UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan for Non-Medicare Eligible Retirees

Summary Plan Description

Updated 2018

The UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan Summary Plan Description (SPD) is intended to be read in conjunction with the separate SPD for the Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program. This SPD, when combined with the SPDs describing the Comcast NBCU Post-Retirement Health Care & Retiree Reimbursement Account Program and the Retiree IBC PPO Plan, forms a complete SPD as required by the Employment Retirement Security Act of 1974, as amended, describing the Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account Program for retirees and eligible dependents.

THE RETIREE HEALTH CARE PROGRAM

Comcast NBCUniversal is proud to offer you valuable benefit programs to support your needs. This Summary Plan Description (also referred to as "SPD") applies to some or all of the benefits you receive or may choose to receive as a retiree of Comcast NBCUniversal. It has been developed to help you learn about and understand the UnitedHealthcare (UHC) Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan. Keep this SPD handy and refer to it when you have questions about your benefits.

If you participate in, or are eligible to participate in, the Post-Retirement Retiree Reimbursement Account and/or the Retiree IBC PPO Plan, refer to those separate SPDs for more information about benefits under those plans. This SPD, when combined with the SPDs describing the Post-Retirement Health Care & Retiree Reimbursement Account Program and the Retiree IBC PPO Plan, forms a complete Summary Plan Description as required by the Employment Retirement Security Act of 1974, as amended, describing the Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account Program for retirees and eligible dependents.

Many of the benefit programs offered are covered under the federal law known as the Employee Retirement Income Security Act of 1974 (also referred to as "ERISA".) This document may serve as the SPD for those benefits. Although the plans have been summarized in everyday language, this SPD does not replace the legal documents governing the plans. If there are any differences between this information and the official plan documents, the plan documents govern. The administration of the benefit plans is the responsibility of the Plan Administrator. The Plan Administrator has the discretionary authority and the responsibility to, among other things, interpret the plan provisions, and to exercise discretion where necessary or appropriate in the interpretation, administration, and determination of eligibility for benefits under the plans.

Please keep in mind that although Comcast NBCUniversal intends to continue the plans in their present forms, Comcast NBCUniversal reserves the right, by action of the appropriate representative, to amend, modify, suspend, or terminate the plans at any time, in whole or in part, in accordance with Comcast NBCUniversal's normal operating procedures. These modifications or terminations may be made for any reasons Comcast NBCUniversal or its representatives deem appropriate, or as a result of changes in the laws that govern the plans. Nothing in this SPD is intended to guarantee that benefit levels or costs will remain unchanged in future years.

If you have any questions after reading this SPD, please contact Mercer Marketplace 365 at 1-866-435-5135. Comcast NBCUniversal has engaged Mercer Marketplace 365SM* to provide Comcast NBCUniversal retirees and their eligible spouses with personalized support from knowledgeable, licensed Benefits Counselors. Mercer Marketplace 365 Counselors are trained to assist with claims and coverage matters. Where directed to contact UnitedHealthcare, please use the contact information provided.

*Services provided by Mercer Health & Benefits Administration LLC.

Retirees, who while employed were represented by a labor union or Guild may, or may not, be eligible for any or all of the benefits, plans or programs described in this document. The eligibility of union-represented former employees for these benefits, plans or programs may be governed by the applicable collective bargaining agreement(s) and/or be subject to collective bargaining.

THE UHC STANDARD AND MINIMUM INDEMNITY PLANS AND CVS/CAREMARK PRESCRIPTION DRUG PLAN

The UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan Summary Plan Description is intended to be read in conjunction with the separate Summary Plan Description for the Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program.

Overview

The Comcast NBCUniversal Retiree Health Care Program is intended for individuals who retire immediately following their separation of employment from Comcast NBCUniversal and is primarily designed to help bridge these individuals to Medicare eligibility, which occurs at age 65. The Program contains the following two components:

- Retiree Reimbursement Account or "RRA" — this account is set up and funded by Comcast NBCUniversal and may be used to reimburse you and your eligible spouse or domestic partner for eligible health care premiums. For more information about the RRA, read the separate *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account* Summary Plan Description.
- Retiree health care coverage you choose — you can access retiree health care coverage through a private health care marketplace (sometimes referred to as a private health care exchange) administered by Mercer Marketplace 365. You may also choose coverage through a public health care exchange. Other coverage options are also available if you meet certain eligibility requirements. See the *Comcast NBCU Post-Retirement Health Care & Retiree Reimbursement Account* SPD for a description of the range of available retiree health care coverage options.

Retirees and their dependents who meet eligibility requirements may participate in the UnitedHealthcare (UHC) Standard and Minimum Indemnity Plans, and the CVS/Caremark Prescription Drug Plan, which may be purchased alone or in addition to an indemnity health care plan option.

Eligibility

Eligibility for the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan is subject to the general eligibility provisions of the Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account Program, including the Standard Eligibility Rule, the Protected Service Rule and the Early Retirement Rule ("Rule of 70"). For these provisions, refer to the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program* SPD, which can be found on the Mercer Marketplace 365 website at http://retiree.mercermarketplace.com/comcastnbcu (or, for those not eligible for an RRA, http://retiree.mercermarketplace.com/comcastnbcuaccess. This Plan is only available to non-Medicare-eligible retirees and their eligible dependents.

Eligibility for Plan Closed to New Entrants

Note: Beginning January 1, 2018, the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan are closed to new retirees. To participate in these plans, you must have been retired on or before December 31, 2017 and enrolled in one of the plans prior to January 1, 2018 or immediately following retirement. If you are not already enrolled in the UHC Standard or Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan, you may enroll in a retiree health care plan through the private retiree health care marketplace or other available option.

Eligible retirees of Fairhaven, MA are not subject to the closed plan rule and may defer enrollment in the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan to a later date.

Spouses and Domestic Partners

If you are married or have an eligible domestic partner they will be eligible for coverage under an optional retiree health care plan made available by Comcast. Domestic partners are only eligible for coverage if mandated by state or local ordinance.

If you marry or enter into an eligible domestic partnership after retirement, your spouse or domestic partner will become eligible to participate at that time on an "access only" basis (i.e., they will be eligible for health plan coverage only and not for the RRA. You cannot cover both a spouse and a domestic partner.

A spouse is an adult with whom you have a legally valid marriage. This includes individuals residing in states that recognize common law marriages who have satisfied the minimum state requirements to be considered married in common law. If you previously created a common law marriage in a state that recognized this relationship and have moved to another state that does not recognize common law marriages, Comcast will continue to recognize your established relationship in the state in which you now reside.

Coverage for domestic partners and civil union partners is provided only where mandated by state or local ordinance. A domestic partner is defined as a mentally competent adult who lives with you in the context of a long-term, committed relationship with mutual obligations similar to those of marriage. This does not include platonic roommate relationships or any relationships prohibited by state law.

An individual cannot be covered as a retiree and a spouse/domestic partner.

Please note: According to federal tax law, your taxes may be affected when you enroll your domestic partner in an optional retiree health plan made available by Comcast NBCUniversal.

If Both You and Your Spouse/Domestic Partner are Retired from Comcast

Neither of you can be covered both as retiree and a dependent under retiree health care benefits. Each of you may be covered as either a retiree or a dependent, but not both.

Termination of Relationship

Spouse/domestic partner eligibility for the optional retiree health care plans ends upon death, divorce or termination of domestic partnership. You must notify Mercer Marketplace 365 at 1-866-435-5135 within 31 days after the death of the spouse or domestic partner or the date on which any of the criteria of marriage or domestic partnership is no longer met.

Termination of a domestic partnership also requires completion of an *Affidavit of Termination of Domestic Partnership Form* within that 31-day period. There is a six-month waiting period, beginning with the Plan Administrator's receipt of the *Affidavit of Termination*, before a new domestic partner can be added (unless prohibited by applicable law).

Dependent Children

Dependent children may be covered under the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan through end of the month in which the child reaches age 23.

Enrolling For Optional Retiree Health Care Plan Coverage

Participation in an optional retiree health care plan is voluntary. Enrollment in an optional health care plan is not automatic upon retirement. If you are eligible for coverage, you and your eligible dependents must enroll in order to receive it.

If you wish to enroll yourself and your eligible dependents for coverage in an optional health care plan made available by Comcast, you should do so within 31 days of the end of the month in which your active employee coverage ends.

Open enrollment periods are generally held in the fall of each year. The benefit choices you make during each year's open enrollment period take effect on January 1 of the following year and remain in effect until December 31. You may terminate coverage during the plan year by contacting Mercer Marketplace 365 at 1-866-435-5135.

If you terminate coverage mid-year, you will not be able to participate again.

If you are already enrolled in coverage and you do not take any action during an annual open enrollment period, your coverage for the new plan year usually defaults to your current election. You will be charged based on the new plan year retiree contributions. Comcast may conduct an active enrollment period and require all retirees to re-enroll for coverage if they want to participate in any of the Comcast benefits programs. If this is the case, you will be notified.

If you have already retired prior to age 65, as you approach age 65, you will receive information from Mercer Marketplace 365 about your retiree health care coverage options and how to enroll. For more information about how to enroll in coverage, contact Mercer Marketplace 365 at 1-866-435-5135.

Please note: If you and your spouse or domestic partner are both pre-Medicare eligible, the retiree must be enrolled in one of the optional retiree health care plans, in order for their spouse or domestic partner to enroll in coverage.

You may request to cancel your coverage at any time. If you cancel coverage and have not reached age 65, your cancellation of coverage will be effective for *all* covered dependents. If you cancel coverage because you have become Medicare-eligible, your cancellation of coverage will be effective for yourself and your Pre-65 covered dependents may continue their coverage in their current health care plan.

Changes must be reported by contacting Mercer Marketplace 365 at 1-866-435-5135.

Entitlement to Governmental Benefits

If you, or your spouse or domestic partner, becomes entitled to Medicaid or certain other governmental group medical programs, you may drop coverage under this plan.

Change in Address, Family Status or Mid-Year Election Change Event

To ensure timely and accurate processing of claims, it is important that you notify Mercer Marketplace 365 by phone at 1-866-435-5135 of any change in your address, family status change event such as marriage, divorce, and death of a spouse. Notice of events and election changes must be made within 31 days of the event. The Plan Administrator will then update your participation information (and that of your spouse or domestic partner, if applicable) as well as any optional health care plan made available by Comcast that you elect, as appropriate.

For Pre-Medicare Eligible Retirees: If You Enroll in a Health Care Plan Through the Public Exchange

If you or your spouse/domestic partner wish to enroll in a health care plan through a public exchange and you are eligible for a federal subsidy due to your income, you should decline the optional retiree healthcare coverage. If you or your spouse/domestic partner is covered under a Comcast Pre-Medicare eligible retiree health care plan, you will not be eligible for a federal subsidy for coverage purchased on the public exchange, even if your household income would otherwise qualify you for a subsidy. Failure to decline Comcast coverage will jeopardize your eligibility for the federal subsidy.

Please note that by declining health care plan coverage made available by Comcast today, you will be ineligible for future participation in the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan (which is closed to new participants as of the timing referenced above) and the RRA. Please refer to the *Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Program* SPD for more information.

When Optional Health Care Coverage Ends

Coverage under the optional health care plans made available by Comcast will automatically terminate on the last day of the month in which any of the following occurs:

- The Plan is discontinued;
- You voluntarily stop your coverage;
- The group contract ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You are rehired by Comcast as a temporary employee, part-time employee, or employee in any non-benefit-eligible group; or
- You die.

Your spouse or domestic partner's coverage will automatically terminate if:

- Your coverage ends for any of the reasons listed above *except* your death;
- He/She is no longer eligible for spouse or domestic partner coverage;
- He/She does not make the required contribution toward the cost of spouse or domestic partner coverage; or
- Spouse or domestic partner coverage is no longer available under the plan.

Paying For Coverage

Retirees who retired from Comcast or NBCUniversal Groups 4, 5 and 6 pay the full cost of the optional retiree health care plan coverage. Retirees from NBCUniversal Groups 1, 2 and 3 share the cost of optional retiree health plan coverage.

Note: If you are a Comcast or NBCU Group 5 participant, you can use your RRA, if you are eligible to receive one, to receive reimbursement for some or all of the cost of this coverage. The cost of coverage for a domestic partner is the same as the cost for a spouse. For more information, see the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program* SPD.

UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan for Non-Medicare Eligible Retirees

How the Plans Work

The UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan offer you the freedom to see any provider you wish. At the same time, you'll save money if you use participating network providers, who agree to charge discounted fees to plan participants.

Both medical options require an annual deductible before the medical plan pays benefits. Once you've met your deductible, the medical plan pays a percentage of the charges for your care. You pay the difference, called coinsurance.

You may have to pay the provider or facility and submit a claim to receive reimbursement from the plan (if you visit a network provider, they will file the claim for you). You will be responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to the provider. When you use an out of network provider, UnitedHealthcare will reimburse you for a covered expense up to the usual and customary charge, less any cost sharing required by you. If you use a participating network provider, the provider has agreed to charge discounted fees to plan participants and the coinsurance you pay is based on a percentage of the carrier's negotiated rate for the service(s).

For certain services, you must obtain precertification before you receive care, meaning you must contact the Claims Administrator for approval in advance to determine whether your care is medically necessary. You are responsible of obtaining precertification. Failure to obtain precertification may result in a penalty or increased out-of-pocket costs. Refer to the *Prior Notification* section for more information on the precertification process.

Medical Plan Network Directory

UnitedHealthcare selects and manages a group of health care professionals and facilities in its network. A listing of providers can be obtained from UnitedHealthcare's web site (www.umr.com) or you can call Member Services to help search for network providers (UnitedHealthcare Member Services can be reached at: 1-888-335-8397).

Usual and Customary

These medical plans only pay usual and customary charges when you use an out of network provider. Only that part of a charge which is less than or equal to the usual and customary charge is a covered benefit. The usual and customary charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; The charge UnitedHealthcare determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
- The provider charge data from Fair Health* at the 90th percentile.

*UnitedHealthcare uses Fair Health as the supplier of Usual and Customary data. The Geographical Area is determined by the zip code of the location where services were rendered (HCFA box 32).

In determining the usual and customary charge for a service or supply that is:

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of providers in the geographic area;

UnitedHealthcare may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The usual and customary charge in other geographic areas.

Annual Deductible

The annual deductible is the amount you must pay each calendar year **before** the medical plan pays any benefits. You may not have to meet an annual deductible for preventive care.

The annual deductibles for the Indemnity Medical Plans are as follows:

	Minimum Indemnity	Standard Indemnity
Per Individual	$1,000	$200

Coinsurance

Coinsurance is a percentage of the covered expenses that must be paid by you or your covered dependent; it is applied after the deductible is met, if any applies. The Minimum Indemnity Plan covers most services at 70%, so your coinsurance is 30%. The Standard Indemnity Plan covers most services at 80%, so your coinsurance is 20%.

As a reminder, if you use a network provider, the coinsurance is based on a percentage of the carrier's negotiated rate for the service(s). If you use an out of network provider, the coinsurance is based on a percentage of the "usual and customary charge", and could result in balance billing to you. For more information on usual and customary, refer to the *Usual and Customary* section on this page.

Annual Out-of-Pocket Maximum

The Annual out-of-pocket maximum is the most coinsurance you or your spouse or domestic partner will have to pay out of your pocket for covered medical services in an entire calendar year. Once the out-of-pocket maximum is reached, the medical plan pays 100% of the eligible expenses incurred for the rest of the year.

The Annual out-of-pocket maximum for the Indemnity Plans are as follows:

	Minimum Indemnity	Standard Indemnity
Per Individual	$3,000	$2,000

Exceptions to the Annual Out-of-Pocket Maximum

In most cases the coinsurance you pay will count toward the medical plan's Annual out-of-pocket maximum; however, some expenses will not count toward the out-of-pocket maximum. This includes:

- Charges applied to deductibles;
- Charges in excess of U&C limits;
- Charges in excess of maximum benefit amounts or other special limits, such as:
- Charges for hearing aid;
- Charges for wigs/hairpieces;
- Charges when you do not follow pre-admission review procedures; and
- Any other expenses not covered by the medical plan.

Prior Notification (Pre-certification)

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying UnitedHealthcare before you receive these Covered Health Services. To notify UnitedHealthcare, you must contact the medical plan Claims Administrator at the telephone number shown on your medical plan ID card.

Understanding Prior Notification (Pre-Certification)

Certain services, such as inpatient stays, certain tests, procedures and outpatient surgery require precertification by UnitedHealthcare. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows UnitedHealthcare to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

The Precertification Process

Prior to being hospitalized or receiving certain other medical services or supplies there are certain precertification procedures that must be followed.

You are responsible for obtaining precertification. You or a member of your family, a hospital staff member, or the attending physician, must notify UnitedHealthcare to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification in accordance with the timelines listed below.

Precertification should be secured within the timeframes specified below. To obtain precertification, call UnitedHealthcare at the telephone number listed on your ID card.

This call must be made:

For non-emergency admissions	It is your responsibility to call and request precertification at least 15 days before the date you are scheduled to be admitted
For an emergency outpatient medical condition	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible
For an emergency admission	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted
For an urgent admission	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset o for change in an illness; the diagnosis of an illness; or an injury
For outpatient non-emergency medical services requiring precertification	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled

UnitedHealthcare will provide a written notification to you and your physician of the precertification decision. If your precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, UnitedHealthcare will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician, or the facility will need to call UnitedHealthcare at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. UnitedHealthcare will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how UnitedHealthcare's decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the *Claims Review and Appeals Process* section in the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account* SPD.

Services and Supplies Which Require Precertification

Precertification is required for the following types of inpatient care medical expenses:

- Inpatient Maternity stays over 48 hours for normal delivery and 96 hours for C-section
- Inpatient Behavioral Health (acute care)
- Transplant and Transplant related services
- Skilled Nursing Facility (extended care facilities)
- Residential Treatment
- Home Health Care
- Partial Hospitalization Program
- DME; $500 for rental/$1500 for purchases/$1000 prosthetics
- Bariatric Surgery
- Chemotherapy
- Radiation
- Dialysis
- MRI/MRI/MRS/CT/PET/SPECT/CTA
- Outpatient spinal procedures (select procedures only)
- Non-emergent ambulance
- Ventricular Assist Devices
- Clinical trials

How Failure to Pre-certify Affects Your Benefits

A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means UnitedHealthcare will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary precertification from UnitedHealthcare prior to receiving services from your provider. Your provider may precertify your treatment for you; however you should verify with UnitedHealthcare prior to the procedure, that the provider has obtained precertification from UnitedHealthcare. If your treatment is not precertified by you or your provider, the benefit payable may be significantly reduced, or your expenses may not be covered.

The chart on below illustrates the effect on your benefits if necessary precertification is not obtained.

If precertification is:	Then expenses are:
Requested and approved by UnitedHealthcare	Covered
Requested and denied	Not covered, may be appealed
Not requested, but would have been covered if requested	Covered after a precertification benefit reduction is applied*
Not requested, would not have been covered if requested	Not covered, may be appealed

It is important to remember that any additional out-of-pocket expenses incurred because your precertification requirement was not met will not count toward your deductible or payment percentage or maximum out-of-pocket limit.

**If you do not notify UnitedHealthcare as outlined above, the allowable benefit will be reduced by 50%.*

Reconstructive Procedures

You should notify UnitedHealthcare fifteen days before receiving services. When you provide notification, UnitedHealthcare can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.

You are urged to confirm with UnitedHealthcare that services you plan to receive are Covered Health Services 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. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services exclusion.
- Any other limitation or exclusion of the medical plan.

Mental Health and Substance Abuse Care

You must contact the medical plan's mental health and substance abuse administrator at the phone number listed on your medical plan ID card before receiving any inpatient mental health or substance abuse care services. You may have your provider make the phone call to precertify care for you; however, it's your responsibility to make sure the call is made and to know whether the care is precertified.

If you receive Inpatient services (including Residential Treatment, Partial Hospitalization, or Intensive Outpatient Care) that have not been precertified but are determined to be Medically Necessary by UnitedHealthcare, the Eligible Expense for these services will be reduced by 50% per admission. Any penalties assessed (plus any charges over the Eligible

Expense) must be paid by you and does not count toward meeting any Deductibles or Out-of-Pocket Maximums described in this benefit summary.

If precertification is not obtained and after clinical review it is determined that the care rendered was not Medically Necessary, the care will not be covered.

The precertification penalty for Inpatient care (including Residential Treatment, Partial Hospitalization and Intensive Outpatient Care) will not apply if:

- The situation meets the definition of a Mental Health Emergency;
- You receive treatment for a Mental Health Emergency in an Inpatient setting; and
- You, your doctor or a family member calls the Claim's Administrator within two business days after the initial treatment.

Covered Medical Services

The Claims Administrator will only pay benefits for services or supplies that are covered health services under the medical plan and that are not specifically excluded by the medical plan. Covered services are health care services and supplies provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse/ chemical dependency, or their symptoms. Covered health services must be provided:

- When the medical plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the medical plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies.

Covered health services also do not include experimental or investigational services or unproven services, including clinical trials.

You must contact the Claims Administrator in advance before you receive certain services to determine whether they are covered health services. Other services require notification to the Claims Administrator within prescribed time periods. Failure to comply with these requirements may result in a reduction of benefits.

When you notify, they will work with you to implement the UnitedHealthcare process and to provide you with information about additional services that are available to you, such as health education, pre-admission counseling and patient advocacy.

In general, you must notify the Claims Administrator for the following types of care:

- Inpatient Maternity stays over 48 hours for normal delivery and 96 hours for C-section
- Inpatient Behavioral Health (acute care)

- Transplant and Transplant related services
- Skilled Nursing Facility (extended care facilities)
- Residential Treatment
- Home Health Care
- Partial Hospitalization Program
- DME; $500 for rental/$1500 for purchases/$1000 prosthetics
- Bariatric Surgery
- Chemotherapy
- Radiation
- Dialysis
- MRI/MRI/MRS/CT/PET/SPECT/CTA
- Outpatient spinal procedures (select procedures only)
- Non-emergent ambulance
- Ventricular Assist Devices
- Clinical trials

Refer to the *Understanding Prior Notification (Pre-Certification)* section for additional information.

You must notify the Claims Administrator whether you are using either an in-network or out-of-network provider. The Claims Administrator will inform you or your doctor whether the proposed service or treatment suggested by your doctor is a covered health service. Note that notification does not ensure payment of benefits — as with all coverage, the provisions of the medical plan will determine benefits.

Regardless of what the plan recommends or what the medical plan will pay, it is always up to the patient and his or her doctor to decide what, if any, care the patient should receive. The Claims Administrator does not provide medical advice.

What's Covered Under the Indemnity Medical Plan Options

The Standard and Minimum Indemnity Medical Plans cover medically necessary services and supplies that are recommended and approved by your doctor, and not specifically excluded by the medical plan. Care must be received while covered by the medical plan.

Medically Necessary or Medical Necessity can be defined as health care services and supplies or prescription drugs that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

a) In accordance with generally accepted standards of medical practice;

b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;

c) Not primarily for the convenience of the patient, physician, other health care provider; and

d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical community, or otherwise consistent with physician or specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

	Minimum Indemnity Plan	Standard Indemnity Plan
Office Care		
Doctor Visits	Covered 70% after deductible	Covered 80% after deductible
Routine Physical Exams	Covered 70% after deductible Limit $300/ calendar year[2]	Covered 80% after deductible Limit $300/calendar year[2]
Routine OB/GYN Care	70%, no deductible Limit $300/calendar year[2]	80%, no deductible Limit $300/calendar year[2]
Prenatal Care	Covered 70% after deductible	Covered 80% after deductible
Hospital Care		
Inpatient Hospitalization[1]	Covered 70% after deductible	Covered 80% after deductible
Outpatient Surgery	Covered 70% after deductible	Covered 80% after deductible
ER Visits	Covered 70% after deductible	Covered 80% after deductible
Ambulance	Covered 70% after deductible	Covered 80% after deductible
Chemical Dependency Care		
Inpatient[1]	Covered 70% after deductible	Covered 80% after deductible
Outpatient	Covered 70% after deductible	Covered 80% after deductible
Mental Health Care		
Inpatient[1]	Covered 70% after deductible	Covered 80% after deductible
Outpatient	Covered 70% after deductible	Covered 80% after deductible

	Minimum Indemnity Plan	Standard Indemnity Plan
Other Services		
Chiropractic	Covered 70% after deductible Limit 40 visits/calendar year	Covered 80% after deductible Limit 40 visits/calendar year
Physical, Occupational and Speech Therapy	Covered 70% after deductible Limit 60 physical therapy, 30 occupational and 30 speech therapy visits/calendar year	Covered 80% after deductible Limit 60 physical therapy, 30 occupational and 30 speech therapy visits/calendar year
Home Health[1]	Covered 70% after deductible Limit 100 visits/calendar year	Covered 80% after deductible Limit 100 visits/calendar year
Hospice	Covered 70% after deductible	Covered 80% after deductible
Skilled Nursing Inpatient Facility[1]	Covered 70% after deductible Limit 120 days/calendar year	Covered 80% after deductible Limit 120 days/calendar year
Durable Medical Equipment[1]	Covered 70% after deductible	Covered 80% after deductible
Vision Care	Not covered	Not covered

[1] Pre-certification/notification required.

[2] Limit combined (OB/GYN routine exam, pap smear, routine exam and routine tests, labs and x-rays; limit excludes mammogram and routine prostate exam). Well-baby/well-child care included in limit for Indemnity plan only.

Acupuncture Services

Acupuncture services for pain therapy when the service is performed by a Physician in the Physician's office. Benefits are limited to 30 visits per calendar year. Acupuncture is also a Covered Health Service for the treatment of:

- Nausea of chemotherapy
- Post-operative nausea
- Nausea of early Pregnancy
- Ambulance Services, Emergency Only & Non-Emergency
- Covered expenses include charges made by a professional ambulance, as follows:

Ambulance Services

- Ground ambulance covered expenses include charges for transportation:
  - To the first hospital where treatment is given in a medical emergency;
  - From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
  - From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
  - From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles;
  - When during a covered inpatient stay at a hosptial, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.
- Air or water ambulance covered expenses include charges for transportation to a hospital by air or water ambulance when:
  - Ground ambulance transportation is not available; and
  - Your condition is unstable, and requires medical supervision and rapid transport; and
  - In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; *and* the two conditions above are met.
- *Not* covered under this benefit are charges incurred to transport you:
  - If an ambulance service is not required by your physical condition; or
  - If the type of ambulance service provided is not required for your physical condition; or

- By any form of transportation other than a professional ambulance service.

Dental Services, Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage;
- Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."; and
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

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

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

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 an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Diagnostic and Preoperative Testing

- Diagnostic Complex Imaging Expenses

  The plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

  - C.A.T. scans;
  - Magnetic Resonance Imaging (MRI);
  - Positron Emission Tomography (PET) Scans

  Complex Imaging Expenses for preoperative testing will be payable under this benefit.

  The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- Outpatient Diagnostic Lab Work and Radiological Services

  Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.

- Outpatient Preoperative Testing

  Prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

  - Related to your surgery, and the surgery takes place in a hospital or surgery center;
  - Performed on an outpatient basis;
  - Covered if you were an inpatient in a hospital;
  - Not repeated in or by the hospital or surgery center where the surgery will be performed.

  Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

  The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

  If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests; however surgery will *not* be covered.

  Important Reminder: Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply.

Durable Medical Equipment

Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

- The initial purchase of DME if:
  - Long term care is planned; and
  - The equipment cannot be rented or is likely to cost less to purchase than to rent.
- Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.
- Replacement of purchased equipment if:
  - The replacement is needed because of a change in your physical condition; and
  - It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in the *Exclusions* section of this SPD. UnitedHealthcare reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of UnitedHealthcare.

Emergency Health Services

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

If you receive services in an emergency room of a Hospital or Alternative Facility that are not Emergency Health Services, you will be responsible for paying all charges and Benefits will not be paid.

Eye Examinations

Eye examinations received from a health care provider in the provider's office but only in conjunction with a Physician's office visit for a medical condition or accidental injury.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Family Planning

Covered Health Services for family planning when provided by or under the direction of a Physician. Benefits will be paid for:

- Diaphragm or intrauterine device and related Physician services
- Voluntary sterilization by either vasectomy or tubal ligation
- Depo Provera
- Norplant

Oral contraceptives are covered under the Prescription Drug program. Infertility benefits are described under *Infertility Services* in this section.

Foot Care

Covered Health Service if done as the result of an infection or disease. Treatment covered for:

- Any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
- Physician's office visit for diagnosis of bunions.
- Treatment of bunions when an open cutting operation or arthroscopy is performed
- Corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease

Hearing Examinations and Hearing Aids

Hearing examinations received from a health care provider in the provider's office. Benefits for hearing examinations are limited to one examination every two calendar years.

Benefits for hearing aids are limited to $1,000 per ear during the entire period of time you are covered under the medical plan and are not subject to the Annual Deductible. Charges for hearing aids are not included in the Out-of-Pocket Maximum.

Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician; and
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

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

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

UnitedHealthcare will decide if skilled home health care is required 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.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, social and spiritual care for the terminally ill person. The Physician must certify that the patient is terminally ill with six months or less to live. Benefits are available when hospice care is received from a licensed hospice agency.

Psychological care and short-term grief counseling for immediate family members may also be provided.

Hospital Inpatient Stay

Inpatient Stay in a Hospital. Benefits are available for:

- Services and supplies received during the Inpatient Stay
- Room and board in a Semi-private Room (a room with two or more beds)

Infertility Services

Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.

Injections Received In a Physician's Office

Benefits are available for injections received in a Physician's office, for example allergy immunotherapy.

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. Birthing centers and nurse midwives are covered.

Benefits will be paid for an inpatient stay of at least:

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Medical Supplies and Wigs

Medical supplies when prescribed by a Physician, including:

- Elastic stockings
- Ace bandages
- Gauze and dressings
- Ostomy supplies

Benefits are provided for one wig or hairpiece per year when prescribed by a Physician for hair loss due to injury, sickness or the treatment of a sickness, including but not limited to:

- Burns (2nd degree full thickness or 3rd degree burns with resulting permanent alopecia)
- Lupus
- Chemotherapy
- Radiation therapy

Wigs or hairpieces for male or female pattern alopecia are not covered under the medical plan.

Benefits for wigs or hairpieces are limited to $500 per calendar year and are not subject to the Annual Deductible. Charges for wigs or hairpieces are not included in the Out-of-Pocket Maximum.

Nutritional Counseling

Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include:

- Diabetes mellitus
- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout
- Renal failure
- Phenylketonuria
- Hyperlipidemias

Obesity Treatment

Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for non-surgical treament of obesity for the following outpatient weight management services:

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

Covered expenses include one morbid obesity surgical procedure, within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided under the plan.

Oral Surgery

Covered Health Services for the diagnosis and surgical and adjunctive treatment of disease, injuries and defects of the mouth, jaws and associated structures when ordered by a Physician. You should contact UnitedHealthcare in advance to verify that the surgical procedure is a Covered Health Service.

Benefits are provided for the treatment of temporomandibular joint disease (TMJ).

Benefits are also provided for dental anesthesia and associated hospital and facility charges provided to an enrolled dependent child if any of the following criteria apply:

- The child has a physical, mental or medically compromising condition;
- The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
- The child is extremely uncooperative, unmanageable or uncommunicative with dental needs deemed sufficiently important that the dental care cannot be deferred; or
- The child has sustained extensive orofacial and dental trauma.

Outpatient Surgery, Diagnostic, and Therapeutic Services

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Surgery and related services
- Lab and radiology/X-ray
- Mammography testing and pap smears
- Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy)

Benefits under this category include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* in this section.

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

Physician's Office Services

Covered Health Services received in a Physician's office including:

- House calls
- Treatment of a Sickness or Injury
- Preventive medical care; $300/calendar year limit
- Voluntary family planning
- Well-baby and well-child care (under age 7 is covered under Standard Indemnity plan only)
- Routine physical examinations, except that vision and hearing examinations are only covered as described under *Eye Examinations* and *Hearing Examinations* in this section
- Routine well woman examinations — $300/calendar year limit
- Routine mammograms

- Routine prostate specific antigen (PSA) test and digital rectal exam (DRE)
- Immunizations
- Growth hormone therapy

Private Duty Nursing

Skilled care services provided by a registered nurse or licensed practical nurse in your home when ordered by a Physician. Benefits are limited to 100 eight-hour shifts per calendar year.

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

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

UnitedHealthcare will decide if skilled home health care is required 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 care giver.

Benefits will not be paid for:

- Private duty nursing services received during an Inpatient Stay
- Care that does not require Skilled Care Services

Professional Fees for Surgical and Medical Services

Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Eligible Expenses for assistant surgeon services for surgical, radiological, and other diagnostic services and procedures performed on the same day, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed. A separate charge will not be allowed under the Plan.

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Eligible Expenses for multiple surgical procedures are limited as follows:

- Eligible Expenses for a secondary procedure are limited to 50% of the Eligible Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session;
- Eligible Expenses for any subsequent procedure are limited to 25% of the Eligible Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session; and
- When these services are performed in a Physician's office, benefits are described under *Physician's Office Services* in this section.

Prosthetic Devices

Prosthetic devices that replace a limb or body part including:

- Artificial limbs
- Artificial eyes
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998

If more than one prosthetic device can meet your functional needs, coverage will be based on medical necessity.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits are provided for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device no more than once every three calendar years.

Reconstructive Procedures

Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target 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.

Cosmetic Procedures

Services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This medical plan does not provide Benefits for Cosmetic Procedures.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Woman'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 Covered Health Service. You can contact UnitedHealthcare for more information about Benefits for mastectomy related services.

Rehabilitation Services, Outpatient Therapy

Short-term outpatient rehabilitation services for:

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Benefits are limited as follows:

- 60 visits of physical therapy per calendar year
- 30 visits of occupational therapy per calendar year
- 30 visits of speech therapy per calendar year

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Benefits will be paid for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

The medical plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Skilled Nursing Facility & Inpatient Rehabilitation Facility Services

Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Services and supplies received during the Inpatient Stay
- Room and board in a Semi-private Room (a room with two or more beds)

Benefits are limited to 120 days per calendar year.

In general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

The Covered Person must be expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).

Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care is usually provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Spinal Treatment, Chiropractic, and Osteopathic Manipulative Therapy

Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits for Spinal Treatment are limited to 40 visits per calendar year.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Please note that the medical plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or your dependent may require an organ transplant (organ means solid organ, stem cell, bone marrow, and tissue):

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within one year of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after one year of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Coverage is provided only for services received at a facility designated by the plan as an Optum Center of Excellence (COE) for the type of transplant being performed. A travel benefit is provided under the plan for travel to and from an Optum COE (see *Transportation and Lodging Transplantation Only* for additional details).The plan covers:

- Charges made by a physician or transplant team;
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program;
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services;
- Charges for activating the donor search process with national registries;
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children;
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either one year from the date of the transplant; *or* upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is late.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within one year from the date of the transplant event.

Important Reminder: To ensure coverage, all transplant procedures need to be precertified by UnitedHealthcare. Refer to the *Prior Notification* section for details about precertification.

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by UnitedHealthcare.

Transportation and Lodging Transplantation Only

UnitedHealthcare will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this medical plan 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 transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Network Facility.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum Benefit of $3,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this medical plan in connection with all transplant procedures.

Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* in this section.

Mental Health and Substance Abuse Care

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

Important Note: Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Covered Medical Services* and *Medical Services Not Covered* for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

Inpatient Treatment

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder: Inpatient care and outpatient treatment must be precertified by UnitedHealthcare. Refer to *Prior Notification* for more information about precertification.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of substance abuse by behavioral health providers.

Importan Note: Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Covered Medical Services* and *Medical Services Not Covered* for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider;
- The program of therapy includes either:
  - A follow-up program directed by a behavioral health provider on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse

Inpatient Treatment

This Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a hospital for the medical complications of substance abuse;
- "Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatits;
- Treatment in a hospital is covered only when the hospital does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received substance abuse while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

Important Reminder: Inpatient care and outpatient treatment must be precertified by UnitedHealthcare. Refer to *Prior Notification* for more information about precertification.

Medical Services Not Covered

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the *What's Covered Under the Indemnity Plan Options* section. Charges made for the following are not covered except to the extent listed under the *What's Covered Under the Indemnity Plan Options* section or by any amendment to this SPD.

Allergy

Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Behavioral Health Services

- Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse that is specifically provided in the *What's Covered Under the Indemnity Plan Options* section;
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field;
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use;
- Treatment of antisocial personality disorder;
- Treatment in wilderness programs or other similar programs;
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What's Covered Under the Indemnity Plan Options* section.

Charges

- Any charges in excess of the benefit, dollar, day, visit or supply limits stated under the plan;
- Charges which are submitted for services or supplies that are not rendered;
- Charges which are submitted for a person who is not eligible for coverage under the plan;
- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Contraception

Except as specifically described in the *What's Covered Under the Indemnity Plan Options* section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic Services and Plastic Surgery

Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as or chin implants); except removal of an implant will be covered when medically necessary;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation (only as the result of a mastectomy);
- Otoplasty.

Counseling

Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

Dental Services

Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- Services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- Non-surgical treatments to alter bite
- or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable Outpatient Supplies

Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, Medications and Supplies

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under the plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient prescription drugs;
- Self-injectable prescription drugs and medications;
- Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational Services

Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;

Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and

Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations

Any health examinations:

- Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- Any special medical reports not directly related to treatment except when provided as part of a covered service.
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What's Covered Under the Indemnity Plan Options* section.

Experimental, Investigational Services or Unproven Services

Any services or supplies related to experimental, investigational or unproven services, including clinical trials.

Facility Charges

Facility charges for care services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums; or
- Infirmaries at schools, colleges, or camps.

Food Items

Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot Care

Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.

Growth/Height

Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a stay in a hospital or other facility;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under *Covered Medical Services* section.
- Plan does not cover Replacement parts or repairs.

Home and Mobility

Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;

- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home Births

Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility

Except as specifically described in the *What's Covered Under the Indemnity Plan Options* section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a physician's practice;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public hospital or other facility is required to provide; or
  - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by UnitedHealthcare, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
- Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in the *What's Covered Under the Indemnity Plan Options* section.

- Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
  - Surgical procedures to alter the appearance or function of the body;
  - Hormones and hormone therapy;
  - Prosthetic devices; and
  - Medical or psychological counseling.
- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.
- Services of a resident physician or intern rendered in that capacity.
- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
- Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account* SPD.
- Services that are not covered under the plan.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.
- Speech therapy for treatment of delays in speech development, except as specifically provided in the *What's Covered Under the Indemnity Plan Options* section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.
- Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What's Covered Under the Indemnity Plan Options* section.
- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
  - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;

  - Drugs or preparations to enhance strength, performance, or endurance; and
  - Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.
- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Miscellaneous

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *What's Covered Under the Indemnity Plan Options* section;
- Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Plan, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal;
- Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs;
- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered;
- Court ordered services, including those required as a condition of parole or release;
- Experimental or investigational drugs, devices, treatments or procedures, including clinical trials;
- Home uterine activity monitoring;
- Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by UnitedHealthcare when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Therapies and Tests

- Any of the following treatments or procedures:
- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;

- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by UnitedHealthcare;
- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the *What's Covered Under the Indemnity Plan Options* section.

Vision

Vision-related services and supplies, except as described in the *What's Covered Under the Indemnity Plan Options* section. The plan does not cover:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;

- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight

Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as provided by the plan, including but not limited to:

- Liposuction
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work Related

Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source.

If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Filing Medical Claims

You or the health care provider must file a claim in order for the program to pay benefits for covered charges.

Your provider can choose to file your claim for you. If he or she will not file a claim for you, then you will have to file a claim yourself. You can obtain information on filing a claim by contacting UMR at 1-888-335-8397.

Be sure to complete the following information:

- Your name and Social Security Number, if required;
- The amount charged;
- The diagnosis;
- Your medical plan ID number;
- The person incurring the expense if a dependent;
- The date the expense was incurred (if different from the date of the bill);
- The name of the supplier of medical services; and
- The type of service.

The Claims Administrator may not accept a claim more than 12 months after the date of service.

For instructions on how to file a claim, you can contact the Claims Administrator at the telephone number shown on your prescription drug plan ID. This number can also be found in the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account* SPD.

When you reach age 65, Medicare becomes the primary health plan. All claims must be submitted to Medicare first. The Comcast medical plan will be the secondary payer.

The Claims Administrator is responsible for evaluating all benefit claims under the medical plan. They will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The medical plan has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide the status of your claim.

You also have certain rights regarding claims and appeals. For more information, see the *Claims Review and Appeals Processes* section in the *Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account* SPD.

Standard Prescription Drug Plan

How the Standard Prescription Drug Plan Works

The Standard Prescription Drug Plan is administered by CVS/Caremark, and is available for non-Medicare retirees only. The plan offers prescription drug benefits through a designated network of participating pharmacies. You are encouraged to use pharmacies affiliated with the Claims Administrator's provider network. A listing of providers is available by contacting the Claims Administrator at the telephone number or the web site address found in the *Administrative Information* section of the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account* SPD. When you fill your prescription at a network retail pharmacy, you pay 50% of the cost of your prescription, and the prescription drug plan pays the rest. The maximum you'll pay to fill a prescription is $100. You also have the option to fill prescriptions through the mail-order program, which is ideal for a chronic condition that requires ongoing treatment, such as arthritis, high blood pressure, diabetes, or allergies. If you fill a prescription through

mail order, you'll pay a $20 copay for a 90-day generic supply, or a $50 copay for a brand name supply. The maximum the prescription drug plan will pay for prescription costs per individual in a calendar year is $2,000 (retail and mail-order combined).

Purchasing Prescriptions through a Pharmacy

You will receive an ID card for your prescription drug plan benefits separate from your medical plan ID card (if applicable). When you or a covered dependent need to have a prescription filled, follow these steps:

- Present your prescription drug plan ID card to the pharmacist along with your prescription,
- Sign the voucher the pharmacist gives you, and
- Pay your portion of the cost to the pharmacy.

You do not have to submit a claim form for reimbursement. Your cost-share applies each time a prescription is filled or refilled.

If you purchase your prescription from a non-member pharmacy or if you do not have your card with you at the time of purchase, you must pay the entire cost of the prescription and submit a claim form for reimbursement.

Purchasing Prescriptions through Mail Order

Mail order is an easy and convenient way to purchase medication if you have a chronic condition that requires ongoing treatment – such as arthritis, high blood pressure, diabetes, or allergies. There are several advantages to mail order, including:

- *Save money* — Prescriptions for ongoing medication are less expensive when receiving them via Mail Order.
- *Delivered to your mailbox* — With mail order, your prescriptions come to you. You don't have to make a special visit to the pharmacy.
- *Easy to use* — Once you've filled out your first mail order application, you can usually order refills by phone and pay with most major credit cards.

For details on how to fill a prescription through mail order, contact the Claims Administrator directly.

Covered Prescription Drugs

In general, coverage is provided for drugs that require a prescription and are furnished in accordance with medical technology assessment guidelines. These include birth control drugs and certain drugs used on an off-label basis (e.g., drugs used to treat cancer and HIV/AIDS). This also includes:

- Diaphragms
- Injectable insulin and disposable syringes and needles needed for its administration
- Materials to test for the presence of sugar when ordered by a network physician
- Prescription prenatal vitamins and pediatric vitamins with fluoride

- Nicotine gum or nicotine patches (or other smoking cessation aids that require a prescription by law) when prescribed by a network physician. You are not required to complete a smoking cessation program in order to receive coverage for smoking cessation aids. Smoking Cessation is covered under HCR with no member cost share.
- Levonorgestrel
- Drugs used in the treatment of infertility (i.e., clomid, follistim)

Prescription Drug Utilization Management

Certain classes of prescription drugs may be subject to Utilization Management (UM) policies. UM is required to ensure safe and appropriate dispensing of medications that may present significant health risks, have strict dosing or duration guidelines, are indicated only for use in the presence of specific clinical criteria, require close monitoring, or are shown to have a potential for abuse.

One of three following UM programs may be applicable to appointed drug classes — Prior Authorization, Step Therapy, Drug Limitations Group I or Drug Limitations Group II.

Prior Authorization

Approval from the prescription drug plan is required before the drug can be obtained through the prescription drug plan. Drug classes requiring Prior Authorization include Growth Hormones and Anti-Obesity agents, Interferons and certain Rheumatoid Arthritis, Crohns Disease, Asthma/Allergy, Psoriasis and Anemia medications.

Step Therapy

Drugs in this group can be obtained only after one or more "prerequisite" medications — clinically appropriate and cost-effective alternative drugs — are tried first. The drug class included in this group is certain Asthma/Allergy medications (Leukotriene Modifiers).

Drug Limitations Group I

Prior approval is not required to obtain the drug through the prescription drug plan but the quantity that may be obtained is limited. Drug classes subject to Drug Limitations include certain Opioid Analgesics (pain medications) and Intranasal Corticosteriods/Antihistamines.

Drug Limitations Group II (Post-Limit Prior Authorization)

Prior approval is not required to obtain a limited quantity of the drug through the prescription drug plan but quantities in excess of the initial limit require prior authorization from the prescription drug plan. Drug classes subject to Drug Limitations with Post-Limit Prior Authorization include Migraine medications (5-Ht1 agonists/triptans, migranal nasal spray) and certain Opioid Analgesics (pain medications).

Prior Authorization, Step Therapy and Post-Limit Prior Authorization determinations are made by the Claims Administrator based on recognized clinical guidelines.

Prescription Drugs Not Covered

The following prescription charges are not covered by the prescription drug plan:

- Therapeutic devices or appliances, support garments and other non-medicinal substances
- Prescriptions filled by a person not licensed to fill them
- Prescriptions filled after your coverage under the prescription drug plan terminates
- Drugs considered experimental by federal law
- Charges for giving or injecting drugs
- Drugs given while confined in a hospital, nursing home or similar place that has its own drug dispensary. These expenses are covered under the health care plan as part of the cost of your or a dependent's hospital stay.
- Drugs for injuries or illnesses not covered under the prescription drug plan
- Any refill in excess of the number specified by the physician or dispensed more than one year after the prescription was written
- Over-the-counter medications, except insulin and certain diabetic supplies
- Drugs available without charge under Workers' Compensation laws
- Biological sera, blood or blood plasma
- Anti-wrinkle agents (e.g., Renova)
- Dermatologicals, hair growth stimulants
- Cosmetic hair removal products
- Certain bulk powders, bases, kits, patches and miscellaneous formulations as part of a compound prescription
- Fertility medications
- Erectile Dysfunction drugs

Filing Prescription Drug Claims

If you visit a participating pharmacy, you do not have to submit a claim form for reimbursement. You are subject to a portion of the cost each time a prescription is filled or refilled. If you forget your ID card and need to file a claim, contact the Claims Administrator at the telephone number shown on your ID card for instructions on how to file a claim.

If you purchase your prescription from a non-member pharmacy or if you do not have your card with you at the time of purchase, you must pay the entire cost of the prescription and submit a claim form for reimbursement.

You have certain rights regarding claims and appeals. For more information, see the *Comcast NBCU Post-Retirement Health Care & Retiree Reimbursement Account* SPD.

Newborns' and Mothers' Health Protection Act

Under federal law, the plan 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 cesarean

section. The plan also may not require the provider to obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). The covered individual, however, may still be subject to certain precertification requirements to avoid a reduction in the dollar amount covered by the plan. Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours following delivery (or 96 hours following cesarean section).

Other Important Information

Coordination of Benefits and Subrogation

Coordination of Benefits (COB) and Subrogation determine the benefits payable if you or a covered family member is entitled to benefits under this Plan and another medical or dental plan or disability program (such as Medicare, a medical or dental plan provided by your spouse/domestic partner/civil union partner's employer, a no-fault insurance plan, Workers' Compensation, state disability plan, or Social Security) or other third-party.

Effect of Other Health Care Benefits

The Plan will coordinate the benefits it pays with those benefits provided by other medical plans so that the total benefit provided by both plans combined is not greater than the total benefit that would have been provided under the Plan if it were the only plan providing coverage. Coordination of benefits is not provided under the prescription drug plan.

COB requires determining which plan is "primary." Eligible expenses are paid first by the primary plan. If the Minimum Indemnity Plan or Standard Indemnity Plan is secondary, it then pays the difference between what was paid under the primary plan and what the Minimum Indemnity/Standard Indemnity Plan would have paid.

To administer the COB rules described in this section, the plan (or its duly authorized delegates) reserves the right to exchange information with other plans involved in paying claims and to require you or your medical care provider to furnish any necessary information.

If this Plan should have paid benefits that were paid by another medical plan, this Plan may reimburse the other plan as appropriate under the plan. An amount paid in this way will be considered to be a benefit paid under the Minimum Indemnity or Standard Indemnity Plan, and the Plan will be fully discharged from any liability it may have to the extent of that payment.

To obtain the entire benefits available, file a claim under each plan that covers the person for the expenses incurred. Please remember that any person claiming benefits under this Plan must provide the Plan Administrator, or the applicable plan insurer, with information about any other coverage the person may have.

Group Health Plans

If you and your eligible dependents are covered under more than one group health plan, the primary plan (the one responsible for paying benefits first) needs to be determined. If this Plan is paying secondary, your Plan coverage will ensure that, in total, you receive benefits up to what you would have received with this Plan as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount. A summary of the

coordination rules (how the Plans coordinate coverage with another group health plan to ensure nonduplication of benefits) is provided below. If you have questions, contact the Claims Administrator for help.

Here is an example of how this Plan coordinates benefits with other group health plans. Assume your spouse has a medically necessary procedure with a reasonable and customary (R&C) charge of $100. If your spouse's plan is primary and pays 70% for that procedure, your spouse will receive a $70 benefit (70% of $100). Also assume that this Plan is secondary and pays 80% for this medically necessary procedure. In this case, your spouse normally would receive an $80 benefit (80% of $100) from this Plan. Because your spouse already received $70 from his or her primary plan, he or she would receive the balance ($10) from this Plan.

Determining Primary Coverage

In order to pay claims, the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan must determine which health plan is primary and which plan is secondary. You will have to give information about any other plans when you file a claim.

There are rules to determine which plan is primary and which plan is secondary. The rules are used until one is found that applies to the situation. They are always used in the following order:

- A plan that has no coordination of benefits provision will be primary to a plan that does have a coordination of benefits provision.
- A plan that covers the person as a retiree will generally be primary to a plan that covers the same person as a dependent. However, if the person is a Medicare beneficiary and, as a result of the Medicare Secondary Payer rules, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (for example, a retiree), then the order of benefits is reversed so that the plan covering the person as a retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.
- The following ordering rules are used to determine which plan is primary and which plans are secondary when a person is covered as a dependent child under two or more medical plans of parents who either 1) are married or are living together (whether or not they have ever been married), or 2) have a court decree that either awards joint custody without specifying that one parent has the responsibility to provide medical coverage, or specifies that both parents are responsible for the dependent child's medical care expenses and coverage:
  - The plan that covers a child of the parent whose birthday is earlier in the calendar year will generally be primary to a plan that covers a child of a parent whose birthday is later in the calendar year. For example, if your birthday is in May and your spouse's birthday is in October, your plan is considered primary for your child, regardless of which spouse is older in actual years.
  - If both parents have the same birthday, the plan that covered one of the parents longer will be primary to the plan that covered the other parent for a shorter period of time.
- For a dependent child whose parents are divorced, if a court decree states that one of the parents is responsible for the dependent child's medical care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no medical care coverage for the dependent child's medical care expenses, but the parent's spouse does, the parent's spouse's plan is primary. This

provision will not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- The following ordering rules are used to determine which plan is primary and which plans are secondary when the parents are divorced, and there is no court decree allocating responsibility for the child's medical care services or expenses:
  - The plan of the parent with custody will pay benefits first.
  - The plan of the stepparent with custody will pay benefits next.
  - The plan of the parent without custody will pay benefits next.
  - The plan of the stepparent without custody will pay benefits next.
- A plan that covers you as an active worker, or as a dependent of that active worker, is primary to any plan that covers the person as a laid-off or retired worker, or as a dependent of that laid-off or retired worker.
- A plan that covers a person as an active or retired worker, or as a dependent of that active or retired worker, is primary to any plan that covers that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law.
- If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan.
- If none of the preceding rules determines the order of benefits, the allowable expenses will be shared equally between the plans.

After it is determined which plan pays benefits first, you will need to submit your initial claim to that plan. After the first plan pays your benefits (up to the limits of its coverage); you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You will need to include a copy of the written explanation of benefits (EOB) from your primary plan.

If the Plan pays more than the required amounts under this coordination of benefits provision, the plan has the right to recover the excess payment from the individual for whom the benefit was paid, the insurance company, or the other benefit plan.

Coordination with Medicare

Benefits for Individuals Who Are Entitled to Medicare

The UHC Standard and Indemnity Plans and CVS/Caremark Prescription Drug Plan pay secondary and Medicare is the primary payer if you (or your covered family member) are covered by Medicare, you (or your covered family member) do not have end-stage renal disease and you do not have current employment status with Comcast/NBCUniversal.

Please note that you must enroll in both Parts A and B of Medicare coverage when you are first eligible; otherwise the Plan or Medicare may not cover the expenses. If you do not enroll in Medicare Part B when first eligible, you may face late enrollment penalties and Medicare can apply this penalty for as long as you are enrolled in Part B.

How the Plan Pays When Medicare Is Primary

If Medicare pays benefits first, the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan pay benefits as described below. This method of payment only applies to a Medicare-eligible person. Medicare statements are required before payment can be made.

First, the Minimum Indemnity/Standard Indemnity Plan determines the amount payable according to the benefits payable under the plan; however, the amount of covered expenses is based on the amount of charges allowed under Medicare rules instead of the allowable charges as defined by the Minimum Indemnity/Standard Indemnity Plan. Then, the Minimum Indemnity/Standard Indemnity Plan subtracts the amount payable under Medicare for the same expenses. The Plan pays only the difference (if any) between Plan benefits and Medicare benefits.

The amount payable under Medicare that is subtracted from the Minimum Indemnity/Standard Indemnity Plan benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare + Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all the rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

The Plan will coordinate its prescription drug coverage with Medicare Part D according to Medicare coordination of benefits rules under federal law. If you are or will become eligible for Medicare Part D while covered under this plan, ask the Plan Administrator for more information.

Medicaid

If you or your dependents are covered under a state Medicaid program, the Minimum Indemnity/Standard Indemnity Plan is primary and pays benefits before Medicaid. The Plan does not reduce or deny benefits for you or your covered dependent(s) to reflect eligibility to receive medical assistance under a state Medicaid program. In addition, the plan reimburses any state Medicaid program for the cost of any items and services provided under the state program that should have been paid for by the Plan, and honors any subrogation rights that a state has in order to recoup such mistaken payments.

Other Government If you are also covered under a government plan, this plan does not cover any services or supplies to the extent that those services and supplies, or benefits for them, are available under the government plan. This provision does not apply to any government plan that by law requires this plan to pay primary.

A government plan is any plan, program, or coverage other than Medicare or Medicaid, that is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Health Plans

Effect of No-Fault Motor Vehicle Coverage

If you (or your dependent) has coverage for health care services or loss of income available to you under any no-fault motor vehicle coverage required by law, that coverage has primary financial liability for losses.

The Minimum Indemnity/Standard Indemnity Plan does not provide coverage for health care services covered by no-fault motor vehicle coverage. Where permitted, the Plan will pay the claims up-front and collect from the auto insurance company later (see Acts of Third Parties). Where subrogation is not permitted, the plan Claims Administrator will request additional information about accident-related services prior to paying benefits.

Effect of Workers' Compensation

If you suffer a work-related injury or sickness covered under Workers' Compensation law, that coverage has primary financial liability for losses.

The Indemnity/Standard Indemnity Plan does not provide benefits for health care services covered under Workers' Compensation law. The Plan will pay benefits subject to its right to recover those payments if and when it is determined that Workers' Compensation law covers them.

Refund of Overpayments

Whenever payments have been made by the Minimum Indemnity/Standard Indemnity Plan that at any time total an amount in excess of the maximum amount payable under the plan provisions, you (or your dependent) must make a refund of the excess amount to the plan or help the plan obtain the refund from another person or organization.

If you or any other person or organization that was paid does not promptly refund the full amount, the plan may reduce the amount of any future benefits that are payable. The reductions will equal the excess amount paid. In the case of recovery from a source other than the plan, the refund equals the amount of recovery up to the amount that would have been paid under the plan. The plan may have other rights in addition to the right to reduce future benefits (see *Acts of Third Parties*).

Acts of Third Parties

When you or your covered dependent ("you") are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, prescription drug, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party within a reasonable time, but no more than 30 calendar days after you knew or should have known of the actions or inactions of the third party that caused you injury or illness, and you must follow special plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery (also referred to as "reimbursement").

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the plan has the right to recover such expenses indirectly out of any payment made to you by the at-

fault party or any other party related to the illness or injury. You must pay the Plan back first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree:

- to notify the Plan and obtain its consent before settling claims with any third party responsible for your illness or injury;
- to notify any third party responsible for your illness or injury of the Plan's right to reimbursement for any claims related to your illness or injury;
- to hold any reimbursement or recovery received by you (or your dependent, legal representative, or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan with respect to such illness or injury and to reimburse the Plan promptly for the benefits paid, even if you are not fully compensated or made whole for your loss;
- that the plan has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- that the plan may appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- that the Plan has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or dependent is made whole) and that the Plan's claim has first priority over all other claims and rights;
- to reimburse the Plan in full up to the total amount of all benefits paid by the Plan in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance, or otherwise, must be turned over to the Plan as reimbursement up to the full amount of the benefits paid;
- that the Plan's claim is not subject to reduction for attorneys' fees, costs, or damages under the "common fund" doctrine or otherwise;
- that, in the event that you elect not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the Plan's request, any right or cause of action to the Plan;
- not to take or omit to take any action to prejudice the Plan's ability to recover the benefits paid;
- to cooperate in doing what is necessary to assist the Plan in recovering the benefits paid or in pursuing any recovery or reimbursement;

- to forward any recovery to the Plan within ten days of disbursement by the third party or to notify the Plan as to why you are unable to do so; and
- to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Plan's attorneys' fees, costs, or damages.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive; or
- any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Notify the Plan within 10 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

If the subrogation provisions in these Acts of Third Party provisions conflict with subrogation provisions in an insurance contract that governs the benefits at issue, the subrogation provisions in the insurance contract will control. If the right of recovery provisions in these Acts of Third Party provisions conflict with right of recovery provisions in an insurance contract that govern the benefits at issue, the right of recovery provisions in the insurance contract will control.

Notwithstanding anything to the contrary, no provision in any governing document or contract will be interpreted to limit the Plan's right to seek subrogation or reimbursement from you, your covered dependent, or the dependent, legal representative, or agent of you or your covered dependent.

Continuation of Coverage — COBRA

This section contains important information about the right to a temporary extension of coverage under the Comcast NBCUniversal-sponsored group health plan. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that Comcast NBCUniversal provide you and/or your covered dependents who are qualified beneficiaries under COBRA with the opportunity to continue coverage under the plan for a temporary period at group plan premium rates in certain instances where your coverage under the plan would otherwise end.

This SPD provides your initial COBRA notice rights with respect to the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan. COBRA continuation rights with respect to RRA benefits are described in the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account* SPD.

You will have to pay the entire premium plus a 2% administrative fee for continuation coverage. Regularly scheduled payment is due postmarked by the first day of each month to which the payments apply. There is a grace period of 30 days for the payment of the regularly scheduled premium.

The Plan Administrator is Comcast NBCUniversal. Information regarding the Plan's COBRA Administrator can be found in *Administrative Information* on page 65.

Who Is Covered

If you are the spouse or eligible domestic partner of a retiree and are covered under the UHC Standard or Minimum Indemnity Plans and/or the CVS/Caremark Prescription Drug Plan on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose coverage under the Plan(s) due to divorce or the termination of your domestic partnership.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Comcast NBCUniversal, and that bankruptcy results in the loss of coverage of any retired employee covered under the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse or domestic partner, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Retiree IBC PPO Plan.

Special Rules for Domestic Partners: Although eligible domestic partners and their eligible dependent children are generally not considered qualified beneficiaries for purposes of legal entitlement to COBRA continuation coverage, Comcast NBCUniversal does make COBRA-like coverage available to domestic partners and their eligible dependent children who meet the requirements for eligibility under the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan. Accordingly, eligible dependents for purposes of receiving COBRA coverage as described in this section also include domestic partners and their dependent children. If your domestic partner and his or her eligible dependent children are covered under the Plan(s) and you terminate your domestic partnership, you must notify Comcast NBCUniversal within 60 days of the event. Your domestic partner and his or her eligible dependent children will thereafter be eligible to continue to receive COBRA continuation coverage under the UHC Standard and Minimum Indemnity and CVS/Caremark Prescription Drug Plan, as described in this section.

Your Duties

Under the law, the retiree or a family member has the responsibility to inform Mercer Marketplace 365 if applicable of a divorce, termination of domestic partnership, or a child losing dependent status under the UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan. This notice must be provided within 60 days from the date of the divorce or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event). For the termination of a domestic partnership, this notice must be provided in writing within 60 days from the date of the termination of domestic partnership. You or a representative acting on your behalf (such as a family member) is responsible for providing the required notice.

The notice must include the following information:

- The name of the retiree who is or was covered under the Plan(s);
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan(s) due to the qualifying event;

- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- The signature, name and contact information of the individual sending the notice.

You must provide this notice to the COBRA administrator at the address listed in the *Administrative Information* section of this SPD.

When the COBRA Administrator is notified that one of these events has happened, the COBRA Administrator will, in turn, notify you that you have the right to elect continuation coverage. If the above procedures are not followed or if you or your family member fail to notify the COBRA administrator within the 60-day notice period, then continuation rights are forfeited. Additionally, if any benefits are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce or termination of domestic partnership or a child losing dependent status, then the retiree and/or family members will be required to reimburse the employer-sponsored group health plans for any benefits mistakenly paid.

Electing COBRA

To inquire about COBRA coverage, contact:

BenefitConnect | COBRA
PO Box 5884
Hopkins, MN 55343-5884
1-877-29-COBRA (26272) [(858) 314-5108 International callers only]

If you or your covered dependent(s) have questions regarding the election forms or process, you should contact the Plan's COBRA Administrator. Information regarding the Plan's COBRA Administrator can be found in *Administrative Information*.

Under the law, you or your covered dependent(s) must elect continuation coverage within 60 days from the date you or your dependent(s) would lose coverage because of one of the events described earlier, or, if later, 60 days after Comcast NBCUniversal provides notice of the right to elect continuation coverage. A qualified beneficiary who does not elect continuation coverage within the time period described above will lose the right to elect continuation coverage. Your or your covered dependent(s) election must be postmarked within the 60-day election period. If you or your covered dependent(s) do not submit a completed election form within the 60-day election period, you or your dependent(s) will lose the right to COBRA.

If you or your covered dependent(s) elect continuation coverage, Comcast NBCUniversal is required to give coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated family members. This means that if the coverage for similarly situated family members is modified, your or your dependent(s) coverage will be modified. "Similarly situated" refers to a current dependent who has not had a qualifying event.

Notice of Unavailability of Continuation Coverage: The Department of Labor requires that the Plan Administrator provide a notification to a qualified beneficiary if continuation of coverage is not available once the Plan Administrator receives notice of an initial qualifying event resulting from divorce, loss of dependent status, or termination of domestic

partnership. This notice must be provided no later than 14 days after the Plan Administrator receives notice from the qualified beneficiary.

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months.

Early Termination of COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the 36-month period for any of the following reasons:

- Comcast NBCUniversal no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of the individual; or
- The qualified beneficiary becomes entitled — after the date COBRA is elected — to benefits under title XVIII of the Social Security Act (Medicare).

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated.

Cost of Coverage

Qualified beneficiaries will be required to pay the full cost of coverage. In addition, there is a 2% administrative fee, making the payment a total of 102% of the cost of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, you will be notified by the COBRA Administrator of any cost changes.

COBRA coverage is not effective and claims for coverage will not be processed until COBRA is elected and the required payments are made. Your first premium is due within 45 days after you elect COBRA coverage. The first payment must cover the cost of COBRA coverage from the time the coverage under the Plan would have otherwise terminated up through the end of the month before the month in which first payments are made. You or your dependent(s) are responsible for making sure that the amount of the first payment is correct. You or your dependent(s) may contact the COBRA Administrator to confirm the correct amount of the first payment.

If you or your covered dependent(s) do not make the first payment for COBRA coverage within the 45 days after the date of the timely election, you or your dependent(s) will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period).

All COBRA premiums must be paid by check or money order. The first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator. If mailed, each payment is considered to have been made on the date that it is postmarked. If you or your dependent(s) pay part but not all the premium, and the amount paid is not significantly less than the full amount due, you or your dependent(s) will have 30 days from the end of the initial 30-day grace period to pay the outstanding amount due. If you or your dependent(s) fail to make a monthly

payment before the end of the grace period for that month, all rights to COBRA coverage under the Plan will be lost. You or your dependent(s) will not be considered to have made any payment by mailing a check if the check is returned due to insufficient funds or otherwise.

If you or your dependent(s) do not make timely payments, the COBRA coverage will be terminated as of the last day of the month for which a timely payment was made.

Conversion Coverage and Special Continuation Rights for California Workers

Some health plans offer conversion to individual coverage. Contact the health plan directly for information on converting to an individual policy. Many health plans will permit you to continue membership or equivalent coverage on an individual policy. Conversion rights may also be available to your spouse and/or dependents when their coverage may not otherwise qualify for health insurance under normal circumstances. Therefore, the cost of coverage is usually high and the conversion plans, prescribed by the state insurance regulations, will not offer the same comprehensive coverage as the plan. For that reason, you should also contact other insurance companies so you can be sure you are getting the best coverage for your money.

For more information about conversion rights, contact the UnitedHealthcare directly.

Claims Review and Appeals Processes

In general, any participant or beneficiary or his/her duly authorized representative (the "claimant") may file a written claim for benefits using the proper form and procedure.

A benefit plan has a specific amount of time, by law, to evaluate and process claims for benefits covered by ERISA. The length of time the benefit plan has to evaluate and process a claim begins on the date the claim is first filed, even if the claim is considered incomplete.

If you have any questions regarding how to file or appeal the initial claim, contact the appropriate Claims Administrator.

Following an adverse benefit determination on review, and after exhausting the applicable plan appeal process described below, you are entitled to bring a civil action in a federal or state court of competent jurisdiction in accordance with Section 502(a) of the Employee Retirement Income Security Act of 1974.

Medical and Prescription Drug Claims

The health care programs listed above recognize four categories of health benefit claims:

Urgent Care Claims — Claims for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician with knowledge of the patient's condition, would subject the patient to severe pain that cannot be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-service Claims — Claims must be decided before a patient will be afforded access to health care (e.g., preauthorization requests).

Post-service Claims — Claims involving the payment or reimbursement of costs for medical care that has already been provided.

Concurrent Care Claims — Claims where the plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments.

Adverse Benefit Determination — If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, the Plan will not rescind coverage under a medical or prescription drug option for a participant or covered dependent unless the participant or covered dependent performs an act, practice, or omission that constitutes fraud (as defined by the plan) or intentionally misrepresents a material fact with respect to the medical or prescription drug coverage.

Initial Benefit Determination

Pre-Service Claims

The Plan Administrator will notify you of the Claims Administrator's determination, whether adverse or not, within a reasonable period of time, but not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and notifies you, within the initial period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information.

If the claim is improperly filed, the Claims Administrator will notify you as soon as possible, but not later than five (5) days after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless you request written notification. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claims

For non-urgent post-service health claims, the plan has up to 30 days following receipt of the claim to evaluate and respond to claims for benefits covered by ERISA. This period may be extended by 15 days provided the Claims Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the plan and notifies you, within the initial period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims

Concurrent care claims may fall under any of the other three categories, depending on when the request is made. If you request an extension of ongoing treatment in an urgent care situation, the claims administrator will notify you within 24 hours of your request, provided your request is made at least 24 hours before the end of the approved treatment. Non-urgent claims will be treated as either pre-service or post-service claims.

If you reside in a county where 10 percent or more of the population is literate in a non-English language, your Comcast/NBCUniversal medical option must provide foreign language assistance for benefit questions, claims, appeals, and external review. If you have questions about foreign language assistance, please see the statements on your Comcast/NBCUniversal medical option explanation of benefits (EOB) or contact your medical carrier using the phone number on the back of your medical identification card.

Appealing a Claim Determination

The following section generally describes the health plan's internal appeals process. The appeals process of fully insured health plans may vary somewhat. Refer to the fully insured plan Certificates of Coverage or Member Guides for additional information.

Coverage for you, your spouse/domestic partner/civil union partner and your or your spouse/domestic partner/civil union partner's dependent children will continue, pending the outcome of an internal appeal. This means that a plan can't terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

An "adverse benefit determination" is a denial, reduction or termination of a benefit, or failure to provide or pay (in whole or in part) for a benefit. This can also include a denial to participate in the plan. For health coverage, an adverse benefit determination also means a claim denial on the grounds that the treatment is experimental or investigational or not medically necessary, this also includes concurrent care determinations. An adverse benefit determination includes any rescission of coverage under the plan, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time. In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reason for the adverse determination,
- The specific provisions of the plan on which the determination is based,

- A description of any additional information needed to reconsider the claim and the reason this information is needed,
- A description of the plan's review procedures and the time limits applicable to such procedures,
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review (after the internal review process),
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request,
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, either an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request,
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than three (3) days after the oral notice,
- The notice will include information sufficient to identify the claim involved. This includes:
  - the date of service,
  - the health care provider,
  - the claim amount (if applicable), and
  - the denial code
- The notice will also include a description of the plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included, and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Internal Appeal

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) may appeal and request a claim review within 180 days after receiving the denial notice. The request must be made in writing and should be filed with the Claims Administrator.

The plan will provide continued coverage pending the outcome of an internal appeal. Further, the plan will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator or other appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

In addition, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the experts' reputation for outcomes in contested cases, rather than based on the professionals' qualifications.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable U.S. Department of Labor regulations. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

You will be able to review your file and present evidence and testimony as part of the review. In addition, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the plan) in connection with the claim. This evidence will be provided at no cost to you, and will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the plan's determination on review within the following timeframes:

- For urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours after receipt of the request for review,
- For pre-service claims, within a reasonable period of time given the medical situation, but no later than 15 days after receipt of the request for review, and
- For post-service claims, within a reasonable period of time, but not later than 30 days after receipt of the request for review.

In certain cases, the plan may obtain a limited extension of time if notice of the extension is provided to the claimant before the end of the initial decision-making period.

In the case of an adverse benefit determination, you will receive notice containing the following:

- The specific reason for the adverse determination on review;

- Reference to the specific provisions of the plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under section 502(a) of ERISA following a final adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- For adverse determinations, the notice will include information sufficient to identify the claim involved. This includes:
  - the date of service,
  - the health care provider,
  - the claim amount (if applicable), and
  - the denial code (if any).
- The notice will also include a description of the plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman and/or the Employee Benefits Security Administration (EBSA) to assist enrollees with the internal claims and appeals and external review processes; and
- A description of your right to obtain additional information upon request about any voluntary appeals procedures under the plan.

If the Claims Administrator fails to strictly adhere to all of the internal review procedures described here, you will be deemed to have exhausted the plan's internal review process and may initiate an external review (as described below) or pursue other legal remedies, including a lawsuit against the plan fiduciaries. Despite the strict adherence rule, the internal claims and appeals procedures are not deemed exhausted on account of violations that are de minimis.

External Review Process

For insured plan options, external review will be handled in accordance with applicable state requirements and are available from the insurer.

If your appeal under the internal review process outlined above is denied, you may request an external review of your claim within four months after being notified of a denied claim. External review is not automatic; you must request it. The external review is conducted by an independent review organization (IRO) and its decision is binding on you and the Plan, except to the extent other remedies are available under federal law. The procedures for filing an appeal under the external review process are outlined below.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health Plan (for example, worker classification and similar issues). External review only applies if the adverse benefit determination is based on:

- Clinical reasons;
- Claims involving medical judgment, as determined by the external reviewer,
- Claims resulting in a rescission of coverage; or
- The exclusions for experimental or investigational services or unproven services.

Within five days of receiving your request, the Plan will conduct a "preliminary review" to ensure the request can be sent for external review (for example, to ensure the denied claim or appeal doesn't relate to Plan eligibility and that the request is complete). The Plan will notify you in writing once the preliminary review is complete. If the request is complete but not eligible for external appeal, such notification must include the reasons for its ineligibility. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and you will have the later of the remaining time within the four-month filing period or 48 hours following the receipt of the notification to perfect your appeal request.

The IRO assigned to conduct your external review will notify you of its acceptance of the assignment and you will have 10 business days to submit any additional written information for the IRO to consider. (Within one business day of receiving your additional information, the IRO must share the new material with the Plan. After considering the new information, the Plan may reconsider and reverse its claim or appeal denial, stopping the external review procedure.) To ensure independence, your medical carrier or other applicable party will randomly assign the appeal request to one of at least three IROs with whom the medical carrier or other applicable party has contracted for such external appeals.

The IRO must conduct its external review "de novo", without giving any weight to the Plan's earlier conclusions or decisions. IROs may consider information beyond the denied claim's records, such as the claimant's medical history, appropriate practice guidelines and Plan terms. The IRO must complete its external review and send notice of its decision to you and the Plan within 45 days for standard (non-urgent) external reviews or within 72 hours for urgent external reviews. Decisions resulting from an external review are binding on the plan or insurer and the claimant, subject to judicial review. If the IRO reverses the Plan's earlier decision to deny a claim or appeal, the Plan will immediately provide coverage or payment for the claim, even if the Plan chooses to challenge that decision in court.

Claims Administrator

The following benefits are self-insured by Comcast through contributions made by Comcast, or contributions made jointly by Comcast and plan participants. These benefits are paid directly out of the general assets of Comcast. There is no special fund or trust from which benefits are paid. Comcast has engaged the services of the following third-party administrators who are responsible for processing claims and appeals for these self-insured benefits:

UMR
PO Box 30541
Salt Lake City UT 84130-0541
1-888-335-8397
www.UMR.com

ADMINISTRATIVE INFORMATION

Plan Information	
Plan Name	UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan
Plan Number	502/506
Plan Year	January 1 through December 31
Plan Type	Group Medical and Prescription Drug Plan
Source of Contributions	The cost is paid for out of the general assets of Comcast NBCUniversal, except for any amount paid by COBRA beneficiaries.
Employer Identification Number	Comcast: 27-0000798 NBCUniversal: 27-3526824
Plan Administrator	Comcast Corporation 1701 John F Kennedy Blvd. Philadelphia, PA 19103 1-877-909-HR4U(4748)
Claims Administrator	UHC Standard and Minimum Indemnity Plans and CVS/Caremark Prescription Drug Plan UMR PO Box 30541 Salt Lake City UT 84130-0541 1-888-335-8397 www.UMR.com Standard Prescription Drug Plan CVS/Caremark 9501 East Shea Boulevard Scottsdale, AZ 85260-6719 1-800-652-5798

COBRA Administrator	BenefitConnect | COBRA PO Box 5884 Hopkins, MN 55343-5884 1-877-29-COBRA (26272) [(858) 314-5108 International callers only]
Agent for Service of Legal Process	Plan Administrator