year before your plan starts to pay as listed in the schedule of benefits.

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This could be done by metabolic or other means determined by a **physician**. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory

The list of **network providers** for your plan. The most up-to-date directory for your plan appears at www.aetna.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain plans.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness or injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness or injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage

The date you and your dependent's coverage begins under this booklet as noted in your employer's records.

Eligible health services

The health care services and supplies listed in the *Eligible health services under your plan* section and not carved out or limited in the *exclusions* section or in the schedule of benefits.

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

Emergency services

Treatment given in a **hospital's** emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition**.

Experimental or investigational

A drug, device, procedure, or treatment that is found to be **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness or injury** involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program

A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital

An institution licensed as a **hospital** by applicable state and federal laws, and is accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility for substance abuse**
- **Residential treatment facility for mental disorders**
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Illness

Poor health resulting from disease of the body or mind.

Infertile/Infertility

A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Injury

Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) facility

A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

Intensive Outpatient Program (IOP)

Clinical treatment provided in a facility or program provided under the direction of a **physician**. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A Myofascial Pain Dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

A pharmacy where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and payment percentage including any **deductible**, to be paid by you or any covered dependents per Plan Year for **eligible health services**.

Medically necessary/Medical necessity

Health care services that a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

Mental disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatrist**, a psychologist or a psychiatric social worker. **Mental disorder** includes substance related disorders.

Morbid obesity/Morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Negotiated charge

The amount a **network provider** has agreed to accept for rendering services or providing **prescription drugs** or supplies to members of your plan.

Some **providers** are part of **Aetna's** network for some **Aetna** plans but are not considered **network providers** for your plan. For those **providers**, the **negotiated charge** is the amount that **provider** has agreed to accept for rendering services or providing **prescription drugs** to members of your plan.

Network provider

A **provider** listed in the UCHP **directory** for your plan and is contracted with UCHP to provide services.

Non-designated network provider

Any non UCHP **network provider** that is contracted with UCHP to provide services for your plan.

Out-of-network provider

A **provider** who is not a UCHP **network provider** or a **provider** that is seen without a **referral**.

Partial hospitalization treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **mental disorders** and **substance abuse**. The treatment plan must meet these tests:

- It is carried out in a **hospital, psychiatric hospital** or **residential treatment facility** on less than a full-time inpatient basis.
- It is in accordance with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatrist** who weekly reviews and evaluates its effect.

Payment Percentage

The specific percentage you have to pay for a health care service listed in the schedule of benefits.

Pharmacy

An establishment where **prescription** drugs are legally dispensed. This includes a **retail, mail order** and **specialty pharmacy**.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Physician Order

This only applies to in-network coverage and is a written or electronic authorization made by your UCHP **PCP** to direct you to a UCHP **network provider** for **medically necessary** services and supplies.

Prescriber

Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription

A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

Prescription drug

An FDA approved drug or biological which can only be dispensed by **prescription**.

Primary care physician (PCP)

A **physician** who:

- The **directory** lists as a UCHP **PCP**
- Is selected by a person from the list of **PCPs** in the UCHP **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist or a pediatrician
- Initiates internal **referrals** for **specialist** care and maintains continuity of patient care

Provider(s)

A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital

An institution specifically licensed as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders**, or mental illnesses.

Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

R.N.

A registered nurse.

Physician Order

This only applies to in-network coverage and is a written or electronic authorization made by your UCHP **PCP** to direct you to a UCHP **network provider** for **medically necessary** services and supplies.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna**, UCHP or is accredited by one of the following agencies, commissions or committees for the services being provided:
 - The Joint Commission (TJC)
 - The Committee on Accreditation of Rehabilitation Facilities (CARF)
 - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
 - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a **psychiatrist** at least once per week.
- The medical director must be a **psychiatrist**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

Residential treatment facility (substance abuse)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for substance abuse residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
 - The Joint Commission (TJC)
 - The Committee on Accreditation of Rehabilitation Facilities (CARF)

- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **physician**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting.
- Residential care must be provided under the direct supervision of a **physician**.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service area

The geographic area where **network providers** for this plan are located.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services
- It does not include institutions that primarily provide for the care and treatment of **mental disorders** or substance abuse.

Skilled nursing services

Services provided by an **R.N.** or **L.P.N.** within the scope of his or her license.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic

A free-standing health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

Additional Information Provided by

University of Chicago Health Plan (Applicable to UCMC Employees)

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan:

University of Chicago Medical Welfare Benefits Plan for Employees of UCMC and Participating Affiliates – University of Chicago Health Plan (Applicable to UCMC Employees)

Employer Identification Number:

36-3488183

Plan Number:

515

Type of Plan:

Welfare

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

University of Chicago Health Plan
c/o UCPG
150 Harvester Drive, Suite 300
Burr Ridge, IL 60527

Agent For Service of Legal Process:

University of Chicago Health Plan
c/o UCPG
150 Harvester Drive, Suite 300
Burr Ridge, IL 60527

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:

June 30, 2020

Source of Contributions:

Employer and Employees

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your 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 documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the

court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan 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.

Assistance with Your Questions

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, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 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.

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 you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.