

# Summary Plan Description

**Scholastic Inc.**  
**Choice Plus POS Plan with HSA**

Effective: January 1, 2020  
Group Number: 199574





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## SECTION 1 - WELCOME

### Quick Reference Box

- Member services, claim inquiries, Custom Care Management and Mental Health/Substance-Related and Addictive Disorder Administrator: (800)599-2912;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: [www.myuhc.com](http://www.myuhc.com).

Scholastic Inc. is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Scholastic Inc. Welfare Benefit Plan (Plan). It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

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

### IMPORTANT

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

Scholastic Inc. intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. This summary is intended to be an easy-to-read reference to help you understand the Plan. It does not describe every feature of the Plan and is not intended to be a full statement of the Plan document. The official terms of the Plan are contained in the Plan document. The Plan document will control in the event of any differences between it and this SPD. However, if there is language in this SPD regarding a topic the Plan document is silent on, the language in this SPD will govern

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

Please read this SPD thoroughly to learn how the Scholastic Inc. Welfare Benefit Plan works. If you have questions contact the Scholastic Benefits Service Center at 1-888-4MY-BENF (1-888-469-2363) or call the number on the back of your ID card.

UnitedHealthcare and Scholastic Inc. cannot advise you regarding tax, investment, or legal considerations relating to the Plan. Therefore, if you have questions regarding benefit planning, you should seek advice from a personal advisor (e.g., legal counsel, tax advisor, investment advisor.)

### **How To Use This SPD**

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at <https://access.scholastic.com> or request printed copies by contacting the Scholastic Benefits Service Center at 1-888-4MY-BENF (1-888-469-2363).
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Scholastic Inc. is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

## SECTION 2 - INTRODUCTION

**What this section includes:**

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

### Eligibility

You are eligible to enroll in the Plan if you are a full-time active employee of Scholastic and regularly scheduled to work at your job at least:

- 20 hours per week in New York, New Jersey, the field offices, Danbury and Book Fairs; or
- 30 hours per week in the National Services Organization (NSO).

Some part-time employees, seasonal and temporary employees may be eligible for medical benefits under the Plan as described below, depending on the number of hours worked by such employees. However, if your hours (actually worked or regularly scheduled to work) fall below the 30-hour weekly minimum, you may lose eligibility for coverage under the Plan. You may then become eligible to elect continuation of your group health coverages under COBRA. All benefits are effective January 1, or for new employees (or newly eligible employees), on your date of hire (or the date you become eligible).

If you are not eligible for medical benefits because of your classification as a non-full-time or a seasonal or temporary employee, Scholastic Inc. will track the hours you work per week for an initial twelve-month measurement period beginning on your date of hire. A new hire who averages at least 30 hours per week during the initial measurement period will be eligible to receive twelve (12) months of medical benefits even if the twelve months does not align with the calendar year (i.e., January 1st – December 31st). After the initial measurement period, Scholastic Inc. will track the hours you work during the general measurement period that runs from October 15 until October 14, annually. Your initial measurement period may overlap with the general measurement period in your first year of work with the Company.

For example, if you average 30 hours per week from 10/15/18 through 10/14/19, then you will be eligible for medical benefits from 1/1/20 through 12/31/20. However, if you do not average 30 hours per week from 10/15/19 through 10/14/20, then you will no longer be eligible for medical benefits from 1/1/21 through 12/31/21. If you are determined to be eligible for medical benefits on this basis, you will be able to enroll in the medical plan during the last two months of the year with coverage taking effect as of the next January and continuing for the calendar year. For purposes of determining your average hours of service during a measurement period, all hours of service for which you are paid will be included

and any weeks for which you are on an approved unpaid Family Medical Leave Act, military leave, or jury duty.

If you are classified as a contract, contingent or temporary employee, you are not eligible for the benefits described in this SPD unless you meet the 30-hour requirement specified above with respect to medical plan coverage. If you are classified as an independent contractor or other individual who is not an employee for payroll purposes and you are later characterized by the Internal Revenue Service, another government agency or a court as an “employee,” any such recharacterization will take effect for eligibility purposes on the actual date of such change in characterization without regard to any retroactive recharacterization.

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

- your Spouse or same sex Domestic Partner, as defined in Section 14, *Glossary* (Domestic Partner coverage is limited to same sex Domestic Partners enrolled prior to January 1, 2016);
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

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

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

## Cost of Coverage

You and Scholastic Inc. share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

**Note:** The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Scholastic Inc.'s cost in covering a

Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Scholastic Inc. reserves the right to change your contribution amount from time to time. Any changes to your contribution amount will be communicated to you in advance.

You can obtain current contribution rates by calling the Scholastic Benefits Service Center at 1-888-4MY-BENF (1-888-469-2363) or logging onto <https://access.scholastic.com>.

## How to Enroll

To enroll, call the Scholastic Benefits Service Center at 1-888-4MY-BENF (1-888-469-2363) or log onto <https://access.scholastic.com> within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections unless you experience a qualified status change event prior to Open Enrollment.

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

### **Important**

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other qualified status change, you must contact the Scholastic Benefits Service Center within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

## When Coverage Begins

Once the Scholastic Benefits Service Center receives your properly completed enrollment, coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective on the date of your marriage, provided you notify the Scholastic Benefits Service Center within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the qualified status change, provided you notify the Scholastic Benefits Service Center within 31 days of the birth, adoption, or placement for adoption.

### ***If You Are Hospitalized When Your Coverage Begins***

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

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, you should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

## Changing Your Coverage

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

- your marriage, divorce, legal separation, annulment or dissolution of your Domestic Partnership;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Scholastic Benefits Service Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Scholastic Benefits Service Center within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse;
- required by a judgment, decree or order, including a qualified medical child support order (QMCSO), resulting from a divorce, legal separation, annulment or change in legal custody that require health care coverage for your child. If the order directs you to cover the child, you may enroll the child (and yourself) in coverage. If the order directs

someone other than you (e.g., your Spouse or former Spouse) to cover the child, you may drop coverage for the child, but only if the other coverage is actually provided. See the “Qualified Medical Child Support Order” section for further details;

- Changes due to entitlement (or loss of entitlement) to Medicare or Medicaid. If you or your covered Dependent becomes entitled to Medicare or Medicaid (i.e., becomes enrolled), you may drop or reduce medical coverage for that individual. If you or your Dependent loses entitlement to Medicare or Medicaid, you may enroll or increase medical coverage for that individual (and yourself) in the plan;
- *Automatic changes.* If the cost of your coverage under the Plan increases (or decreases) during a period of coverage, and the increase (or decrease) in cost is not significant in the sole discretion of the Plan Administrator, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions for the Plan;
- *Significant cost changes.* If the cost charged to you for a Plan option significantly increases or decreases during a period of coverage, you may make a corresponding medical plan election change. For example, you can begin participation in the medical plan option with a decrease in cost. In the case of a cost increase, you can: (a) revoke your election for that Plan option and receive coverage going forward under another Plan option providing similar coverage; or (b) drop coverage if no other Plan option providing similar coverage is available;
- *Significant curtailment without loss of coverage.* If you (or your Dependent) have a significant curtailment of health coverage under a Plan option that is not a loss of coverage as described below, you may revoke your election for that Plan option and elect to receive coverage going forward under another Plan option providing similar coverage. A significant curtailment without a loss of coverage includes a significant increase in the deductible, the copay or the out-of-pocket cost sharing limit. However, since health coverage will only be considered significantly curtailed if there is an overall reduction in coverage provided so as to constitute reduced coverage generally, in most cases, the loss of one particular physician in a network will not constitute a significant curtailment;
- *Significant curtailment with loss of coverage.* If you (or your Dependent) have a significant curtailment that is a loss of health coverage under the Plan, you may revoke your election for that Plan option and elect either to receive coverage going forward under another health Plan option providing similar coverage or to drop coverage if no similar health Plan option is available. A loss of coverage means a complete loss of health coverage under the Plan option or other health Plan option — such as the elimination of a health Plan option. In addition, the Plan Administrator, in its discretion, may treat the following as a loss of coverage;
- A substantial decrease in the health care providers available under the health Plan option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a preferred provider network);
- A reduction in benefits for a specific type of medical condition or treatment with respect to which you, your Spouse or your Dependent is currently in a course of treatment; or



- *Addition or improvement of a medical Plan option.* If a new Plan option or if coverage under an existing Plan option is significantly improved during a period of coverage, you may revoke your election under this Plan option and make an election going forward for coverage under the new or improved medical plan option. This provision applies whether or not you have previously made an election under this Plan.

Unless otherwise noted above, if you wish to change your elections, you must contact the Scholastic Benefits Service Center within 31 days of the change in qualified status (or 60 days for those who lost coverage under Medicaid or CHIP or who become eligible to receive premium assistance under those programs). Otherwise, you will need to wait until the next annual Open Enrollment.

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

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

***Change in Qualified Status - Example***

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

## SECTION 3 - HOW THE PLAN WORKS

**What this section includes:**

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

### Accessing Benefits

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

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

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

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

**Non-Network Benefits** apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way

of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

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

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

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

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

#### **Looking for a Network Provider?**

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

### ***Network Providers***

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

Network providers are independent practitioners and are not employees of Scholastic Inc. or UnitedHealthcare.

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

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

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular

Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

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

### ***Designated Providers***

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

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

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

### ***Limitations on Selection of Providers***

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

## Eligible Expenses

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

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

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

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 80% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS) for Medicare* for the same or similar service within the geographic market.

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

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

**Don't Forget Your ID Card**

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

## Annual Deductible

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

The Annual Deductible applies to all Covered Health Services under the Plan, including Network Covered Health Services provided by the separate Prescription Drug plan administered by ExpressScripts.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

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

## Copayment

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

**Coinsurance**

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

**Coinsurance - Example**

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

**Out-of-Pocket Maximum**

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

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Network Covered Health Services provided by the separate Prescription Drug plan administered by ExpressScripts.

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

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

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, including Network Covered Health Services provided by the separate Prescription Drug plan administered by ExpressScripts	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments, including Network Covered Health Services provided by the separate Prescription Drug plan administered by ExpressScripts	Yes	Yes
Charges for non-Covered Health Services	No	No

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No



## SECTION 4 – CARE ADVOCACY AND PRIOR AUTHORIZATION

**What this section includes:**

- An overview of the Care Advocacy program; and
- Covered Health Services which Require Prior Authorization.

### Care Advocacy Program

The Claims Administrator provides a program called the Care Advocacy program designed to encourage personalized, efficient care for you and your covered Dependents.

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

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

Care Advocates provide a variety of different services to help you and your covered family members receive appropriate medical care, including but not limited to:

- condition management;
- cardiovascular;
- cancer;
- asthma;
- kidney/renal;
- maternity;
- neonatal care;
- case management;
- decision support for medical treatments;
- pre-admission and post-discharge counseling;
- obesity surgery; and
- social/economic support;

Program components are subject to change without notice.

If you do not receive a call from a Care Advocate Nurse but feel you could benefit from any of these programs, please call 866-229-2312.

## Prior Authorization

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

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

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

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

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

## Covered Health Services which Require Prior Authorization

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

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator or

contacting the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

The services that require prior authorization are:

- ambulance – non-emergent;
- Cellular and Gene Therapy;
- Clinical Trials;
- Congenital heart disease surgery;
- Durable Medical Equipment or orthotics, including diabetes equipment for the management and treatment of diabetes for items that will cost more than \$1,000 to purchase or rent;
- home health care for nutritional foods and Private Duty Nursing;
- hospice care - inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics - Outpatient - Genetic Testing – BRCA, sleep studies;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment facility); intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*;
- obesity surgery;
- Prosthetic Devices for items that will cost more than \$1,000 to purchase or rent;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility);

intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;

- Surgery - Outpatient - blepharoplasty, uvulopalatopharyngoplasty, vein procedures, orthognathic surgeries, cochlear implant and sleep apnea surgery;
- Therapeutics - dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound; and
- Transplants.

When you choose to receive services from non-Network providers, UnitedHealthcare urges you to confirm that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services.

Notification is required within 24 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For prior authorization timeframes, and reductions in Benefits that apply if you do not obtain prior authorization from the Claims Administrator, see Section 6, *Additional Coverage Details*.

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, the Claims Administrator's final coverage determination will be modified to account for those differences, and the Plan will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

### Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

**SECTION 5 - PLAN HIGHLIGHTS**

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

<b>Plan Features</b>	<b>Network</b>	<b>Non-Network</b>
<b>Copays<sup>1</sup></b>		
<ul style="list-style-type: none"> <li>■ Emergency Health Services</li> </ul>		\$125
<b>Annual Deductible<sup>2</sup></b>		
<ul style="list-style-type: none"> <li>■ Individual</li> </ul>	\$1,500	\$3,000
<ul style="list-style-type: none"> <li>■ Family (cumulative Annual Deductible<sup>3</sup>)</li> </ul>	\$3,000	\$6,000
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b>		
<ul style="list-style-type: none"> <li>■ Individual</li> </ul>	\$6,350	\$12,700
<ul style="list-style-type: none"> <li>■ Family (cumulative Out-of-Pocket Maximum<sup>4</sup>)</li> </ul>	\$7,350	\$14,700
<b>Lifetime Maximum Benefit<sup>5</sup></b>		
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.		Unlimited

<sup>1</sup>In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

<sup>2</sup>Copays do not apply toward the Annual Deductible but do apply toward the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

<sup>3</sup>The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

<sup>4</sup>The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

<sup>5</sup>Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<b>Acupuncture Services</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Ambulance Services - Emergency Only</b>	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
<b>Ambulance Services - Non-Emergency</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Cancer Resource Services (CRS)<sup>2</sup></b> <ul style="list-style-type: none"> <li>■ Hospital Inpatient Stay</li> </ul>	80% after you meet the Annual Deductible	Non-Network Benefits are not available
<b>Cellular and Gene Therapy</b> (If services rendered by a Designated Provider)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available
<b>Clinical Trials</b>	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<b>Congenital Heart Disease (CHD) Surgeries</b> ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Dental Services - Accident Only</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Diabetes Services</b>  Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care          Diabetes Self-Management Items ■ Diabetes equipment.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.          Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.          Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.



Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> <li>■ Diabetes supplies.</li> </ul>	For diabetes test strips the Benefit is 80% after you meet the Annual Deductible. All other diabetic supplies including diabetic test strips and insulin are covered under the separate Prescription Drug plan administered by ExpressScripts.	For diabetes test strips the Benefit is 50% after you meet the Annual Deductible. All other diabetic supplies including diabetic test strips and insulin are covered under the separate Prescription Drug plan administered by ExpressScripts.
<b>Durable Medical Equipment (DME)</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<p><b>Emergency Health Services – Outpatient</b></p> <p>If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.</p>	80% after you meet the Network Annual Deductible and pay a \$125 Copay per admission	
<p><b>Hearing Aids</b></p> <p>See Section 6, <i>Additional Coverage Details</i>, for limits</p>	80% after you meet the Annual Deductible	50% after you meet the Network Annual Deductible
<p><b>Home Health Care</b></p> <p>See Section 6, <i>Additional Coverage Details</i>, for limits</p>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<p><b>Hospice Care</b></p> <p>See Section 6, <i>Additional Coverage Details</i>, for limits</p>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Hospital - Inpatient Stay</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<p><b>Infertility Services and Fertility Solutions (FS) Program</b></p> <p>Infertility services must be received at a Designated Provider.</p> <p>See Section 6, <i>Additional Coverage Details</i>, for limits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.</p> <ul style="list-style-type: none"> <li>■ Physician's Office Services</li> <li>■ Outpatient services received at a Hospital or Alternate Facility</li> </ul> <p>See Section 6, <i>Additional Coverage Details</i>, for limits.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section</p> <p><i>ART, Diagnosis and Treatment</i></p> <p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p>	<p>Non-Network Benefits are not available</p> <p><i>Diagnosis and Treatment</i></p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>
<p><b>Injections in a Physician's Office</b></p>	<p>80% after you meet the Annual Deductible <i>Allergy Injections</i></p> <p>Coinsurance and Annual Deductible do not apply if no Physician's charge is assessed</p> <p>100%</p>	<p>50% after you meet the Annual Deductible</p>
<p><b>Kidney Resource Services (KRS)</b></p>	<p>80% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p>

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<b>Lab, X-Ray and Diagnostics - Outpatient</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Mental Health Services</b>		
■ Inpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Neonatal Resource Services (NRS)</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Neurobiological Disorders - Autism Spectrum Disorder Services</b>		
■ Inpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Obesity Surgery</b>	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<b>Ostomy Supplies</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Physician Fees for Surgical and Medical Services</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Physician's Office Services - Sickness and Injury</b>	80% and after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Pregnancy – Maternity Services</b>	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.
<b>Preventive Care Services</b> <ul style="list-style-type: none"> <li>■ Physician Office Services</li> <li>■ Lab, X-ray or Other Preventive Tests including PSA and Rubella screenings.</li> <li>■ Breast Pumps</li> </ul>	<p>100%</p> <p>100%</p> <p>100%</p>	<p>Non-Network Benefits are not available</p> <p>Non-Network Benefits are not available</p> <p>Non-Network Benefits are not available</p>
<b>Private Duty Nursing - Outpatient</b> See Section 6, <i>Additional Coverage Details</i> , for limits	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Prosthetic Devices</b> See Section 6, <i>Additional Coverage Details</i> , for limits	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<b>Reconstructive Procedures</b> <ul style="list-style-type: none"> <li>■ Physician's Office Services</li> <li>■ Hospital - Inpatient Stay</li> <li>■ Physician Fees for Surgical and Medical Services</li> <li>■ Prosthetic Devices</li> <li>■ Surgery - Outpatient</li> </ul>	<p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>
<b>Rehabilitation Services - Outpatient Therapy</b> See Section 6, <i>Additional Coverage Details</i> , for visit limits	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b> See Section 6, <i>Additional Coverage Details</i> , for limits	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Substance-Related and Addictive Disorder</b> <ul style="list-style-type: none"> <li>■ Inpatient</li> <li>■ Outpatient</li> </ul>	<p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<b>Surgery - Outpatient</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Temporomandibular Joint Dysfunction (TMJ)</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Therapeutic Treatments - Outpatient</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Transplantation Services</b> (If services rendered by a Designated Provider)	80% after you meet the Annual Deductible	Non-Network Benefits are not available
<b>Travel and Lodging</b> (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing cancer, obesity surgery services, Congenital Heart Disease treatment or transplant procedures	
<b>Urgent Care Center Services</b>	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<b>Virtual Visits</b>  Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Non-Network Benefits are not available

<sup>1</sup>You must obtain prior authorization from the Claims Administrator, as described in Section 4, *Prior Authorization* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from Custom Care Management before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

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

## SECTION 6 - ADDITIONAL COVERAGE DETAILS

### What this section includes:

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

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

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

### Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

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

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

### Did you know...

You generally pay less out-of-pocket when you use a Network provider?

### Ambulance Services - Emergency Only

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



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

### **Ambulance Services - Non-Emergency**

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

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

#### **Prior Authorization Requirement**

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization as soon as possible prior to transport.

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

### **Cancer Resource Services (CRS)**

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

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

- work with your Care Advocate Nurse;
- call the Care Advocacy Program toll-free at (866) 229-2312; or
- visit [www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com).

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

- Physician's Office Services;

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

Cancer clinical trials and related treatment and services are covered by the Plan. Such treatment and services must be recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

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

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

### Cellular and Gene Therapy

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

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

#### **Prior Authorization Requirement**

For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid. You will be responsible for paying all charges and no Benefits will be paid.

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

### Clinical Trials

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

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;

- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*);
  - *Centers for Disease Control and Prevention (CDC)*;
  - *Agency for Healthcare Research and Quality (AHRQ)*;
  - *Centers for Medicare and Medicaid Services (CMS)*;
  - a cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
  - a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - ◆ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - ◆ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

#### **Prior Authorization Requirements**

You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

### **Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation

of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact the Care Advocacy Program at 866-229-2312 for information about these guidelines.

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

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

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or the Claims Administrator to be proven procedures for the involved diagnoses. Contact the Care Advocacy Program at 866-229-2312 for information about CHD services.

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

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

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

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

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises.

For non-Network Benefits, if you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

**Dental Services - Accident Only**

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

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

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

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

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- emergency examination.
- Necessary diagnostic X-rays.
- endodontic (root canal) treatment.
- temporary splinting of teeth.

- prefabricated post and core.
- simple minimal restorative procedures (fillings).
- extractions.

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

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

## Dental - Anesthesia

Anesthesia Services: Benefits are available for anesthesia services if administered at the same time as a covered surgical procedure in a hospital or ambulatory surgical facility or by a physician other than the operating surgeon or by a CRNA. Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a hospital or ambulatory surgical facility if a medical condition requiring hospitalization for dental care is present.

## Diabetes Services

### *Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care*

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

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

### *Diabetic Self-Management Items*

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

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

- Lancets and lancet devices.

Diabetic test strips are covered under the medical plan and as described under the separate prescription drug plan administered by Express Scripts; all other disposable medical supplies are covered as described under the prescription drug plan.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME for the management and treatment of diabetes that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

**Durable Medical Equipment (DME)**

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

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

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

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;



- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient* in this section;
- orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, foot orthotics and custom molded shoe inserts prescribed to treat a disease or illness. Coverage for foot orthotics and shoe inserts is subject to medical review guidelines;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

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

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

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

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

**Prior Authorization Requirements**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

## Emergency Health Services - Outpatient

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

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

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 24 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

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

**Note:** If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 24 hours or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

## Hearing Aids

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. The Plan also provides coverage for hearing exams performed by an audiologist.

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable

medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

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

Any combination of Network Benefits and Non-Network Benefits for hearing aids and hearing aid exams is limited to \$2,500 per calendar year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.

### Home Health Care

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

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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

Any combination of Network Benefits and Non-Network Benefits is limited to 100 visits per calendar year combined with Private Duty Nursing. One visit equals four hours of Skilled Care services.

#### **Prior Authorization Requirements**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

### Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person (6 month terminal prognosis), and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are

available only when hospice care is received from a licensed hospice agency, which can include a Hospital. Bereavement services are provided to the family or primary care person after the death of the hospice patient. Bereavement services can include contacts, counseling, communication and correspondence.

**Prior Authorization Requirement**

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

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

**Hospital - Inpatient Stay**

Hospital Benefits are available for:

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

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

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

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

**Prior Authorization Requirement**

For Non-Network Benefits, for:

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

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

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

**Infertility Services**

Therapeutic services for the treatment of Infertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- ICSI - (intracytoplasmic sperm injection).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Embryo transportation related network disruption.
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty.
- Electroejaculation.
- Pre-implantation Genetic Diagnosis (PGD) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

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

Benefits for certain Pharmaceutical Products, including specialty Pharmaceutical Products, for the treatment of Infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under *Pharmaceutical Products*.

Benefits for Pharmaceutical Products for outpatient use that are filled by a prescription order or refill are described under the *Prescription Drug Program*.

### ***Enhanced Benefit Coverage***

***Donor Coverage:*** The plan will cover associated donor medical expenses, including collection and preparation of ovum and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm. The plan will not pay for donor charges associated with compensation or administrative services.

### ***Criteria to be eligible for Benefits***

To be eligible for the Infertility services Benefit you must have a diagnosis of infertility.

- To meet the definition of Infertility you must meet one of the following:
  - You are not able to become pregnant after the following periods of time of regular unprotected intercourse or Therapeutic Donor Insemination:
    - One year, if you are a female under age 35.
    - Six months, if you are a female age 35 or older.
  - You are female and have failed to achieve or maintain a Pregnancy due to impotence/sexual dysfunction;
  - You are female and have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
  - You are male and have a diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- You are a female under age 44 and using own oocytes (eggs).
- You are a female under age 55 and using donor oocytes (eggs).
- You have Infertility that is not related to voluntary sterilization.
- You are male and have a diagnosis of a male factor causing Infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- Not a Child Dependent.

Any combination of Network and Non-Network Benefits is limited to \$25,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Physician office visits for the treatment of Infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.

There are separate limits under the Plan for medical services and outpatient prescription drugs. Infertility medications are covered under a separate prescription drug plan administered by ExpressScripts and are limited to \$10,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. Mail order and generic substitution are mandatory.

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

- Surgeon.

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

### ***Fertility Solutions Program***

For Designated Network Benefits, you must enroll in the Fertility Solutions Program to receive services from a Designated Provider. To enroll you can call the telephone number on your ID card or the *Fertility Solutions Program Nurse Team* at 888-936-7246.

### **Injections in a Physician's Office**

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

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

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

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

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

### **Kidney Resource Services (KRS)**

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Provider participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

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

You or a covered Dependent may:

- be referred to KRS by a Care Advocate Nurse; or
- call the Care Advocacy program at 866-229-2312.

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

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

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

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

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

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

Benefits under this section include:

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

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.



Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Coverage is provided for the oncotype test for patients with localized, early stage (I, II or III) breast cancer, who are lymph node negative and estrogen receptor positive, as a way to establish prognosis and to make the decision whether to use adjuvant chemotherapy.

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

#### **Prior Authorization Requirement**

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

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

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

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

### **Mental Health Services**

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

Benefits include the following levels of care:

- inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.

- Intensive Outpatient Treatment.
- outpatient treatment.

Services include the following:

- diagnostic evaluations, assessment and treatment planning.
- treatment and/or procedures.
- medication management and other associated treatments.
- individual, family, and group therapy.
- provider-based case management services.
- crisis intervention.

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Prior Authorization Requirement**

For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

**Neonatal Resource Services (NRS)**

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Provider participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Provider is defined in Section 14, *Glossary*.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

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

### **Neurobiological Disorders - Autism Spectrum Disorder Services**

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

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

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

Benefits include the following levels of care:

- inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

- outpatient treatment.

Services include the following:

- diagnostic evaluations, assessment and treatment planning.
- treatment and/or procedures.
- medication management and other associated treatments.
- individual, family, and group therapy.
- crisis intervention.
- provider-based case management services.

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Prior Authorization Requirement**

For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management. Pre-service notification is also required for Benefits provided for Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

**Obesity Surgery**

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

- you have a minimum Body Mass Index (BMI) of 40;

- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years; and
- you are over the age of 21; and
- the surgery is performed at a Network Hospital by a Network surgeon even if there are no Network Hospitals near you.

Specialized nurses provide support through all stages of the weight loss surgery process. Our Bariatric Resources Services (BRS) program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence.

Surgery is not required to be performed at a BRS facility however for obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling 1-888-936-7246.

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

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

#### **Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

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

## **Ostomy Supplies**

Benefits for ostomy supplies are limited to:

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

## Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

## Physician Fees for Surgical and Medical Services

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

## Physician's Office Services

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

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

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

Covered Health Services include Genetic Counseling.

Benefits include Physician's office visits for smoking cessation.

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

<p><b>Please Note</b></p>
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<p>Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.</p>
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## Pregnancy - Maternity Services

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

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

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

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

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

### **Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

**It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**

### **Healthy moms and babies**

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

## Preventive Care Services

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

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

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

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

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

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

In addition to the services listed above, this plan includes coverage for the following screenings that do not have in effect a rating of "A" or "B":

- prostate-specific antigen (PSA) screenings for men age 40 or older regardless of diagnosis; and
- rubella screenings for all women of childbearing age.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis.

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



## Private Duty Nursing - Outpatient

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

Any combination of Network Benefits and Non-Network Benefits is limited to 100 visits per calendar year combined with Home Health Care visits.

### **Prior Authorization Requirements**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

## Prosthetic Devices

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

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

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

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

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

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

Benefits are also provided for wigs except for loss of hair resulting from radiation or chemotherapy. Any combination of Network and Non-Network Benefits for wigs is limited to \$1,500 per Covered person per lifetime.

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

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 penalty.

**Reconstructive Procedures**

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

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

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

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

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

**Prior Authorization Requirement**

For Non-Network Benefits for:

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

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

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

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

The Plan provides short-term outpatient rehabilitation services limited to:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- vision therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

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

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

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. The Plan

will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

### ***Habilitative Services***

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

- the services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- it is ordered by a Physician and provided and administered by a licensed provider.
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- it requires clinical training in order to be delivered safely and effectively.
- it is not Custodial Care.

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

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

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

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

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

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

Benefits are limited to:

- 90 visits per calendar year for physical, occupational and speech therapy combined;
- unlimited visits per calendar year for pulmonary rehabilitation therapy;
- unlimited visits per calendar year for cardiac rehabilitation therapy;
- unlimited visits per calendar year for post-cochlear implant aural therapy;
- 30 visits per calendar year for Manipulative Treatment; and
- 20 visits for employees or spouse per lifetime or 30 visits per child per lifetime for vision therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Physical, occupational and speech therapy visit limits do not apply to diagnosis of Autism Spectrum Disorder.

### **Scopic Procedures - Outpatient Diagnostic and Therapeutic**

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

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

Benefits under this section include:

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

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

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

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

## Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

Benefits are available only if:

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

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

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

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

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

Any combination of Network Benefits and Non-Network Benefits is limited to 60 days per calendar year.

**Prior Authorization Requirement**

For Non-Network Benefits for:

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

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

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

**Substance-Related and Addictive Disorders Services**

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- outpatient treatment.

Services include the following:

- diagnostic evaluations, assessment and treatment planning.
- treatment and/or procedures.
- medication management and other associated treatments.
- individual, family, and group therapy.
- crisis intervention.
- Provider-based case management services.

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Prior Authorization Requirement**

For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization from the MH/SUD Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

**Surgery - Outpatient**

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

**Prior Authorization Requirement**

For Non-Network Benefits blepharoplasty, uvulopalatopharyngoplasty, vein procedures and sleep apnea surgeries and cochlear implant, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior as required, Benefits will be subject to a \$500 reduction.

**Temporomandibular Joint Dysfunction (TMJ)**

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

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



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

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

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

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

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

### Therapeutic Treatments - Outpatient

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

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

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

Benefits under this section include:

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

#### **Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require notification: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization, Benefits will be subject to a \$500 reduction.

## Transplantation Services

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

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

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

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

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

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

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

The Plan has specific guidelines regarding Benefits for transplant services. Contact the Care Advocacy program at 866-229-2312 for information about these guidelines.

### **Prior Authorization Requirement**

For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization from the Claims Administrator and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid. You will be responsible for paying all charges and no Benefits will be paid.

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

## Travel and Lodging Assistance Program

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the

qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

### ***Travel and Lodging Expenses***

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

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- the Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- if the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- the bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of \$10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

### ***Lodging***

- a per diem rate, up to \$50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- a per diem rate, up to \$100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- groceries.
- alcoholic beverages.
- personal or cleaning supplies.

- meals.
- over-the-counter dressings or medical supplies.
- deposits.
- utilities and furniture rental, when billed separate from the rent payment.
- phone calls, newspapers, or movie rentals.

### ***Transportation***

- automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- taxi fares (not including limos or car services).
- economy or coach airfare.
- parking.
- trains.
- boat.
- bus.
- tolls.

#### **Support in the event of serious illness**

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

### **Urgent Care Center Services**

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services* earlier in this section.

### **Virtual Visits**

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

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

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

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

## SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

### **What this section includes:**

Health and well-being resources available to you, including:

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

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

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

### ***NOTE:***

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

## Consumer Solutions and Self-Service Tools

### ***Health Improvement Plan***

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

Online coaching is available for:

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

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

### ***NurseLine<sup>SM</sup>***

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

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

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

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

**Note:** If you have a medical emergency, call 911 instead of calling NurseLine<sup>SM</sup>.

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

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

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

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

### ***Reminder Programs***

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

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

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

### ***Treatment Decision Support***

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

This program offers:

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

Conditions for which this program is available include:

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

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

### ***UnitedHealth Premium® Program***

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines



to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

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

***www.myuhc.com***

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

With **www.myuhc.com** you can:

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

**Registering on www.myuhc.com**

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

Visit **www.myuhc.com** and:

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

**Want to learn more about a condition or treatment?**

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

## Support for Chronic Conditions

### *Cancer Support*

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

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the Care Advocacy Program directly at (866) 229-2312.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

### *Disease Management Support*

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

These programs offer:

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

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

### ***HealtheNotes<sup>SM</sup>***

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

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

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

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

## **Wellness Programs**

### ***Orthopedic Health Support Program***

Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond.

This program offers:

- early intervention and appropriate care.
- coaching to support behavior change.
- shared decision-making.
- pre-and post-surgical counseling.
- support in choosing treatment options.
- education on back-related information and self-care strategies.
- long-term support.

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

If you are considering orthopedic surgery, you must contact an Orthopedic nurse prior to surgery to enroll in the program in order for the surgery to be considered a Covered Health Service under the Plan.

### ***Maternity Support***

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the Care Advocacy Program directly at (866) 229-2312. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- enrollment by an OB nurse;
- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;
- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the Care Advocacy Program directly at (866) 229-2312.

As a program participant, you can always call your nurse with any questions or concerns you might have.

### ***Fertility Solutions***

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates made available to you by the Plan Sponsor. The Infertility Solutions program provides:

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

The Plan pays Benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions program provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.

Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment. For infertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

## SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

**What this section includes:**

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

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

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

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

### Alternative Treatments

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

### Comfort and Convenience

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

1. television;

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

## Dental

1. dental care (which includes dental X-rays, supplies and appliances and all associated expenses, with the exception of hospitalizations and anesthesia as described under *Dental Anesthesia* in Section 6, *Additional Coverage Details*).

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

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- transplant preparation.
- prior to the initiation of immunosuppressive drugs.
- the direct treatment of acute traumatic Injury, cancer or cleft palate.

dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

endodontics, periodontal surgery and restorative treatment are excluded;

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

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

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

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

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

4. dental braces (orthodontics); and
5. treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

## Drugs

1. prescription drug products for outpatient use that are filled by a prescription order or refill;
2. self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by the UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.;
3. non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office;
4. over the counter drugs and treatments;
5. growth hormone therapy;
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

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



7. a Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. a Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
10. certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

### **Experimental or Investigational or Unproven Services**

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

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

### **Foot Care**

1. routine foot care. Examples include the cutting or removal of corns and calluses.

This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. nail trimming, cutting, or debriding (removal of dead skin or underlying tissue);
3. hygienic and preventive maintenance foot care. Examples include:
  - cleaning and soaking the feet;
  - applying skin creams in order to maintain skin tone.

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

4. treatment of flat feet;

5. treatment of subluxation of the foot;
6. shoes;
7. shoes orthotics;
8. shoe inserts except custom molded shoe inserts prescribed to treat a disease or illness of the foot; and
9. arch supports.

### Medical Supplies and Appliances

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

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;
  - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.
3. tubings, nasal cannulas, connectors and masks that are not used in connection with DME.
  4. orthotic appliances that straighten or re-shape a body part except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*. Examples of excluded orthotic appliances and devices include, but are not limited to, any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.
  5. cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.;
  6. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
  7. powered and non-powered exoskeleton devices.

## Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services

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

1. services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

## Nutrition and Health Education

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods);
2. individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to nutritional counseling services that are billed as *Preventive Care Services* or to nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional;
3. food of any kind. Foods that are not covered include:
- enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
  - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
  - oral vitamins and minerals;
  - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
  - other dietary and electrolyte supplements;
4. health club memberships and programs, and spa treatments; and
5. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

### Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Sclerotherapy treatment of veins.
  - Hair removal or replacement by any means.
  - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Skin abrasion procedures performed as a treatment for acne.
  - Treatments for hair loss.
  - Varicose vein treatment of the lower extremities, when it is considered cosmetic.
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;
4. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy; and

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

## Providers

Services:

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

This exclusion does not apply to mammography testing.

## Reproduction

1. The following Infertility:
  - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility.
  - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
  - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
  - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
  - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease.
  - Ovulation predictor kits.
2. The following services related to Gestational Carrier or Surrogate:
  - Fees for the use of a Gestational Carrier or Surrogate.

- Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
  - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
    - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under *Infertility Services* including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
    - Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under *Infertility Services* including thawing and insemination.
  4. The reversal of voluntary sterilization.
  5. Infertility services not received from a Designated Provider.
  6. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.
  7. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
  8. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
  9. Infertility treatment following unsuccessful reversal of voluntary sterilization.
  10. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

### Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

### Transplants

1. health services for organ and tissue transplants,

- except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details*;
  - determined by Custom Care Management not to be proven procedures for the involved diagnoses; and
  - not consistent with the diagnosis of the condition;
2. Health services for transplants involving animal organs.
  3. transplants that are not performed at a Designated Provider (this exclusion does not apply to cornea transplants); and
  4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

### Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and
2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging Assistance Program* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

### Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;
2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
3. purchase cost and associated fitting charges for eyeglasses or contact lenses;
4. bone anchored hearing aids except when either of the following applies:
  - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
  - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

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

### All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
  - missed appointments;
  - room or facility reservations;
  - completion of claim forms;
  - record processing; or
  - services, supplies or equipment that are advertised by the Provider as free;
3. charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;
4. charges prohibited by federal anti-kickback or self-referral statutes;
5. chelation therapy, except to treat heavy metal poisoning;
6. Custodial Care as defined in Section 14, *Glossary*, or services provided by a personal care assistant;
7. diagnostic tests that are:
  - delivered in other than a Physician's office or health care facility; and
  - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
8. Domiciliary Care, as defined in Section 14, *Glossary*;
9. expenses for health services and supplies:
  - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
  - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
  - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
  - that exceed Eligible Expenses or any specified limitation in this SPD;
  - for which a non-Network provider waives the Annual Deductible or Coinsurance amounts;



10. foreign language and sign language services;
11. long term (more than 30 days) storage of blood, umbilical cord or other material.  
Examples include cryopreservation of tissue, blood and blood products;
12. health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
  - Medically Necessary.
  - Described as a Covered Health Service in this SPD under Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights*.
  - Not otherwise excluded in this SPD under this Section 8, *Exclusions*.

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

13. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

14. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded;
15. private duty nursing received on an inpatient basis;
16. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;
17. rest cures;
18. sex transformation operations and related services;
19. speech therapy to treat stuttering, stammering, or other articulation disorders;
20. rehabilitation services for speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, Sickness, stroke, cancer, autism spectrum disorder or a Congenital Anomaly, or is needed following the

placement of a cochlear implant as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

21. Manipulative Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;
22. storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery;
23. the following treatments for obesity:
  - non-surgical treatment, even if for morbid obesity; and
  - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*; and
24. treatment of hyperhidrosis (excessive sweating).
25. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
26. the following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.
27. Habilitative services for maintenance/preventive treatment.
28. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
  - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
  - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
  - Related to judicial or administrative proceedings or orders.
  - Required to obtain or maintain a license of any type.
29. Intracellular micronutrient testing.
30. Health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

## SECTION 9 - CLAIMS PROCEDURES

**What this section includes:**

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

### Network Benefits

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

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

### Non-Network Benefits

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

### If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting [www.myuhc.com](http://www.myuhc.com), calling the toll-free number on your ID card or contacting the Scholastic Benefits Service Center. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and

- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

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

### ***Payment of Benefits***

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

### ***Form of Payment of Benefits***

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

### **Health Statements**

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy

for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at [www.myuhc.com](http://www.myuhc.com). You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

### **Explanation of Benefits (EOB)**

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

#### **Important - Timely Filing of Non-Network Claims**

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

### **Claim Denials and Appeals**

#### ***If Your Claim is Denied***

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

#### ***How to Appeal a Denied Claim***

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

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

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

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

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

**Types of claims**

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

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

***Review of an Appeal***

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

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

***Filing a Second Appeal***

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

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

**Federal External Review Program**

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

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

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

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

An external review request should include all of the following:

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

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

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

### ***Standard External Review***

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

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

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

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and

- has provided all the information and forms required so that UnitedHealthcare may process the request.

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

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

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

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

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

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

### ***Expedited External Review***

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

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



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

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

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

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

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

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

### ***Timing of Appeals Determinations***

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

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

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

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

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

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

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

<b>Pre-Service Request for Benefits*</b>	
<b>Type of Request for Benefits or Appeal</b>	<b>Timing</b>
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	<b>5 days</b>
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	<b>15 days</b>
You must then provide completed request for Benefits information to UnitedHealthcare within:	<b>45 days</b>
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	<b>15 days</b>
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	<b>15 days</b>
You must appeal an adverse benefit determination no later than:	<b>180 days</b> after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	<b>15 days</b> after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	<b>60 days</b> after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	<b>15 days</b> after receiving the second level appeal

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

<b>Post-Service Claims</b>	
<b>Type of Claim or Appeal</b>	<b>Timing</b>
If your claim is incomplete, UnitedHealthcare must notify you within:	<b>30 days</b>
You must then provide completed claim information to UnitedHealthcare within:	<b>45 days</b>
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	<b>30 days</b>
■ after receiving the completed claim (if the initial claim is incomplete), within:	<b>30 days</b>

<b>Post-Service Claims</b>	
<b>Type of Claim or Appeal</b>	<b>Timing</b>
You must appeal an adverse benefit determination no later than:	<b>180 days</b> after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	<b>30 days</b> after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	<b>60 days</b> after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	<b>30 days</b> after receiving the second level appeal

***Concurrent Care Claims***

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

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

**Limitation of Action**

You cannot bring any legal action against Scholastic Inc. or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Scholastic Inc. or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Scholastic Inc. or the Claims Administrator.

You cannot bring any legal action against Scholastic Inc. or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Scholastic Inc. or the Claims Administrator you must do so within three years of the date you are

notified of the final decision on your appeal or you lose any rights to bring such an action against Scholastic Inc. or the Claims Administrator.

## SECTION 10 - COORDINATION OF BENEFITS (COB)

### What this section includes:

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

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

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

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

### Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to [www.myuhc.com](http://www.myuhc.com) or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

## Determining Which Plan is Primary

### *Order of Benefit Determination Rules*

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

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

- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child.
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

**Determining Primary and Secondary Plan - Examples**

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

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

## When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

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

### *Determining the Allowable Expense If This Plan is Secondary*

#### **What is an allowable expense?**

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

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

## When a Covered Person Qualifies for Medicare

### *Determining Which Plan is Primary*

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

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, domestic partners are excluded as provided by Medicare);
- Individuals with end-stage renal disease, for a limited period of time; and
- Disabled individuals under age 65 with current employment status and their Dependents



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

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

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

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

***If This Plan is Secondary to Medicare***

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

- The Plan determines the amount it would have paid based on the primary plan's (i.e., Medicare) allowable expense.
- If this Plan would have paid less than the primary plan (i.e., Medicare) paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan (i.e., Medicare) paid, the Plan will pay the difference.

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

**Medicare Crossover Program**

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

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

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

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

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

### **Right to Receive and Release Needed Information**

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

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

### **Overpayment and Underpayment of Benefits**

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

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

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

#### ***Refund of Overpayments***

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

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

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits that are payable in connection with services provided to other Covered Persons under the Plan. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

## SECTION 11 - SUBROGATION AND REIMBURSEMENT

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

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

### ***Subrogation – Example***

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

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

### ***Reimbursement – Example***

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

The following persons and entities are considered third parties:

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

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

You agree as follows:

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

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

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

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

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

## Right of Recovery

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

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible; or

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

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

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

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

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

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



## SECTION 12 - WHEN COVERAGE ENDS

### What this section includes:

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

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

When your coverage ends, Scholastic Inc. will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from Scholastic Inc. to end your coverage, or the date requested in the notice, if later.

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

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from Scholastic Inc. to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

### *Other Events Ending Your Coverage*

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period.

Please also refer to the *How to Appeal a Denied Claim* section above. The notice will contain information on how to pursue your appeal.

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

### Coverage for a Disabled Child

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

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

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

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

### Extended Coverage for Total Disability

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

- the Total Disability ends; or
- twelve months from the date coverage would have ended.

### Continuing Coverage Through COBRA

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

***Continuation Coverage under Federal Law (COBRA)***

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

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

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

***Qualifying Events for Continuation Coverage under COBRA***

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

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

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

***How Your Medicare Eligibility Affects Dependent COBRA Coverage***

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

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

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

***Getting Started***

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

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

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

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

- during Open Enrollment; and
- following a change in qualified status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

### ***Notification Requirements***

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

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

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

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

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

### ***Notification Requirements for Disability Determination***

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

***Trade Act of 2002***

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

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

**When COBRA Ends**

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

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to (i.e., enrolled in) Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months;
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends unless a second qualifying event has occurred;
- the date the entire Plan ends; or
- the date the applicable 18-, 29- or 36-month COBRA continuation coverage period ends.

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

### **Continuation of Coverage While on a Family and Medical Leave**

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected coverage during this time. Scholastic Inc. is required to maintain medical plan coverage for employees on FMLA leave whenever such coverage was provided before the leave was taken and on the same terms as if you had continued to work. If you are receiving a paycheck from Scholastic Inc. while on FMLA leave, your contributions will be taken out of that paycheck on the same pre-tax or after-tax basis as you paid prior to commencing leave. If you are not receiving a paycheck from Scholastic Inc. while on FMLA leave, your contributions will be billed and you will need to pay Scholastic Inc. by check for your coverage or collected upon your return to work. Contact the Scholastic Benefit Service Center at 1-888-469-2363 for additional information.

### **Uniformed Services Employment and Reemployment Rights Act**

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

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

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

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this

reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

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



## SECTION 13 - OTHER IMPORTANT INFORMATION

**What this section includes:**

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

### Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

### Your Relationship with UnitedHealthcare and Scholastic Inc.

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

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

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

### **Relationship with Providers**

The Claims Administrator has agreements in place that govern the relationships between it and Scholastic, Inc. and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

Scholastic Inc. and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Scholastic Inc. and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Scholastic Inc.'s employees nor are they employees of UnitedHealthcare. Scholastic Inc. and, UnitedHealthcare are not responsible for any act or omission of any provider.

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

Scholastic Inc. is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

### **Your Relationship with Providers**

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

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and

- must decide with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Scholastic, Inc. is that of employer and employee, Dependent or other classification as defined in this SPD.

### **Interpretation of Benefits**

Scholastic Inc. and UnitedHealthcare have the sole and exclusive discretion to:

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

Scholastic Inc. and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

### **Information and Records**

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

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

Scholastic Inc. and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Scholastic Inc. is required to do by law or regulation. During and after the term of the Plan, Scholastic Inc. and UnitedHealthcare and its related entities may use and transfer the information gathered

under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

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

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

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

### **Incentives to Providers**

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in Section 5, *Plan Highlights*.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract,

including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

### **Incentives to You**

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but Scholastic Inc. recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

### **Rebates and Other Payments**

Scholastic Inc. and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Scholastic Inc. and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays or Coinsurance.

### **Workers' Compensation Not Affected**

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

### **Future of the Plan**

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

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

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

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

## Plan Document

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

## Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

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

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

## SECTION 14 - GLOSSARY

### What this section includes:

- Definitions of terms used throughout this SPD.

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

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

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

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

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

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

**Annual Deductible (or Deductible)** - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided by the separate Prescription Drug plan administered by ExpressScripts.

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

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).

- Zygote intrafallopian transfer (ZIFT).

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

**Bariatric Resource Services (BRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by Scholastic Inc. The BRS program provides:

- specialized clinical consulting services to Participants and enrolled Dependents to educate on obesity treatment options; and
- access to specialized Network facilities and Physicians for obesity surgery services.

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

**BMI** - see Body Mass Index (BMI).

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

**Cancer Resource Services (CRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by Scholastic Inc. The CRS program provides:

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

**Care Advocacy Program** - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

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

**Cellular Therapy** - administration of living whole cells into a patient for the treatment of disease.

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

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



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

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

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

**Company** - Scholastic Inc.

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

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

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

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

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

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

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

**Covered Health Services** - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and 6, *Additional Coverage Details*.

- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions*.

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

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

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

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

**Custom Care Management** - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

**Custom Care Advocate** - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Custom Care Advocate is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

**Deductible** - see Annual Deductible.

**Definitive Drug Test** - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

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

**Designated Provider** - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or

- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.
- A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Designated Virtual Network Provider** - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

**DME** - see Durable Medical Equipment (DME).

**Domestic Partner** - an individual of the same sex with whom you have established a domestic partnership as described below. Domestic Partner coverage is limited to same sex Domestic Partners enrolled prior to January 1, 2016.

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

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
  - they have a single dedicated relationship of at least 12 months duration;
  - they have joint ownership of a residence; or
  - they have at least two of the following:
    - ◆ a joint ownership of an automobile;
    - ◆ a joint checking, bank or investment account;
    - ◆ a joint credit account;
    - ◆ a lease for a residence identifying both partners as tenants; or
    - ◆ a will and/or life insurance policies which designate the other as primary beneficiary.

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

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

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

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

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

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or

as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

**Emergency** - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

**Emergency Health Services** - with respect to an Emergency, both of the following:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).

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

**Employer** - Scholastic Inc.

**EOB** - see Explanation of Benefits (EOB).

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

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

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

Exceptions:

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

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

- the Benefits provided (if any);

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

**Fertility Solutions (FS)** - a program administered by UnitedHealthcare or its affiliates made available to you by Scholastic Inc.. The FS program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

**Gene Therapy** - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

**Genetic Counseling** - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

**Genetic Testing** - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

**Gestational Carrier** - A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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

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

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

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

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

**Infertility** - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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

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

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

**Intensive Behavioral Therapy (IBT)** – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

**Intensive Outpatient Treatment** - a structured outpatient Mental Health or substance-related and addictive disorder treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

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

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

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

**Manipulative Treatment** - the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods

rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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

**Medically Necessary** - healthcare services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

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

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

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

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

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

**Mental Health Services** - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of*



*Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance-Related and Addictive Disorders Administrator** - Optum Behavioral Health, an associated entity of UnitedHealthcare that specializes in the administration of Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

**Mental Illness** – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Neonatal Resource Services (NRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by Scholastic Inc. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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

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

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

**New Pharmaceutical Product** - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.

- December 31st of the following calendar year.

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

**Open Enrollment** - the period of time, determined by Scholastic Inc., during which eligible Participants may enroll themselves and their Dependents under the Plan. Scholastic Inc. determines the period of time that is the Open Enrollment period.

**Out-of-Pocket Maximum** - the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided by the separate Prescription Drug plan administered by ExpressScripts.

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

**Participant** - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

**Pharmaceutical Product(s)** – U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

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

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

**Plan** - The Scholastic Inc. Welfare Benefit Plan.

**Plan Administrator** - Scholastic Inc. or its designee.

**Plan Sponsor** - Scholastic Inc.

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

**Prescription Drug List (PDL) Management Committee** - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

**Presumptive Drug Test** - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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

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

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

**Residential Treatment** – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

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

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private

Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Shared Savings Program** – a program in which UnitedHealthcare may obtain a discount to a non-Network provider’s billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

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

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

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

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

**Substance-Related and Addictive Disorders Services** - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a

disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Surrogate** - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

**Therapeutic Donor Insemination (TDI)** - Insemination with a donor sperm sample for the purpose of conceiving a child.

**Total Disability** - a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's inability to perform the normal activities of a person of like age and gender.

**Transitional Living** - Mental Health Services/Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

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

**UnitedHealth Premium Program<sup>SM</sup>** - a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program<sup>SM</sup> Physician or facility for certain medical conditions.

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

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

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

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

Please note:

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

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

**Urgent Care** – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

**Urgent Care Center** – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

**SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA****What this section includes:**

- Plan administrative information, including your rights under ERISA.

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

***Plan Sponsor and Administrator***

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

Plan Administrator - Medical Plan  
Scholastic Inc.  
557 Broadway  
New York, NY 10012-3999  
(212) 343-6100

***Claims Administrator***

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

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

UnitedHealthcare Service LLC.  
2950 Expressway Drive South  
Suite 240  
Islandia, NY 11749-1412

***Agent for Service of Legal Process***

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - Medical Plan

Scholastic Inc.  
557 Broadway

New York, NY 10012-3999  
 (212) 343-6100

***Other Administrative Information***

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

***Type of Administration***

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

<b>Plan Name:</b>	Scholastic Inc. Welfare Benefit Plan
<b>Plan Number:</b>	501
<b>Employer ID:</b>	13-1824190
<b>Plan Type:</b>	Welfare benefits plan
<b>Plan Year:</b>	January 1 - December 31
<b>Plan Administration:</b>	Self-Insured
<b>Source of Plan Contributions:</b>	Employee and Company
<b>Source of Benefits:</b>	Assets of the Company

***Your ERISA Rights***

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

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

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

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are



called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$147 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

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

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

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

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

## ATTACHMENT I - HEALTH CARE REFORM NOTICES

### Patient Protection and Affordable Care Act ("PPACA")

#### *Patient Protection Notices*

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

## ATTACHMENT II - LEGAL NOTICES

### Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

### Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

## ATTACHMENT III - HEALTH SAVINGS ACCOUNT

**What this attachment includes:**

- About Health Savings Accounts;
- Who is eligible and how to enroll;
- Contributions;
- Additional medical expense coverage available with your Health Savings Account;
- Using the HSA for Non-Qualified Expenses; and
- Rolling over funds in your HSA.

### Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the Scholastic Inc. Welfare Benefit Plan, which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

Scholastic Inc. has entered into an agreement with UnitedHealthcare Service LLC., Islandia, NY, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is the Plan's intention to comply with *Department of Labor* guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by Scholastic Inc. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

### About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- Scholastic Inc. Welfare Benefit Plan, a high deductible medical plan which is discussed in your Summary Plan Description;
- an HSA you establish; and
- health information, tools and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

**What is an HSA?**

An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- accumulate over time with interest or investment earnings;
- are portable after employment; and
- can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

**Who Is Eligible And How To Enroll**

Eligibility to participate in the Health Savings Account is described in the SPD for your high deductible medical plan. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- must not be covered by any group health plan that is not considered a high deductible health plan by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- must not participate in a full health care Flexible Spending Account (FSA);
- must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare); and
- must not be claimed as a dependent on another person's tax return.

**Contributions**

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at [www.irs.gov](http://www.irs.gov).

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

*Note:* Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

### **Reimbursable Expenses**

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

### **Additional Medical Expense Coverage Available with Your Health Savings Account**

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services in the Plan, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

### **Using the HSA for Non-Qualified Expenses**

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense

under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

### **Rollover Feature**

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

#### **Important**

Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Scholastic Inc. and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Scholastic Inc. and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

### **Additional Information About the HSA**

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at [www.irs.gov](http://www.irs.gov). You may also contact your tax advisor.



## ATTACHMENT IV – NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service LLC, on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

<b>Claims Administrator Civil Rights Coordinator</b>
<b>UnitedHealthcare Service LLC Civil Rights Coordinator</b> UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

**ATTACHMENT V – GETTING HELP IN OTHER LANGUAGES OR FORMATS**

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր ստորոցապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n’amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomeru ya telephone y’ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k’umugambi wawe w’ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকরে অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711



Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ‘ana aku iā ‘oe ma ka maopopo ‘ana o kēia ‘ike ma loko o kāu ‘ōlelo pono ‘i me ka uku ‘ole ‘ana. E kama ‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa imuta asusu gi n'efu n'akwughị ugwo. Maka ikpoturu onye nsughari okwu, kpoo akara ekwentị nke di n'akwukwo njirimara gi nke emere maka ahụike gi, pia 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。

Language	Translated Taglines
28. Karen	<p>မူအိဉ်ဒီးတၢ်ခွဲးတၢ်ဖၢၣ်လၢနကဒီးန့ၢ်ဘၣ်တၢ်ဖၢၣ်စၢၤဒီးတၢ်ဂၢၢ်တၢ်ကၤလၢနကဒီးဒၣ်န့ၢ်လၢတၢ်လိၣ်ဟ့ၣ်အပူၤတၢ်န့ၣ်လီၤလၢတၢ်ကယုန့ၢ်ပၤကတိၤကၤတၢ်တၢ်အဂီၢ်ကိၤတၢ်ဘၣ်လိၣ်တၢ်အကၤလၢကရၢဖိအတၢ်လိၣ်ဟ့ၣ်အပူၤလၢအအိဉ်လၢနကဒီးအိဉ်ခ့ၣ်အိဉ်ခ့ၣ်အတၢ်ရၣ်တၢ်ကၤအကးအလၢဒီးဆိဉ်လီၤနီၢ်ဂံၢ် 0 တက့ၢ်. TTY 711</p>
29. Korean	<p>귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711</p>
30. Kru- Bassa	<p>Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711</p>
31. Kurdish-Sorani	<p>مافه‌ی ئه‌وه‌ت هه‌یه‌ که‌ بیه‌رامیه‌ر، یارمه‌تی و زانیاری پێویست به‌ زمانێ خۆت وهرگریت. بۆ داواکردنی وهرگیرێکی زاره‌کی، په‌یوه‌ندی بکه‌ به‌ ژماره‌ ته‌له‌فۆنی نووسراو له‌ناو ئای دی کارتی پیناسه‌یی پلانی ته‌ندروستی خۆت و پاشان 0 داگره‌ .TTY 711</p>
32. Laotian	<p>ທ່ານມີສິດທິ 'ຈະໄດ້' ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທິ 'ເປັນພາສາຂອງທ່ານ' ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍ ຮ້ອງນາຍພາສາ,ໂທຟຣີ ຫາຫາມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທິ 'ໄດ້' ລະບຸ ໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711</p>
33. Marathi	<p>आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबद्ध केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711</p>
34. Marshallese	<p>Eor aṃ maroñ ñan bok jipañ im mejeje ilo kajin eo aṃ ilo ejjeļok wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711</p>
35. Micronesian-Pohnpeian	<p>Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.</p>
36. Navajo	<p>T'áá jíík'eh doo bááh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee níká'e'eyeego bee ná'ahoot'í'. 'Ata' halne'í ła yíníkeedgo, ninaaltsos</p>

Language	Translated Taglines
	nit[ 'iz7 'ats'77s bee baa' ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodílnih d66 0 bił 'adidíłchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाउँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëc, ke yin cöl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	<b>Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711</b>
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. <b>TTY 711</b>
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. <b>TTY 711</b>
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਬਾਰੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦੱਤੇ ਗਏ ਟਾਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. <b>TTY 711</b>
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. <b>TTY 711</b>
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate,





Language	Translated Taglines
54. Telugu	ఎలాంటి ఖర్చు లోకుండా మనీ భూషణ్ సాయంబు మరయు సమచార పొందడానికి మనకు హాక్కు ఉంది. ఒకవేళ దుబాషీ కావాలంటే, మనీ హాల్ తో పోలాన్ ఐడో కారడ మనీద జాబితా చేయబడడ లోల ఫోన్ నంబరుకు ఫోన్ చేసే, 0 వోర్స్ చేసేకో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอสามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ‘a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711

Language	Translated Taglines
62. Yiddish	<p>איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל, דרוקט .0 TTY 711</p>
63. Yoruba	<p>O ní ẹ̀tọ̀ lati rí iranwọ̀ àti ifitónilétí gbà ní èdè ẹ̀ rẹ̀ láisanwọ̀. Látí bá ògbuḟọ̀ kan sọ̀rọ̀, pè sọ̀rí nọmbà ẹ̀rọ̀ ibánisọ̀rọ̀ láisanwọ̀ ibodè ti a tò sọ̀rí kádí idánimọ̀ ti ètò ilera ẹ̀, tẹ̀ '0'. TTY 711</p>

## ADDENDUM – SCHOLASTIC PRESCRIPTION DRUG PROGRAM

### About Your Prescription Drug Coverage

The Scholastic Prescription Drug Program is designed to help you control medical costs by providing you and your eligible family members with specially-negotiated prices on prescription medications at participating network pharmacies and through a mail-order service. The Scholastic Prescription Drug Program is administered by Express Scripts, not UnitedHealthcare.

The Pharmacy Benefits described on the following pages are NOT administered by UnitedHealthcare. The administrator for the Pharmacy Benefits is Express Scripts.

Customer Service Availability: Representatives are available to assist you with claim questions or other inquiries 24 hours a day; 365 days a year.

You can reach Express Scripts Member Services at (888)749-3873.

Scholastic's prescription drug program is designed to help you save on out-of-pocket costs when you choose generic over brand name drugs, an effective way to slow the rise in prescription drug costs.

If your doctor prescribes medicines from a list of preferred brand-name and generic medications, called the Formulary Drug List, you will pay a lower percentage of the cost than if you purchase non-formulary drugs. You can find the formulary listing at [www.express-scripts.com](http://www.express-scripts.com).

The eligibility of a prescription medication is subject to the terms of the Scholastic Prescription Drug Program. Covered and excluded medications under the Prescription Drug Program are defined later in this section.

There are three ways to purchase prescription drugs:

- At an Express Scripts participating retail pharmacy;
- Through the Express Scripts mail order pharmacy;
- Through a non-network pharmacy (this will not be covered under the plan).

### ID Card

You and each of your covered family members will receive an identification (ID) card that shows if you are enrolled in the **Choice Plus POS Plan with HSA**. Your medical ID card is also your pharmacy card. You can also download the Express Scripts mobile app. The app has a wide range of features to facilitate the management of prescriptions anywhere, anytime. After downloading the app, you can use your [express-scripts.com](http://express-scripts.com) user name and password to log in. If you have not registered via [express-scripts.com](http://express-scripts.com), you can create a user name and password right from the app — and use the same user name and password to access the member website, [express-scripts.com](http://express-scripts.com).

When available on your device, you have the option to use touch ID or facial recognition authentication to log in via the app to your Express Scripts account, if desired. You can access your virtual member ID card at any time, check order status, refill a prescription, set dosage reminders, and more using the Express Scripts mobile app. You can use the app in place of an ID card.

## Scholastic Prescription Drug Program at a Glance

### Coverage for Active Employees

The following chart shows what you'll pay for prescription drugs in 2020:

Pharmacy Benefits	Choice Plus POS Plan with HSA
<b>In-Network   Participating Retail Pharmacies – For up to a 30-day supply</b>	
Generic	\$8 co-payment (after deductible)
Preferred Brand-Name (“Formulary”)	30% of discounted cost, minimum \$30 /maximum \$75 (after deductible)
Non-Preferred Brand-Name (“Non-Formulary”)	50% of discounted cost, minimum \$50 /maximum \$125 (after deductible)
Claim Forms	Claims are filed automatically if you present your ID card; however, you must file a manual claim if you do not present your ID card
<b>Out-of-Network   Non-Participating Pharmacies – For up to a 30-day supply</b>	
Generic	No out-of-network coverage
Preferred Brand-Name (“Formulary”)	No out-of-network coverage
Non-Preferred Brand-Name (“Non-Formulary”)	No out-of-network coverage
Claim Forms	N/A
<b>Mail Order Pharmacy – For up to a 90-day supply</b>	
Generic	\$20 co-payment (after deductible)
Preferred Brand-Name (“Formulary”)	30% of discounted cost, minimum \$60 /maximum \$150 (after deductible e)
Non-Preferred Brand-Name (“Non-Formulary”)	50% of discounted cost, minimum \$100 /maximum \$250 (after deductible)
Claim Forms	Claims filed automatically
<b>Annual Pharmacy Out-of-Pocket Maximum</b>	
Employee Only Coverage	Combined with the medical annual out-of-pocket maximum of \$6,350 for <i>Employee</i> only and \$12,700 for <i>Employee +Ch, Employee +Sp</i> and Family
EE+Ch, EE+Sp, Family	

### Preferred Drug List (Formulary Drug list)

The Plan has a list of “preferred” prescription drugs, sometimes called a formulary, which includes a wide range of brand-name and generic drugs. These are the products that the Plan

prefers for filling prescriptions. You will pay a lower co-payment for generic medications or the preferred version of a brand name drug, than for the non-preferred version. When a prescription drug becomes available as a generic, the brand-name version may no longer be on the preferred drug list and the brand-name co-payment may increase to the non-preferred level.

The preferred drug list is available online at [www.express-scripts.com](http://www.express-scripts.com) or Express Scripts at 888-749-3873 to check on the classification of a prescription drug.

***Note:** If you purchase a Brand-Name Drug when there is a Generic Drug equivalent available, you will pay the Generic Drug Co-Payment plus the difference in cost between the Brand-Name Drug and the Generic Drug.*

### Network Retail Pharmacies

All prescriptions with the exception PPACA preventive drugs are subject to the deductible before the co-payment/coinsurance applies. Network pharmacies will fill your prescription with a generic drug whenever possible. To research the cost of prescription drugs, visit the Express Scripts website, [www.express-scripts.com](http://www.express-scripts.com).

### Out of Network Pharmacies

If you fill a prescription at an out-of-network retail pharmacy, you will pay that pharmacy's full retail cost of the prescription drug at the time of purchase.

***Only In-Network coverage is covered under the Scholastic Pharmacy Plan:***

Out-of-network costs will not count toward your deductible or out-of-pocket maximum.

***To locate a Network pharmacy near you:***

Visit [www.express-scripts.com](http://www.express-scripts.com), or ask your local retail pharmacy whether it participates in the Express Scripts network

### Prescriptions by Mail

#### ***Mandatory mail-order program – Prescriptions by Mail***

For maintenance medications, or prescriptions you take on an on-going basis, you may use a participating retail pharmacy for your initial fill (30-day supply) and one refill (i.e., two fills in total). Thereafter, if you remain on that medication, you **must** order subsequent refills through the Express Scripts mail order pharmacy. Purchasing drugs through the mail order program is less expensive, and more convenient than purchasing the same medications at a retail pharmacy. You can order online, mail or fax your prescriptions through Express Scripts., **or pay the entire cost of the drug yourself at the participating retail pharmacy.**

You can find out if your prescriptions are on the mandatory mail listing by going online at [www.express-scripts.com](http://www.express-scripts.com) or you can call Express Scripts at 888-749-3873.

Order forms and fax forms, as well as directions on how to place your order, are available online at [www.express-scripts.com](http://www.express-scripts.com), or you can call Express Scripts at 888-749-3873 to request a form and get answers to your questions.

### **Fewer Refills Saves You Money**

If your doctor writes a prescription for a 30-day supply of medication with 11 refills (for a total of 12 “fills”), Express Scripts can fill your prescription for a 90-day supply of medication in a single fill. You’ll then have three additional 90-day refills remaining. Express Scripts refers to this as “consolidation of refills.” What’s important for you to know is this consolidation saves you money by requiring fewer co-payments, when applicable. For that reason, it is better that your doctor write a prescription for a 90-day supply with three refills. Express Scripts will, if possible, consolidate your refills to save you money.

Refills for some medications – such as controlled substances, sleeping medications, inhalers and certain other drugs – can’t be consolidated.

#### ***What does this mean for you?***

Consolidating your prescription will enable you to receive a 90-day supply for a single home delivery co-payment rather than pay three separate 30-day co-payments. And, you won’t need to refill as often with a 90-day supply.

Remember, it’s best if you let your doctor know in advance that your prescription for home delivery from the Express Scripts Pharmacy should be written for a 90-day supply, with three refills.

**Note:** *If you live in the states of Oklahoma or Texas, Express Scripts is prohibited by state law from automatically consolidating your prescription. To save yourself some money, have your doctor write your prescription for a 90-day supply with three refills.*

### **Preventive Prescription Drugs**

In accordance with the Affordable Care Act, certain classes for preventive medications are covered at 100% by the Plan, and not subject to the aforementioned co-payments, coinsurance and/or deductible. You can reference <https://www.healthcare.gov/coverage/preventive-care-benefits> for a complete listing of these classes or contact Express Scripts if you have questions about the specific preventive drugs that are covered under the Plan

**Note:** Some preventive drugs which are covered at 100% may be subject to limitations related to dosage, age, and quantities. For more information, contact Express Scripts either by calling or visiting the website.

Preventive prescription drugs can help mitigate the risk factors for certain conditions you may be at risk of developing. Express Scripts is responsible for determining whether a prescription drug is considered preventive based on federal guidelines.

## Managing Prescription Drug Costs

### ***Supply Limits***

Certain prescription drugs are subject to supply limits. If your prescription is for a quantity over the supply limit, you will need to request approval from Express Scripts for the additional quantity.

### ***Lifetime Maximum Benefits***

Fertility drugs are subject to a \$10,000 lifetime Maximum Benefit.

### ***Prior Authorization Program***

Certain prescription drugs require that you notify Express Scripts before you purchase them. In this case, your pharmacist will request that your doctor call Express Scripts. Express Scripts will review the prescription and approve or deny it. If you did not notify Express Scripts before the prescription was dispensed and paid for the prescription, you can submit a manual claim and the Plan will consider reimbursement. Claim forms are available on the [www.express-scripts.com/esi](http://www.express-scripts.com/esi) website, or may be obtained by contacting Express Scripts Member Services at (888) 749-3873. You can submit the completed claim form by mail to:

Express Scripts, Inc.  
ATTN: Claims Department  
PO Box 2849  
Clinton, IA 52733-2894

For mail order prescriptions, the mail order program will contact your doctor.

A List of applicable drugs is available online at [www.express-scripts.com](http://www.express-scripts.com), and you can also call Express Scripts at (888) 749-3873 for more information.

### ***Drug Utilization Review – Safe and Appropriate Use of Medications***

By continually using participating pharmacies or by using the mail pharmacy, you also gain the advantage of a prescription review. This confidential online system allows the pharmacist access to important information, such as your individual drug history, the possibilities of interaction among various drugs and how long it has been since your last prescription was filled. If the potential for drug-related illness or incompatibility is flagged, an alert message is sent to the pharmacist who can then inform you to check with your doctor or make a professional judgment whether to dispense your prescription.

Under the Managed Pharmacy Retail Program there is a “refill-too-soon” feature which does not allow a refill of medication until 75% of the original prescription has been used. This feature helps to prevent overuse of medication and the purchase of more medication than is medically necessary. Additionally, under the mail program, your refill slip will indicate your earliest refill date. If you request a refill prior to the earliest refill date, your refill request will be held and sent on the appropriate refill date.

As noted in this section, there is also a coverage management program which has established appropriate threshold levels of utilization (e.g. limit on number of doses) for specific drug



therapy categories and payment will be rejected at the point of sale (retail or mail) whenever the drugs being dispensed exceed those predetermined limits or if you do not meet the clinical criteria to receive the medication (determined by the prior authorization review).

### ***The Benefits of Step Therapy***

Step therapy is all about health and value – about getting the most effective medication for your health and money. That means using a tried-and-true medication that’s proven safe and effective for your condition at the lowest possible cost to you and your plan sponsor.

### ***How does Step Therapy work?***

Step therapy is designed for people who regularly take prescription drugs to treat ongoing medical conditions such as arthritis, asthma or high blood pressure. Prescription medications are grouped into two categories:

***Step 1:*** medications are generic drugs that have been rigorously tested and approved by the FDA. Generics should be prescribed first because they can provide the same health benefits as higher-cost medications.

***Step 2:*** medications are brand-name drugs such as those you see advertised on TV. They’re recommended only if a Step 1 medication doesn’t work for you. Step 2 medications almost always cost you and your plan sponsor more than Step 1 medications.

### ***What if my doctor prescribes a Step 2 medication?***

Ask if a generic (Step 1) medication may be right for you. Please share your formulary – the list of prescription drugs covered by your plan – with your doctor. The pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 2 medication to a Step 1 medication. If a Step 1 medication is not a good choice for you, then your doctor can request prior authorization to determine if a Step 2 medication will be covered by your plan.

### ***Who decides which prescription drugs are included in step therapy?***

A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medications for inclusion in the step therapy program. Together, they review the most current research on thousands of prescription drugs tested and approved by the FDA for safety and effectiveness, recommending appropriate prescription drugs for the program. Scholastic then selects the medications that will be covered on your prescription drug plan. For more information on step therapy in your benefit plan, visit [www.express-scripts.com](http://www.express-scripts.com).

Keep in mind, some specialty medications require a clinical review to be used for continued treatment or when they are first prescribed. Contact Express Scripts Customer Care for more information.

## **Express Scripts Specialty Pharmacy**

If you need covered prescription medications that require special handling or administration, like chemotherapy drugs, you will need to order them through Express Scripts’ Specialty Pharmacy, Accreddo, moving forward.

This full-service specialty pharmacy provides personalized care to patients with chronic and complex health conditions. By receiving covered prescription medications this way, you may pay less for them overall. Additionally, you may be able to have them shipped directly to you or your doctor's office at no additional charge. Contact Express Scripts Customer Care for more details.

Note that specialty drugs specialty drugs purchased at a retail pharmacy will be not be covered.

All specialty drugs must be obtained through Accredo, except as follows:

- Specialty medications provided by your medical provider that are billed as part of your office visit, will still be covered; and
- If a medication's manufacturer has an exclusive arrangement with a specialty pharmacy other than Accredo, that pharmacy will fulfill your medication instead of Accredo, and you will have coverage under the Plan.

### *Accredo, your specialty pharmacy*

- Accredo offers several comprehensive disease-specific patient-care management programs:
- Patient counseling – convenient access to highly trained specialty experts, including
- pharmacists, nurses and patient care coordinators who provide the support you need to manage your condition
- Patient education – clinicians and disease-specific educational materials available 24/7
- Convenient medication delivery – coordinated delivery to your home, doctor's office or any other approved location
- Refill reminders – ongoing refill reminders from a patient care coordinator
- Language assistance – translation services are available for non-English speaking patients

### **Definitions**

The definitions below are to be used to support and clarify administrative policies and procedures described elsewhere in this document and are not intended to amend any terms or definitions in the Managed Prescription Drug Program Agreement between the Plan and Express Scripts.

**Brand Name Drug** – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

**Covered Service** – Medically necessary Prescription Drug prescribed by a physician for the treatment of illness or injury and dispensed by a pharmacist.

**Generic Drug** – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

**Mail Order** - The ESI Pharmacy program that offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service, and sent directly to your home.

**Maintenance Medication** - Maintenance drugs are those generally taken on a long-term basis for conditions such as high blood pressure and high cholesterol. Examples of maintenance medications are Zocor (generic simvastatin) and Lipitor (generic atorvastatin) to lower cholesterol/lipids. Short-term drugs include antibiotics and other medications that you take for short periods of time.

**Prescription Order** - A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

**Prescription Legend Drug, Prescription Drug, or Drug** - A medicinal substance that is produced to treat illness or injury and is dispensed to patients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under the Plan.

**Prior Authorization** - The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

**Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

**Specialty Drug** - Specialty Drugs are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Specialty Drugs are Prescription Legend Drugs which are normally injected, infused or require close monitoring by a physician or clinically trained individual; or often have limited availability, special dispensing and delivery requirements, and/or require additional patient support.

**Step Therapy Rule** - A plan rule that requires a member to first try one or more specified drugs to treat a particular medical condition before the plan will cover another (usually more expensive) drug that the member's physician may have prescribed.

## Covered Medications

The following items are covered when prescribed by a physician and medically necessary. This is not a complete list of all covered medications. If there is question about a certain drug you've been prescribed, please call Express Scripts to confirm it's available under your benefit:

- Federal legend drugs;
- State restricted drugs;
- Insulin;
- Needles and syringes;
- Certain over-the-counter diabetic supplies with a prescription;
- Retin-A and Avita cream through age 34 (may be eligible beyond age 34 with prior authorization);
- Legend prenatal vitamins;
- Legend vitamin D and K;
- Legend folic acid;
- Hematinic vitamins;
- Legend vitamin B12/Cyanocobalamin; and
- Oral contraceptives, the contraceptive patch (Orthro-EVRA), contraceptive devices and implants. (**Note:** Contraceptive devices and implants not available through the Scholastic Prescription Drug Program may be covered under the Scholastic Medical Plan.)

## Non-covered Medications Under the Prescription Drug Program

- Drugs purchased at an out-of-network pharmacy;
- Drugs that are excluded on Scholastic's formulary (available through Express Scripts);
- Drugs dispensed in any amount that exceeds the supply limits;
- Drugs that are prescribed, dispensed or intended for use while in a hospital, skilled nursing facility or an alternate facility;
- Experimental, investigational or unproven services and medications and/or dosage amounts;
- Drugs that are provided by the local, state or federal government (Medicare, for example) to the extent that they are provided by the local, state or federal government whether or not you receive the benefits, except as provided by law;
- Drugs for any condition, injury, sickness or mental illness for which workers' compensation benefits are available, whether or not you receive the benefits;

- Appetite suppressants and other weight loss products. Weight Management drugs are covered if medically necessary for Morbid Obesity. Express Scripts must give prior approval;
- Specialty drugs (such as immunizations and allergy serum) that are typically administered or supervised by a qualified provider in an outpatient setting (this exclusion does not apply to Depo Provera and other injectable drugs used for contraception);
- Durable medical equipment, and other outpatient supplies other than the diabetic supplies and inhaler spacers specifically stated as covered;
- General vitamins (except for prescribed prenatal vitamins, vitamins with fluoride and single entity injections, which are covered);
- Unit dose packaging of drugs;
- Drugs used for cosmetic purposes;
- Drugs, or new drugs or dosages that Express Scripts determines are not covered;
- Replacement drugs resulting from a lost, stolen, broken or destroyed prescription or refill
- Drugs that do not contain at least one ingredient that requires a prescription or refill;
- Drugs available over-the counter that do not require a prescription or refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug;
- The following drugs will be excluded from your plan coverage. These drugs have alternatives which can be discussed with your doctor:
  - Duexis/Vimovo
- New products and/or dosage forms until they are reviewed and approved by Express Scripts; and
- Drugs used for the treatment of erectile dysfunction or sexual dysfunction in excess of five tablets for a 31-day period.

### **Other Important Information**

Other features of the Scholastic Prescription Drug Program include keeping a profile of your medication history and providing a toll-free number to speak with a pharmacist.

As part of this administration, Express Scripts generally reports that information to the administrator of the Scholastic medical plan option that you selected, and your Medical Plan administrator reports your medical information to Express Scripts. Your prescription and medical data is used to identify potential overuse, abuse and waste of particular medications as well as appropriateness of the medications prescribed. Express Scripts may send alerts to prescribing physicians and dispensing pharmacists about the situations it identifies. Express Scripts also uses the prescription data gathered from claims submitted nationwide for reporting and analysis without identifying individual patients.

Express Scripts may also take other actions to address concerns it identifies with utilization of the Prescription Drug Program, including limiting you to the use of one retail pharmacy if your pattern of utilization for a particular medication warrants it.

**Appeal Process for Prescription Claims**

If you have a question or concern about a benefit determination, you can contact Express Script’s Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you can submit your appeal to the Plan at the following address:

Express Scripts, Inc. ATTN: ADMINISTRATIVE APPEALS DEPARTMENT  
 PO BOX 66587  
 ST. LOUIS, MO 63166-6587  
 Phone: 800-946-3979

Please refer to Section 9 of this SPD - Claims Procedures for additional detail regarding claims and appeals.

**Administrative Information**

<b>Plan Name:</b>	Scholastic Inc. Welfare Benefit Plan
<b>Plan Administrator/ Plan Sponsor</b>	Scholastic Inc. 557 Broadway New York, NY 10012-3999 1-212-343-6100
<b>Type of Plan</b>	The Plan described in this Summary Plan Description is a group health plan for purposes of ERISA.
<b>Type of Administration</b>	Express Scripts, St. Louis, MO. 63121 (Pharmacy)
<b>Source of Funds</b>	Funded by direct benefit payments from Scholastic’s general assets
<b>Plan year:</b>	January 1 – December 31
<b>Plan Number</b>	501
<b>Employer Identification Number (EIN)</b>	13-1824190
<b>Agent for Service of Legal Process</b>	The Plan Sponsor named above

**Where to Get More Information**

For more information about your prescription plan you can call Express Scripts at 888-749-3873 (24 hours a day, 7 days a week). You will also find information on the Express Scripts web site at [www.express-scripts.com](http://www.express-scripts.com). You can also contact The Scholastic Benefit Service Center.

**Scholastic Benefit Service Center**

Mailing Address: Empyrean Benefit Solutions

P.O. Box 572256

Houston, TX 77257-2256

Phone: 1-888-4MY-BENF (1-888-469-2363) Fax: 1-281-727-0870

Email: [Scholastic@Empyreanbenefits.com](mailto:Scholastic@Empyreanbenefits.com)





