New York University
Retiree Medical Plan

( Employees Retired after December 31, 1988 )

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Group Number: 175396
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SECTION 1 - WELCOME

Quick Reference Box

- Member services and claim inquiries.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800.

New York University is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the New York University Retiree Medical Plan. It includes summaries of:

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

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

New York University intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

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

Please read this SPD thoroughly to learn how the New York University Retiree Medical Plan works. If you have questions contact NYU’s PeopleLink or call the number on your ID card.
How To Use This SPD

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

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

- You can find copies of your SPD and any future amendments at http://www.nyu.edu/employees/benefit.html or you may request printed copies by contacting PeopleLink.

- Capitalized words in the SPD have special meanings and are defined in Section 13, Glossary.

- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 13, Glossary.

- New York University is also referred to as the University.

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

What this section includes:

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

Eligibility

You are eligible to enroll in the Plan if you are a person who retires from NYU on or after January 1, 1989, were eligible to participate in one of the University's group health plans immediately before retirement, and are a member of one of the following groups of full-time employees:

- Faculty
- Administrative and Professional Research staff
- Office and Clerical staff (Local 3882)
- Laboratory and Technical staff (Local 3882)
- Office and Professional staff (Local 153)
- Security Officers and Security Specialists (Local 1)
- Sergeant Guards (Sergeants)
- Service and Maintenance staff (Local 810)
- Non Union Service staff

Age And Service Requirements

Generally, you are eligible for retiree medical coverage from NYU if:

- Your age plus years of continuous, full-time service equals 70 or more, and you are at least age 55 or older with at least ten years of continuous, full time service; or
- For Faculty, Professional Research staff and Administrative and Professional staff, you have 10 or more years of continuous, full-time service and you are found eligible for Long-Term Disability, regardless of age;
- For Office and Clerical staff, Laboratory and Technical staff, Security Officers, Sergeants, and Service and Maintenance staff, you have 15 or more years of continuous, full-time service and you are found eligible for Long-Term Disability, regardless of age; and
- For Faculty, Professional Research staff and Administrative and Professional staff you die after being employed by NYU for at least 10 years of continuous, full-time service.
Regardless of age, your survivors are eligible for continuation of retiree medical coverage.

How To Enroll

- You should contact NYU’s PeopleLink at least 3 months before you plan to retire.
- You must return a completed NYU Retiree Benefits Election Form to PeopleLink within 31 days of the date you retire and become eligible for NYU retiree health coverage. (If you do not submit your enrollment form within 31 days of first becoming eligible, coverage will not be available to you. NYU will not accept late enrollments in the NYU Retiree Medical Plan under any circumstances.)
- You must indicate on this form whether you elect or waive coverage under one the NYU retiree health plan options available in your residential area.
- If you elect to waive coverage, you can only re-elect the Retiree Medical Plan within 31 days of a Qualifying Status Change. See Qualifying Status Changes.

Covering Your Dependents:

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

- Your Spouse, as defined in Section 13, Glossary.
- Your or your Spouse's child who is under age 19, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 19 or over who is or becomes disabled and dependent upon you.
- Your unmarried child age 19 but under age 25 who is:
  - a Full-time Student, as defined in Section 13, Glossary;
  - not regularly employed on a full-time basis; and
  - primarily dependent on you for support and maintenance.

Dependents are not eligible for coverage if they are in the military. Dependents are not eligible for coverage if they marry.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 12, Other Important Information.

- If your spouse or registered domestic partner is an NYU employee or an NYU retiree and is eligible for an NYU Retiree Health Plan or an NYU Medical Plan for active employees, and you have eligible children, your eligible children may only be covered under one plan – either your plan or your spouse's or domestic partner’s.
- If your spouse or registered domestic partner is an active NYU employee and you have no eligible children, that spouse or partner will have coverage under an NYU Medical Plan option available to active employees and you will have individual retiree coverage under the NYU Retiree Medical Plan.
If both you and your spouse or registered domestic partner are NYU retirees and you have no eligible children, you will each be covered at the individual level of coverage under the NYU Retiree Medical Plan.

**Enrolling Your Dependents**

You must indicate any dependents you wish to cover on your NYU Retiree Benefits Election Form.

*Important:* You will be required to furnish proof of relationship in order to cover any dependents, if you have not already submitted proof. Proof of relationship is a copy of a marriage certificate, NYU Domestic Partner registration affidavit, birth certificate, final adoption papers, or documentation substantiating placement for adoption.

**Cost of Coverage**

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

You will be billed for your portion of the cost of NYU retiree medical coverage by EBPA, NYU’s third party billing administrator. Your coverage may be cancelled if you fail to make payments on time. *Note:* The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of New York University's cost in covering a Domestic Partner and/or their eligible dependents may be imputed to the Retiree as income and a 1099 would be issued for tax purposes.

Your contributions are subject to review and New York University reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by contacting PeopleLink or visiting [https://www.nyu.edu/employees/benefit/retirees.html](https://www.nyu.edu/employees/benefit/retirees.html).

**Important**

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact PeopleLink within 31 days of the event. Otherwise, you will not be able to add your dependent to your coverage.

**When Coverage Begins**

Once PeopleLink receives your properly completed enrollment form, coverage will begin the first of the month following your retirement date. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify PeopleLink within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify PeopleLink within 31 days of the birth, adoption, or placement.
If You Are Hospitalized When Your Coverage Begins

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

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

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

- Your marriage, divorce, legal separation or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's.
- Coverage under your spouse’s/partner’s plan is significantly curtailed or ceases.
- Your spouse’s/partner’s employer adds new health plan options.
- NYU adds new health plan options.
- Your spouse/partner commences or returns from an FMLA leave.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
■ Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.

■ Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact PeopleLink within 60 days of termination).

■ You or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact PeopleLink within 60 days of the date of determination of subsidy eligibility).

■ A strike or lockout involving you or your Spouse.

■ A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact PeopleLink within 31 days of the change in family status.

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

**Note:** Any child under age 25 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

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**Change in Family Status - Example**

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

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

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay.

UnitedHealthcare arranges for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under Eligible Expenses as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described at the end of this section.

The NYU Retiree Medical Plan covers a wide range of services and calculates its benefit based on reasonable and customary charges and maximum Medicare allowable charges. The plan is designed so that benefit payments are coordinated with Medicare.

CALENDAR YEAR

You must pay a calendar year deductible of $200 each year for each covered person's eligible medical expenses before the plan starts making payments. After you've paid this amount, the
plan will begin reimbursing you for some of your expenses. If you or a family member is covered by Medicare, the amounts used to meet your annual Medicare Part B deductible may also be used to meet your NYU Retiree Medical Plan deductible.

The family deductible of $500 applies if you have chosen family coverage. If the combined deductible amounts paid by all your covered family members reach the family deductible amount, and at least one family member has satisfied the $200 individual deductible, no further deductible amounts need to be paid for the year. The plan will begin reimbursing you for eligible expenses for all covered family members. This applies to such expenses incurred on or after the date the family deductible is met for the calendar year.

**COINSURANCE AND OUT-OF-POCKET MAXIMUM**

After you have paid the calendar year deductible, you and the plan share any additional eligible expenses. Coinsurance is the percentage of these expenses that you and the plan pay. In most cases, the plan will pay 80% of covered expenses. The amount of coinsurance you are responsible for paying is described as follows:

- In determining how much reimbursement you will receive under the plan; the coinsurance will be applied only to the eligible expense for the service or supply; it will not be applied to the actual charge if this exceeds the eligible expense.

- The coinsurance maximum is the most you will have to pay for covered expenses each calendar year after you have paid the deductible. If you are also covered by Medicare, the coinsurance will be applied to the Medicare allowable charge, not the eligible expense. When the total you have paid for your coinsurance—including expenses used to meet the deductible—reaches $1,000, the plan pays 100% of all your eligible expenses for the remainder of the calendar year (or 100% of your Medicare covered expenses if you are Medicare eligible).

The family coinsurance maximum limits the amount you have to pay for all of your family’s covered medical expenses in a calendar year to $2,000. This includes expenses used to meet the deductible. When the total you and your covered family members have paid for coinsurance—including expenses used to meet the deductible—reaches $2,000, the plan will then pay 100% of all covered medical expenses incurred for the remainder of the calendar year for you and your covered family members.

- The individual out-of-pocket limit and the $2,000 family out-of-pocket limit apply to benefits subject to 80% coinsurance; therefore, these expenses count toward the out-of-pocket limit (for example: outpatient treatment of mental and nervous disorders).

**LIFETIME MAXIMUM BENEFIT**

The most that the plan will pay for any person in a lifetime is $1,000,000. This maximum may be restored in full each January 1 up to the amount of benefit payments you received or $1,000, whichever is less. For example, if you incurred $5,000 in claims during the previous plan year, only $4,000 would be applied toward the lifetime maximum. If you incur only $500 in claims during the previous plan year, however, no amount will be applied toward the lifetime maximum.
Note: Under the restoration feature of the plan, if you reach the lifetime maximum during the plan year and incur additional expenses for that year, the $1,000 restoration amount will only apply to expenses incurred during the next plan year.

NON-OCCUPATIONAL COVERAGE
Only non-occupational Injuries and illnesses are covered under this plan. Work related Injuries and illnesses, even if they continue in retirement but were incurred while employed, are Workers’ Compensation expenses to be submitted to the Workers’ Compensation Plan of the employer at the time the Injury or illness occurred.

MEDICARE
If you and/or your covered dependent is eligible for Medicare, the plan will coordinate your benefits with Medicare. It is important that you enroll for Medicare benefits when you first become eligible. For example, when you reach age 65 and become eligible for Medicare due to age, the NYU Retiree Medical Plan provides secondary coverage. That means it bases plan payments on what Medicare pays first — even if you have not applied for Medicare. Medicare is divided into two parts—Part A for hospital benefits and Part B for other medical expenses. You make no contribution toward Part A hospitalization coverage; however, you must pay a premium for Part B. You must also pay a deductible before Medicare pays Part A and Part B benefits on your behalf.

For an explanation and examples of how the plan coordinates payments with Medicare, see How the Plan Coordinates With Other Plan.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under the Plan.

Eligible Expenses
New York University has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

For Covered Health Services from non-Network providers, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Plan will pay for Eligible Expenses.

- For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which**
notice and consent has been satisfied as described below, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

■ For Covered Health Services that are Emergency Health Services provided by a non-Network provider, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

■ For Covered Health Services that are Air Ambulance services provided by a non-Network provider, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

■ For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the Eligible Expenses is based on either:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, and for non-Ancillary Services provided without notice and consent, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

■ For Emergency Health Services provided by a non-Network provider, the Eligible Expense is based on either:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by Independent Dispute Resolution (IDR).

**IMPORTANT NOTICE:** You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

**For Air Ambulance transportation provided by a non-Network provider,** the Eligible Expense is based on either:
- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by Independent Dispute Resolution (IDR).

**IMPORTANT NOTICE:** You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

Except as described above, Eligible Expenses are based on either of the following:

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

- **When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator,** Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

- **When Covered Health Services are received from a non-Network provider,** Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
When a rate is not published by CMS for the service, the Claims Administrator uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare’s website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

**IMPORTANT NOTICE:** Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section 2799B-2(d) of the Public Service Act.

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

### Annual Deductible
The Annual Deductible is the amount of Eligible Expenses, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to receive Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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

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

### Out-of-Pocket Maximum
The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.
The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Applies to the Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments toward the Annual Deductible</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments</td>
<td>Yes</td>
</tr>
<tr>
<td>Charges for non-Covered Health Services</td>
<td>No</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses or the Recognized Amount when applicable.</td>
<td>No</td>
</tr>
<tr>
<td>Prescription Copays</td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>■ Individual</td>
<td>$200</td>
</tr>
<tr>
<td>■ Family (not to exceed the applicable Individual amount per Covered Person)</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Coupons:</strong> The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>■ Individual</td>
<td>$1,000</td>
</tr>
<tr>
<td>■ Family (not to exceed the applicable Individual amount per Covered Person)</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Coupons:</strong> The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.</td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

1The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

2If a Covered Person uses all or part of the Maximum Benefit, up to $1,000 will be restored to that person's maximum on each January 1. This restoration will happen each January 1 even if the person did not have any Covered Expenses during the prior year.
This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary*.

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Center Services</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Anesthetics</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Cellular and Gene Therapy</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Services must be received at a Designated Provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td></td>
</tr>
<tr>
<td>■ Hospital Services - Inpatient Stay</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment Provider Services (DME)</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>(Including Foot Orthotics and Prosthetic Devices)</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.</td>
<td></td>
</tr>
</tbody>
</table>
## Covered Health Services

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under Eligible Expenses in Section 3: How the Plan Works.</td>
<td></td>
</tr>
<tr>
<td><strong>Enteral Nutrition</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Foot Care</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Habilitative Services</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits for habilitative services will be the same as those stated under Rehabilitation Therapy and Spinal Manipulations stated in this section.</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care Provider Services (including Home IV therapy)</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care Provider Services</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Hospital Pre-Admission Tests</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Laboratory Tests and X-rays</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Medical Transportation Services</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, How the Plan Works.</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>■ Inpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</td>
<td></td>
</tr>
<tr>
<td>■ Inpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Nurse-Practitioner Services</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Oral Surgery and Dental Services</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Organ/Tissue Transplants</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Orthoptic Training (Eye Muscle Exercise)</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Outpatient Occupational Therapy</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Physical Therapy</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
</tr>
<tr>
<td>■ Office Visit</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ All other services (except Office Visit)</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Pregnancy Benefits</td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Psychologist Services</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Inpatient</td>
<td></td>
</tr>
<tr>
<td>■ Outpatient</td>
<td></td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>100%</td>
</tr>
<tr>
<td>Skilled Nursing Facility Confinement Services</td>
<td>100% of expenses from day 21 to 120 that are not covered by Medicare. 80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Convalescent facility charges</td>
<td></td>
</tr>
<tr>
<td>The stay must begin within 14 days following a hospital stay of at least three consecutive days.</td>
<td></td>
</tr>
<tr>
<td>See Section 5, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 5, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Hospital Services</td>
<td></td>
</tr>
<tr>
<td>■ Office Visits</td>
<td></td>
</tr>
<tr>
<td>Travel and Lodging (If services rendered by a Designated Facility)</td>
<td>For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Treatment of Gender Dysphoria</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Urinary Catheters</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Voluntary Sterilization</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Wigs</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>
## SECTION 5 - ADDITIONAL COVERAGE DETAILS

**What this section includes:**
- Covered Health Services for which the Plan pays Benefits.

This section supplements the second table in Section 4, *Plan Highlights.*

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, *Exclusions.*

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

### Acupuncture Services

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

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

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

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

Benefits are limited to 14 treatments per calendar year.

### Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

### Anesthetics

The Plan covers general anesthetics and local anesthetics.
Cardiac Rehabilitation

Services of a licensed cardiac rehabilitation therapist, provided the following conditions are met:

■ The therapy must be ordered and monitored by a Physician.

■ The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

■ The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person’s condition.

Covered Health Services are limited to 20 visits each Calendar Year.

Cellular and Gene Therapy

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

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

Chemotherapy

The Plan covers chemotherapy treatment.

Congenital Heart Disease (CHD) Surgeries

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

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

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.
If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under each Covered Health Service described in Section 4, Plan Highlights.

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

**Durable Medical Equipment Provider Services (DME)**
(Including Foot Orthotics and Prosthetic Devices)

Durable Medical Equipment means equipment which meets all of the following:

- It is for repeated use and is not a consumable or disposable item.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.
- Breast prosthesis following mastectomy as required by the Women’s Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

UnitedHealthcare decides whether to cover the purchase or rental of the equipment.

UnitedHealthcare provides Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years.

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

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

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

**Emergency Care**

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment. When Emergency Care is required and results in a confinement, the Covered Person (or that person's representative or Physician) must call Personal Health Support within one working day of the date the confinement begins.

A working day is a business day of UnitedHealthcare. It does not include Saturday, Sunday or a State or Federal holiday. If it is not reasonably possible to call Personal Health Support within one working day, Care Coordination must be notified as soon as reasonably possible.

When the Emergency Care has ended, however, Personal Health Support must be called before any additional services that require notification are received.

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

**Enteral Nutrition**

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.
For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment.
- Chronic physical disability.
- Intellectual disability; or
- Loss of life.

**Family Planning**

*Infertility Services*

Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

To be eligible for Benefits, you must meet all of the following:

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
  - One year, if you are a female under age 35.
  - Six months, if you are a female age 35 or older.
- You are a female under age 44.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purposes of this Benefit, "therapeutic donor insemination" means using a donor sperm sample to enable a female to become pregnant.

**Footcare**

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Health Service only if needed due to severe systemic disease.
Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.

- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under this section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under your separate prescription drug coverage from Caremark.

- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.

- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction.
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchietomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation of vagina)
  - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery

**Documentation Requirements:**

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

- The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

**Habilitative Services**

Benefits for habilitative services are subject to the limits and are provided as stated under Rehabilitation Therapy, Outpatient Occupational Therapy, Outpatient Physical Therapy and Spinal Manipulations in Section 5, Additional Coverage Details and are subject to the requirements stated below.

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.

- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.

- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

**Hearing Aids**

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

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

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

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

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 36 months.
Home Health Care Provider Services (including Home IV therapy)

The following Covered Health Services must be given by a Home Health Care Agency:

■ Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
■ Temporary or part-time care by a home health aide.
■ Physical therapy.
■ Occupational therapy.
■ Speech Therapy.

Covered Health Services are limited to 200 visits each Calendar Year. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit. The limit on the number of visits does not apply to Hospice patients.

Hospice Care Provider Services

■ Room and Board.
■ Other Services and Supplies.
■ Part-time nursing care by or supervised by a registered graduate nurse (R.N.).
■ Home Health Care Services as shown under Home Health Care. The limit on the number of visits shown under Home Health Care does not apply to Hospice patients.
■ Counseling for the patient and Covered Family Members.

Counseling must be given by a Licensed Counselor.

Services for the patient must be given in an inpatient Hospice facility or in the patient’s home.

The Physician must certify that the patient is terminally ill with six months or less to live.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment.

Hospital Pre-Admission Tests

Tests performed on a Covered Person in a Hospital before confinement as a resident inpatient provided they meet all of the following requirements:

■ The tests are related to the performance of scheduled surgery.
■ The tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital.
■ The Covered Person is subsequently admitted to the Hospital, or the confinement is
canceled or postponed because a Hospital bed is unavailable or because there is a change
in the Covered Person's condition which precludes the surgery.

Hospital Services
■ Room and Board.
Covered Health Services for a private room are limited to the regular daily charge made by
the Hospital for a semi-private room
■ Other Services and Supplies.
■ Emergency Room.
Emergency room services are covered only if it is determined that the services are Covered
Health Services and there is not a less intensive or more appropriate place of service,
diagnostic or treatment alternative that could have been used in lieu of emergency room
services. If UnitedHealthcare, at its discretion, determines that a less intensive or more
appropriate treatment could have been given then no benefits are payable.

Laboratory Tests and X-rays
X-rays or tests for diagnosis or treatment.
■ Benefits include:
■ The facility charge and the charge for supplies and equipment.
■ Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other
Physician services are described under Physician Fees for Surgical and Medical Services.)
■ Presumptive Drug Tests and Definitive Drug Tests.
Benefits are limited to 18 Presumptive Drug Tests per year.
Benefits are limited to 18 Definitive Drug Tests per year.

Medical Supplies
■ Surgical supplies (such as bandages and dressings). Supplies given during surgery or a
diagnostic procedure are included in the overall cost for that surgery or diagnostic
procedure.
■ Blood or blood derivatives only if not donated or replaced.

Medical Transportation Services
Transportation by professional ambulance, other than air ambulance, to and from a medical
facility.
Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest
medical facility qualified to give the required treatment.
Mental Health Services

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

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

Mental Health Services for Children with Serious Emotional Disturbances - Inpatient Confinement or Outpatient Treatment

Benefits for the treatment of certain Mental Illnesses are covered on the same basis as Benefits provided for the treatment of physical illnesses. These Mental Illnesses are defined as Biologically Based Mental Illnesses. Benefits are provided for the treatment of Biologically Based Mental Illness received on an inpatient or intermediate basis in a Hospital or an Alternate Facility.

Benefits are provided for the treatment of Biologically Based Mental Illness and Children with serious Emotional Disturbances received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Biologically Based Mental Illness evaluations and assessment.
- Diagnosis.
- Treatment planning.
■ Referral services.
■ Medication management.
■ Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
■ Crisis intervention.

Biologically based mental illness is defined as a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as the following:

■ Schizophrenia/psychotic disorders.
■ Major depression.
■ Bipolar disorder.
■ Delusional disorders.
■ Panic disorder.

The term children with serious emotional disturbances is defined as persons under the age of eighteen who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

■ Serious suicidal symptoms or other life-threatening self-destructive behaviors.
■ Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors).
■ Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage.
■ Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Neurobiological Disorders - Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

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

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.
Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

**Enhanced Autism Spectrum Disorder**

Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

**Outpatient Pre-Service Notification:**

To receive outpatient benefits for ABA, contact United Behavioral Health two business days prior to receiving services by calling 1-800-557-5745.

The Mental Health/Substance-Related and Addictive Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

**Nurse-Practitioner Services**

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

**Nutritional Counseling**

The Plan will pay for Covered Health Services provided by a registered dietician in an individual session for Covered Persons with diabetes.
Obesity Surgery

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

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

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 13, Glossary and are not Experimental or Investigational or Unproven Services.

Panniculectomy, abdominoplasty, thighplasty, brachioplasty, and mastopexy are covered when considered reconstructive in nature and meet the clinical guidelines for coverage.

The procedures are covered when necessary for functional deficit, or physical impairment, such as skin rashes, and are paid as any other surgery. This is not covered if deemed cosmetic.

Oral Surgery and Dental Services

- Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.

- The following services and supplies are covered only if needed because of accidental injury to natural teeth:
  - Oral surgery.
  - Full or partial dentures.
  - Fixed bridge work.
  - Prompt repair to natural teeth.
  - Crowns.

Surgery is covered if teeth are partially or completely impacted into the bone of the jaw.

You must submit dental EOB in order for the plan to pay the difference.

- Wisdom teeth extraction.

Organ/Tissue Transplants

Services and supplies for necessary organ or tissue transplants including CAR-T cell therapy for malignancies are payable under this Plan.

Donor Charges for Organ/Tissue Transplants

- In the case of an organ or tissue transplant, donor charges are considered Covered Health Services ONLY if the recipient is a Covered Person under this Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.
Medical Care and Treatment

The Covered Health Services for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and physician fees.
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search.

Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician.

Outpatient Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person’s condition within 2 months of the start of the treatment.

Covered Health Services are limited to 33 visits each Calendar Year.

Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person’s condition within 2 months of the start of the treatment.

Covered Health Services are limited to 33 visits each Calendar Year. Covered Health Services are limited to three types of treatment to each body part during each visit.
Pharmaceutical Products - Outpatient

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

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

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

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Benefits are not available for that Pharmaceutical Product.

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

Physician Services

Medical Care and Treatment

- Hospital, office and home visits.
- Emergency room services.

Benefits under this section include allergy injections.

Surgery

Services for surgical procedures.
Reconstructive Surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
  - Birth defect.
  - Sickness.
  - Surgery to treat a Sickness or accidental injury.
  - Accidental injury.

- Reconstructive breast surgery following a necessary mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury.

- Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

By notifying UnitedHealthcare, UnitedHealthcare can verify that the service is a reconstructive procedure rather than cosmetic one.

Assistant Surgeon Services

Eligible Expenses for assistant surgeon services are limited to 1/5 of the amount of Eligible Expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

Multiple Surgical Procedures

Multiple surgical procedures mean 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 50% of the Eligible Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.
Well Woman Mammogram

Benefits are payable for mammography screening:

- Age 30 - 34: Limited to one baseline.
- Age 35-39: Limited to one every two years.
- Age 40 and over: Limited to one per calendar year.

Pregnancy Benefits

Benefits are payable for Covered Health Services and Supplies for pregnancy given to the Covered Person while covered under this Plan.

Benefits for pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery.
- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

The hospital or other provider is not required to get authorization from UnitedHealthcare for the time periods stated above. Authorizations are required for longer lengths of stay.

Federal law does not prohibit the mother’s or newborn’s attending Physician, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable).

After coverage under this Plan stops, extended benefits for pregnancy are the same as for Sickness.

Additional Covered Health Services and Supplies specific to pregnancy are listed below. These Additional Covered Health Services and Supplies are subject to the same requirements as Covered Health Services and Supplies listed.

Additional Covered Health Services and Supplies

Birth Center Services

- Room and Board.
- Other Services and Supplies.
- Anesthetics.

Nurse-Midwife’s Services

Services of a licensed or certified Nurse-Midwife.
Psychologist Services
Covered Health Services provided by a person who specializes in clinical psychology and fulfills one of these requirements:

■ A person licensed or certified as a psychologist.
■ A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Pulmonary Rehabilitation
Services of a licensed therapist, provided the following conditions are met:

■ The therapy must be ordered and monitored by a Physician.
■ The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
■ The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person’s condition within 2 months of the start of the treatment.

Covered Health Services are limited to 20 visits each Calendar Year.

Radiation Therapy
The Plan covers radiation therapy.

Rehabilitation Therapy
Inpatient

■ Services of a Hospital or Rehabilitation Facility for room, board, care and treatment during a confinement.
■ Inpatient rehabilitative therapy is a Covered Health Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Covered Health Services are limited to a combined total of 365 days of confinement in a convalescent inpatient facility, Skilled Nursing Facility and/or Rehabilitation Facility each Calendar Year.

Outpatient

■ Services of a Hospital or Alternate Facility.
■ Covered Health Services are limited to 20 days of therapy each Calendar Year. A day of therapy includes all services given by or visits to the Hospital or CORF in any one day.
■ Covered Health Services for each day of therapy reduces the number of visits under Covered Health Services for Outpatient Physical Therapy, Outpatient Occupational
Therapy or Speech Therapy. This reduction only applies to days of therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.

- Covered Health Services include cardiac rehabilitation.

**Second Surgical Opinion**

The Plan covers Second Surgical physician services.

**Skilled Nursing Facility Services**

- Room and Board.

Covered Health Services for Room and Board are limited to the facility's regular daily charge for a semi-private room.

Covered Health Services are limited to a combined total of 365 days of confinement in a convalescent inpatient facility, Skilled Nursing Facility and/or Rehabilitation Facility each Calendar Year.

**Speech Therapy**

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

- Congenital Abnormality.
- Surgery, radiation therapy or other treatment which affects the vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Accidental injury, which happens while, covered under the plan.

The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition within 2 months of the start of the treatment.

Covered Health Services are limited to 60 visits each Calendar Year.

**Speech Therapy for Children Under Age 3**

Services of a licensed speech therapist for treatment given to a child under age 3 whose speech is impaired due to one of the following conditions:

- Autism Spectrum Disorders.
- Developmental delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.
Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

Covered Health Services are limited to 60 visits each calendar year.

Substance Use Disorder Services

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

Benefits for Substance Use Disorder Services include:

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

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

Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance-Related and Addictive Disorder Administrator. Contact the Mental Health/Substance-Related and Addictive Disorder Administrator regarding Benefits for Substance Use Disorder Services.

Travel and Lodging

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

- Congenital Heart Disease (CHD);
- organ transplant and
■ cancer-related treatments.

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

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

■ transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the obesity surgery service, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;

■ Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or

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

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

■ airfare at coach rate;

■ taxi or ground transportation; or

■ mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

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

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

Treatment of Gender Dysphoria
The Plan pays Benefits for the treatment of gender dysphoria as described under non-surgical or surgical treatment for gender dysphoria.
**Non-Surgical Treatment of Gender Dysphoria:**

The Plan covers non-surgical treatment for gender dysphoria; the following non-surgical treatments are covered:

- **Psychotherapy** for gender dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in Section 6, *Additional Coverage Details*.

- **Continuous hormone replacement therapy** - hormones of the desired gender injected by a medical provider.
  - The patient must be age 18 years or older; and
  - A documented real-life experience (living as the other gender) of at least three months prior to the administration of hormones; or
  - A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

  **Note.** Coverage may be available for oral and self-injected hormones under the prescription drug products portion of the Plan.

- **Laboratory testing** to monitor the safety of continuous hormone therapy.

**Surgical Treatment of Gender Dysphoria:**

The Plan covers surgical treatment for gender dysphoria; the following are covered when the eligibility qualifications for surgery are met below:

- Genital Surgery and Surgery to Change Secondary Sex Characteristics (including Thyroid Chondroplasty, Bilateral Mastectomy, and Augmentation Mammoplasty) and related services.
  - The treatment plan must conform to identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance; and
  - For irreversible surgical interventions, the Covered Person must be age 18 years or older, and
  - Prior to surgery, the Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender, and

  **Important:**
  - Certain Covered Persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the Covered Person's physician, this will be determined on a case-by-case basis.
  - Augmentation Mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

The Claims Administrator has specific guidelines regarding Benefits for treatment of gender dysphoria. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Benefits are limited to one sex transformation reassignment per lifetime, which may include several staged procedures.
Sterilization surgery is not required in order to receive the covered services under this benefit.

**Urgent Care Center Services**

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 13, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services* earlier in this section.

**Voluntary Sterilization**

- Vasectomy.
- Tubal ligation.
SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:
■ Consumer Solutions and Self-Service Tools.

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

■ Take care of yourself and your family members.
■ Manage a chronic health condition.
■ Navigate the complexities of the health care system.

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

Consumer Solutions and Self-Service Tools

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

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

If you need any assistance with the online survey, please call the number on your ID card.

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

This program offers:
■ Access to accurate, objective and relevant health care information.
■ Coaching by a nurse through decisions in your treatment and care.
■ Expectations of treatment.
■ Information on high quality providers and programs.

Conditions for which this program is available include:

■ Back pain.
■ Knee & hip replacement.
■ Prostate disease.
■ Prostate cancer.
■ Benign uterine conditions.
■ Breast cancer.
■ Coronary disease.
■ Bariatric surgery.

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

**www.myuhc.com**

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

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

■ Research a health condition and treatment options to get ready for a discussion with your Physician.
■ Search for Network providers available in your Plan through the online provider directory.
■ Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
■ Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
■ Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

**Registering on www.myuhc.com**

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

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

Disease Management Services

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

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming Physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

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

Complex Medical Conditions Programs and Services

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation’s leading cancer programs.
To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Travel and Lodging Assistance Program.

**Cancer Support Program**

UnitedHealthcare provides a program that identifies and supports a Covered Person who has cancer. You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies and treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on your ID card or call the program directly at 1-866 936-6002.

**Kidney Resource Services (KRS) program**

**End-Stage Renal Disease (ESRD)**

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you’ll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it’s available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

**Congenital Heart Disease (CHD) Resource Services**

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and
education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries, you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Travel and Lodging Assistance Program.

Transplant Resource Services (TRS) Program
Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation’s leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a “best practices” approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the Travel and Lodging Assistance Program, refer to the provision below.

Travel and Lodging Assistance Program
Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

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

Travel and Lodging Expenses
The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:
- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.

- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.

- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.

- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.

- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

- The cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

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

**Lodging**

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.

- A per diem, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

**Transportation**

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.

- Taxi fares (not including limos or car services).

- Economy or coach airfare.

- Parking.
Women’s Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

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

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

As a program participant, you can always call your nurse with any questions or concerns you might have.
SECTION 7 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, Additional Coverage Details.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 5, Additional Coverage Details, those limits are stated in the corresponding Covered Health Service category in Section 4, Plan Highlights. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, Plan Highlights. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments
1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in Section 5, Additional Coverage Details.

Dental
1. dental care, except as identified under Oral Surgery and Dental Services in Section 5, Additional Coverage Details;

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

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

   - extractions (except for wisdom teeth extraction);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;
     This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Oral Surgery and Dental Services in Section 5, Additional Coverage Details.

3. dental implants, bone grafts, and other implant-related procedures;
   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Oral Surgery and Dental Services in Section 5, Additional Coverage Details.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and
   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 5, Additional Coverage Details.

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

Devices, Appliances and Prosthetics

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

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment Provider Services (DME) in Section 5, Additional Coverage Details: This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria.
   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

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

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

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment Provider Services (DME) in Section 5, Additional Coverage Details; and

7. oral appliances for snoring.

8. Powered and non-powered exoskeleton devices.

**DRUGS (SEE ATTACHMENT I – PRESCRIPTION DRUG BENEFITS)**

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

2. self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion;

3. growth hormone therapy;

4. certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator’s designee, but no later than December 31st of the following calendar year. This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, Additional Coverage Details.

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

6. over the counter drugs and treatments;

7. compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.
Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 13, Glossary.

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

Foot Care

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

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

2. treatment of flat feet;

3. treatment of subluxation of the foot;

4. shoe inserts;

5. arch supports;

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

7. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies that are not specifically identified under Durable Medical Equipment Provider Services (DME) and Medical Supplies in Section 5, Additional Coverage Details.

2. Examples of supplies that are not covered include, but are not limited to:
   - compression stockings, ace bandages, diabetic strips, and syringes;
   - ostomy bags and related supplies; and
   - urinary catheters.

This exclusion does not apply to:

   - disposable supplies necessary for the effective use of Durable Medical Equipment Provider Services (DME) for which Benefits are provided as described under Durable Medical Equipment Provider Services (DME) in Section 5, Additional Coverage Details; or
3. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

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

5. the replacement of lost or stolen Durable Medical Equipment.

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

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance-Related and Addictive Disorders Services in Section 5, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services.


9. high intensity residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
Nutrition

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

2. nutritional counseling, except as described in Section 5, Additional Coverage Details;

3. food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 6, Additional Coverage Details.

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

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:
   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - electric scooters;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

### Physical Appearance

1. Cosmetic Procedures, as defined in Section 13, Glossary, are excluded from coverage. Examples include:
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - sclerotherapy treatment of veins;
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

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

### Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Spinal Manipulations to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

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

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or autism
spectrum disorders as identified under Speech Therapy in Section 5, Additional Coverage Details;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy, unless they are medically necessary when considered reconstructive in nature and meet the clinical guidelines for coverage;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty), unless they are medically necessary when considered reconstructive in nature and meet the clinical guidelines for coverage;

8. psychosurgery (lobotomy);

9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

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

11. manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function);

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

14. the following treatments for obesity:
   - non-surgical treatment, even if for morbid obesity; and
   - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in Section 5, Additional Coverage Details;

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

16. upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea; and
17. breast reduction surgery that is determined to be a Cosmetic Procedure;

This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 5, Additional Coverage Details.

18. charges for routine physical, vision, or hearing examinations, or immunizations or other preventive services and supplies;

19. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition;

20. intracellular micronutrient testing.

Providers

Services:

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

2. a provider may perform on himself or herself;

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

4. ordered or delivered by a Christian Science practitioner;

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

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

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

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

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

This exclusion does not apply to mammography testing.

Reproduction

1. The following Infertility treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
- Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
   - IVF for a traditional Surrogate.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under Infertility Services including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
   - Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under Infertility Services including thawing and insemination.

1. The reversal of voluntary sterilization.
2. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 9, Coordination of Benefits (COB);
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under Organ/Tissue Transplants in Section 5, Additional Coverage Details unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. health services for transplants involving animal organs; and
3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

**Travel**

1. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

**Treatment of Gender Dysphoria (Gender Identity Disorder)**

1. reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
2. sperm preservation in advance of hormone treatment or gender surgery;
3. cryopreservation of fertilized embryos;
4. voice modification surgery; and
5. facial feminization surgery, including but not limited to: facial bone reduction, face “lift,” facial hair removal, and certain facial plastic procedures.
6. Treatment received outside of the United States.

**Types of Care**

1. Custodial Care as defined in Section 13, *Glossary* or maintenance care;
2. Domiciliary Care, as defined in Section 13, *Glossary*;
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
Vision and Hearing
1. routine vision examinations, including refractive examinations to determine the need for vision correction;

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

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

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

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

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

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

2. charges for:
   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing;

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

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

5. expenses for health services and supplies:
   - that do not meet the definition of a Covered Health Service in Section 13, Glossary;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply
to Covered Persons who are civilians injured or otherwise affected by war, any act of
war or terrorism in a non-war zone;
- that are received after the date your coverage under this Plan ends, including health
services for medical conditions which began before the date your coverage under the
Plan ends;
- for which you have no legal responsibility to pay, or for which a charge would not
ordinarily be made in the absence of coverage under this Benefit Plan;
- that exceed Eligible Expenses or any specified limitation in this SPD;
- for which a provider waives the Annual Deductible or Coinsurance amounts;
6. foreign language and sign language services;

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

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

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

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

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

10. Charges for routine physical, vision, or hearing examinations, or immunizations or other
preventive services and supplies

11. Charges covered by a Worker’s Compensation Act or similar legislation

12. Charges incurred during confinement in a hospital owned or operated by the
government or any of its agencies, and charges for services, treatments, or supplies
furnished by or for the United States government (including the U.S. armed forces) or
any of its agencies;

13. Charges for which there is no legal obligation to pay (for example, the amount of a
discount on a product or service);

14. Charges for services or supplies that any school system is legally required to provide

15. Charges for completing forms.
SECTION 8 - CLAIMS PROCEDURES

What this section includes:
■ How claims work.
■ What to do if your claim is denied, in whole or in part.

When to Submit a Claim
If you receive a bill for Covered Health Services from a provider, you must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your ID card.

How to File Your Claim
You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

■ Your name and address.
■ The patient's name, age and relationship to the Participant.
■ The number as shown on your ID card.
■ The name, address and tax identification number of the provider of the service(s).
■ A diagnosis from the Physician.
■ The date of service.
■ An itemized bill from the provider that includes:
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

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

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.
When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

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

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

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

Payment of Benefits

Except as required by the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260), you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.
As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 9: Coordination of Benefits.

**Form of Payment of Benefits**

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

**Health Statements**

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

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

**Explanation of Benefits (EOB)**

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also
Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

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

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

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

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

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

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

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

- Urgent care request for Benefits.
- Pre-service request for Benefits.
Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

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

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

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

Filing a Second Appeal

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

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Timing of Appeals Determinations

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

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
■ Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.

■ Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

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

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

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

**Urgent Care Request for Benefits***

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

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

**Pre-Service Request for Benefits**

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

<table>
<thead>
<tr>
<th>Post-Service Claims</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Type of Claim or Appeal</em></td>
<td><em>Timing</em></td>
</tr>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>■ after receiving the completed claim (if the initial claim is incomplete), within:</td>
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<td>You must appeal an adverse benefit determination no later than:</td>
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### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
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<tbody>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td><strong>60 days</strong> after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td><strong>30 days</strong> after receiving the second level appeal decision</td>
</tr>
</tbody>
</table>

### Concurrent Care Claims

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

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

### Coverage While Traveling Abroad

The Plan pays Benefits for Covered Persons while traveling outside the United States. Eligible Expenses for non-Emergency services incurred while outside the United States are reimbursed at the non-Network benefit level based on billed charges (converted to U.S. Dollars) and are subject to the Annual Deductible. Emergency services received outside the United States will be paid at the network benefit level subject to the Annual Deductible. If you receive treatment while traveling outside the United States, you will have to pay for the services up-front and then submit a claim form along with the receipt and an itemized bill from the provider. All foreign claims should be submitted to UnitedHealthcare, P.O. Box 740817, Atlanta GA 30374.

### Limitation of Action

You cannot bring any legal action against New York University or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against New York University or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against New York University or the Claims Administrator.
You cannot bring any legal action against New York University or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against New York University or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against New York University or the Claims Administrator.
SECTION 9 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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

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

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

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.

- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, 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 (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall 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.
      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
   a) The Plan covering the Custodial Parent.
   b) The Plan covering the Custodial Parent's spouse.
   c) The Plan covering the non-Custodial Parent.
   d) The Plan covering the non-Custodial Parent's spouse.
For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

   c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

   d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
   (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.
How Are Benefits Paid When This Plan is Secondary?

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

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

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

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

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

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

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

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

Determining the Allowable Expense When this Plan is Secondary to Medicare

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

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

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

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

**Medicare Crossover Program**

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

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

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

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

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

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

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

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

**Does This Plan Have the Right of Recovery?**

**Overpayment and Underpayment of Benefits**

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

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

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

**Refund of Overpayments**

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

- The Plan’s obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.

- All or some of the payment the Plan made exceeded the Benefits under the Plan.

- All or some of the payment was made in error.

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

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under
other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan’s overpayment recovery rights are assigned to such other plans in exchange for such plans’ remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.
SECTION 10 - SUBROGATION AND REIMBURSEMENT

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

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

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

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

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

The following persons and entities are considered third parties:

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

Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

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

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

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

If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

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

By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

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

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

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

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

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

In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

**Right of Recovery**

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

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.
Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

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

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

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

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.
SECTION 11 - WHEN COVERAGE ENDS

What this section includes:
■ Circumstances that cause coverage to end.
■ Conversion from a group policy to an individual policy.
■ How to continue coverage after it ends.

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

When your coverage ends, New York University will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

■ The last day of the month you are no longer in the eligible class of retired employees described in Section 2, Introduction.

■ The last day of the month you stop making the required contributions.

■ When you die.

■ The date the group policy for retiree coverage terminates.

■ The last day of the month UnitedHealthcare receives written notice from New York University to end your coverage, or the date requested in the notice, if later.

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

■ A dependent becomes covered as an NYU employee.

■ The date your coverage ends, except when due to your death.

■ The last day of the month you stop making the required contributions.

■ The last day of the month UnitedHealthcare receives written notice from New York University to end your coverage, or the date requested in the notice, if later.

■ The last day of the year your Dependent child who is not a Full-time Student no longer qualifies as a Dependent under this Plan.

■ The last day of the month your Dependent child who is a Full-time Student no longer qualifies as a Dependent under this Plan.

■ The last day of the month your Spouse no longer qualifies as a Dependent under this Plan.

■ You elect not to continue to cover that dependent.

■ All coverage for dependents under the group policy is terminated.
If your coverage ends, you or your covered dependents should contact the NYU Benefits Office immediately to find out if you or your covered dependents are eligible for continuation coverage or conversion privileges.

If you die while you have plan coverage, your covered dependents (surviving spouse or registered domestic partner and eligible children) automatically remain covered by the plan until they lose eligibility for coverage under the plan. In the event of your death, your surviving spouse or registered domestic partner are eligible to remain covered under this plan for the rest of their lives. Eligible children may remain covered until the end of the year in which they turn 19, or until the end of the month in which they turn 25 if a full time student.

Other Events Ending Your Coverage

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

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

Coverage for a Disabled Child

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

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

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

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

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 13, Glossary.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if New York University is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

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

Qualifying Events for Continuation Coverage under COBRA

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

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

¹ You may elect COBRA for up to 60 days following the qualifying event.
If Coverage Ends Because of the Following Qualifying Events:

<table>
<thead>
<tr>
<th>Event Description</th>
<th>For Yourself</th>
<th>For Your Spouse</th>
<th>For Your Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
<td>N/A</td>
<td>36 months</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
<td>See table below</td>
<td>See table below</td>
</tr>
<tr>
<td>New York University files for bankruptcy under Title 11, United States Code.²</td>
<td>36 months</td>
<td>36 months³</td>
<td>36 months³</td>
</tr>
</tbody>
</table>

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

²This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

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

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

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

**Getting Started**

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

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

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

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

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2, Introduction.

**Notification Requirements**

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

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.
You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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

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

**Notification Requirements for Disability Determination**

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 14, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

**Trade Act of 2002**

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

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

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

■ The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.

■ The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.

■ The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).

■ The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).

■ The date the entire Plan ends.

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

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

Uniformed Services Employment and Reemployment Rights Act

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

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

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

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

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

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

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.
SECTION 12 - OTHER IMPORTANT INFORMATION

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

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

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

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

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

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

■ New York University and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
■ UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.
The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

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

### Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and New York University and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

New York University and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, New York University and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not New York University's employees nor are they employees of UnitedHealthcare. New York University and UnitedHealthcare are not responsible for any act or omission of any provider.

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

New York University is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U. S. Department of Labor.
Your Relationship with Providers

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

■ Are responsible for choosing your own provider.
■ Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
■ Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
■ Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
■ Must decide with your provider what care you should receive.

Interpretation of Benefits

New York University and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

■ Interpret Benefits under the Plan.
■ Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMsand/or Amendments.
■ Make factual determinations related to the Plan and its Benefits.

New York University and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator’s affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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

Information and Records

New York University and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. New York University and UnitedHealthcare may request additional information from you to decide your claim for Benefits. New York University and UnitedHealthcare will keep this information confidential. New York University and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.
By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish New York University and UnitedHealthcare with all information or copies of records relating to the services provided to you. New York University and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. New York University and UnitedHealthcare agree that such information and records will be considered confidential.

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

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

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

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

**Incentives to Providers**

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

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

- bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments...
regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your Schedule of Benefits.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

**Incentives to You**

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but New York University recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 6, Clinical Programs and Resources.

**Rebates and Other Payments**

New York University and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. New York University and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays and/or Coinsurance.

New York University and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. New York University and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays and/or Coinsurance.

**Workers' Compensation Not Affected**

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

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

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

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

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

Plan Document

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

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in
UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by OptumInsight and/or a third party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.
SECTION 13 - GLOSSARY

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

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

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

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in 42 CFR 414.605.

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

■ Surgical services.
■ Emergency Health Services.
■ Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

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

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

■ Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
■ Provided by assistant surgeons, hospitalists, and intensivists;
■ Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
■ Provided by such other specialty practitioners as determined by the Secretary; and
■ Provided by a non-Network Physician when no other Network Physician is available.
Annual Deductible (or Deductible) - the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, Plan Highlights.

Assisted Reproductive Technology (ART) - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

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

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

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

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

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as UnitedHealthcare Service LLC.) and its affiliates, who provide certain claim administration services for the Plan.

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

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

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

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.
Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

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

Covered Health Services - those health services, including services or supplies, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance-related and addictive disorders, or their symptoms.
- Included in Section 4, Plan Highlights and Section 5, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 2, Introduction.
- Not identified in Section 7, Exclusions and Limitations.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on www.myuhc.com or by calling the number on your ID card. This information is available to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

Covered Health Services - those health services, including services or supplies, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance-related and addictive disorders or their symptoms.
- Included in Section 4, Plan Highlights and Section 5, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 2, Introduction.
- Not identified in Section 7, Exclusions and Limitations.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding...
specific services. You can access these clinical protocols (as revised from time to time) on www.myuhc.com or by calling the number on your ID card. This information is available to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

**Covered Person** - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**CRS** - see Cancer Resource Services (CRS).

**Custodial Care** - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Deductible** - see Annual Deductible.

**Definitive Drug Test** - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

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

**Designated Physician** - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Designated Provider** - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.
You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**DME** - see Durable Medical Equipment (DME).

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

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

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
  - they have a single dedicated relationship;
  - they have joint ownership of a residence; or
  - they have at least two of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; or
    - a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by PeopleLink upon your request.

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

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

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, How the Plan Works.

Eligible Expenses are determined in accordance with the Claims Administrator’s reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

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

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

Emergency Health Services – with respect to an Emergency:

- An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of
the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

**Employee Retirement Income Security Act of 1974 (ERISA)** - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

**Employer** - New York University.

**EOB** - see Explanation of Benefits (EOB).


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

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

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

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

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

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

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

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

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Gender Dysphoria - A disorder characterized by the diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
■ Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

**Genetic Testing** - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

**Gestational Carrier** - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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

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

**Hospital** - an institution, operated as required by law and that meets both of the following:

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

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

**Independent Freestanding Emergency Department** – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

**Infertility** - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

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

**Inpatient Rehabilitation Facility** - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.
**Inpatient Stay** - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intensive Outpatient Treatment** - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

**Medicaid** - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

**Mental Health Services** - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder (MH/SUD) Administrator** - the organization or individual designated by New York University who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

**Mental Illness** – those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator’s affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

**New Pharmaceutical Product** - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

**Non-Medical 24-Hour Withdrawal Management** - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

**Open Enrollment** - the period of time, determined by New York University, during which eligible Participants may enroll themselves and their Dependents under the Plan. New York University determines the period of time that is the Open Enrollment period.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

**Participant** - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

**Pharmaceutical Product(s)** – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

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

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

**Plan** - The New York University Medical Plan.
Plan Administrator - New York University or its designee.

Plan Sponsor - New York University.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on either:

1) An All Payer Model Agreement if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.
The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

**Note:** Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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

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

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

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

**Retired Employee** - an Employee who retires while covered under the Plan.

**Secretary** – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.
Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider’s billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider and a third party vendor. When this program applies, the non-Network provider’s billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare.

This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by UnitedHealthcare, such as:

- A percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.

In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

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

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

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Transitional Living - Mental Health Services/Substance Use Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in American Society of Addiction Medicine (ASAM) criteria, that are either:

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

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

University - New York University.

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

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

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

Please note:

■ If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

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

■ Do not require an appointment.

■ Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends.

■ Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.
SECTION 14 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

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

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 13, Glossary. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

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

Plan Administrator - Medical Plan
New York University
Benefits Office 1st Floor
105 East 17th St
New York, NY 10003
(212) 995-4050

Claims Administrator

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

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

UnitedHealthcare Service LLC.
2950 Expressway Drive South
Suite 240
Islandia, NY 11749-1412

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - Medical Plan
New York University
Benefits Office 1st Floor
105 East 17th St
New York, NY 10003
(212) 995-4050

Legal process may also be served on the Plan Administrator.

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

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

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>New York University Employee Welfare Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
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<td>501</td>
</tr>
<tr>
<td>Employer ID:</td>
<td>13-5562308</td>
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<tr>
<td>Plan Type:</td>
<td>Welfare benefits plan</td>
</tr>
<tr>
<td>Plan Year:</td>
<td>January 1 - December 31</td>
</tr>
<tr>
<td>Plan Administration:</td>
<td>Self-Insured</td>
</tr>
<tr>
<td>Source of Plan Contributions:</td>
<td>Employee and University</td>
</tr>
<tr>
<td>Source of Benefits:</td>
<td>Assets of the University</td>
</tr>
</tbody>
</table>

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

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

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.
In addition to creating rights for Plan participants, **ERISA** imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under **ERISA**.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 8, **Claims Procedures**, for details.

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

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

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

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under **ERISA**, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the **Employee Benefits Security Administration, U.S. Department of Labor**, listed in your telephone directory, or write to the **Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor**, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under **ERISA** by calling the publications hotline of the **Employee Benefits Security Administration** at 1-(866)-444-3272.

The Plan’s Benefits are administered by New York University, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and New York University are not responsible for any decision you or your Dependents make to receive treatment, services or supplies from a provider UnitedHealthcare and New York University are neither liable nor responsible for the treatment, services or supplies you receive from providers.
ATTACHMENT I – PRESCRIPTION DRUG BENEFITS

When you enroll in an NYU medical plan, you automatically receive prescription drug coverage. Prescription drug coverage under the plan includes a retail prescription drug program and a mail service prescription drug service, both of which are administered by Caremark, Inc. Your copayment will depend on the type of drug you obtain:

- generic,
- brand-name medication on Caremark's Primary Drug List, or
- brand-name medication that is not on Caremark's Primary Drug List.

Your copayment will be lowest when you choose a generic drug. If you obtain a brand-name medication from Caremark's Primary Drug List, your copayment will be lower than if you choose a brand-name medication that is not on the Primary Drug List.

A generic drug is a copy that is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance and intended use. It is less expensive because generic manufacturers don't have the investment costs of the developer of a new drug. Generic drugs look different from brand-name drugs because trademark laws do not allow a generic drug to look exactly like brand-name drugs. However, a generic drug must duplicate the active ingredient of the brand-name drug. Colors, flavors and certain other inactive ingredients may be different. Not every brand-name drug has a generic equivalent because brand-name drugs are generally given a patent protection for 20 years from the submission of a patent. Once the patent expires, other drug companies can introduce competitive generic versions, but only after they have been thoroughly tested by the manufacturer and approved by the FDA.

A Primary Drug List is a list of FDA-approved prescription drugs that are priced competitively for a therapeutic class of drugs. The brand-name drugs listed on Caremark's Primary Drug List are a preferred list of drugs that are selected based on their ability to meet patient needs at a reasonable cost. Caremark's Primary Drug List is updated quarterly. The Primary Drug List will be included in the booklet that you will receive from Caremark in December. To view Caremark's current Primary Drug List visit www.caremark.com.

Here are the prescription drug benefits provided under the NYU Retiree Medical Plan:

<table>
<thead>
<tr>
<th>Type</th>
<th>Retail Pharmacy in the Caremark Network (30-day supply)</th>
<th>Purchased at a Purchased by Mail Service through Caremark (90-day supply)</th>
<th>Purchased by Mail Service through Caremark (180-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$10</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Medications on the Primary Drug List</td>
<td>$35</td>
<td>$75</td>
<td>$150</td>
</tr>
<tr>
<td>Medications not on the Primary Drug List</td>
<td>$55</td>
<td>$90</td>
<td>$180</td>
</tr>
</tbody>
</table>
Encouraging Your Use of Generic Drugs

A key goal of your prescription drug plan is to provide pharmacy benefits in a convenient and cost-effective way. One way to save money is to use generic drugs. As of January 2015, CVS Caremark will dispense a generic medicine, if available, as a substitute for a brand-name medicine when filling your prescriptions. If either you or your doctor request a brand-name medicine when a generic equivalent is available (your doctor may indicate “DAW” or Dispense As Written on the prescription), you will pay the generic drug copay, PLUS the difference in cost between the brand-name and the generic medicine. In addition, the CVS Caremark Generic Step Therapy program applies to therapies to treat the following conditions: high blood pressure and cholesterol, acne, prostate, asthma, osteoporosis, pain and inflammation, cholesterol (triglycerides), allergies, glaucoma, stomach/ulcer, migraine, sleep related problems, and incontinence. This program helps you and your doctor choose a lower-cost, generic medicine as the first step in treating these two health conditions. In order to have coverage for some prescription medications in certain drug classes, you first must try a generic drug to treat your condition. If you try (or have tried) a generic drug and it does not work for you, then you may receive coverage for a non-preferred brand drug that your doctor prescribes. If no generic is available – or if it is not right for you – your plan provides coverage for preferred select brand drugs, which may also save you money. However, if you choose to use a non-preferred brand drug without trying a generic first or without your doctor getting prior approval for a non-preferred brand, coverage may be denied and you may have to pay the full cost of the brand drug. CVS Caremark will contact you and your doctor prior to any Step Therapy change.

Maintenance Medications

If you or your dependent(s) take any maintenance medications regularly (i.e., for three months or more), you are required to fill your prescription through the convenient mail order service to your home. If you choose to fill your maintenance medication at a retail pharmacy, you will be required to pay a $75 copayment on your third and subsequent retail fills. An alternative option is to request that your mail order prescription be delivered to your local CVS pharmacy, rather than your home, through CVS Caremark’s Maintenance Choice program. You may refill a 90-day prescription through Caremark mail service at day 50. You may also receive as much as a 180-day supply at mail service, for the cost of two mail order copays, if your physician will write a prescription for a 180-day supply. If you use a pharmacy that does not participate in CVS Caremark to fill a prescription, you will pay 100% of the retail price. You will then need to submit a claim form for reimbursement, along with an original prescription receipt. You will only be reimbursed...
for the cost the plan would have paid had you gone to a network pharmacy (discounted
price), less the applicable copay. In most cases, the discounted price will be less than the
retail price, so you will end up paying more. You may view a list of network pharmacies on
the CVS Caremark website or call a CVS Caremark representative at 800-421-5501.

**Retail Prescription Drug Program**

The retail prescription drug program is used for immediate drug needs or short-term
medications. The retail prescription drug program offers you access to a network of over
55,000 Caremark participating retail pharmacies, including over 20,000 independent
community pharmacies, which have agreed to provide prescription drugs to members at
discounted rates.

**Using a Caremark Participating Retail Pharmacy**

Step 1. Call a Caremark Customer Service Representative at 1-800-421-5501 to find out if
your prescription is considered —maintenance medication. If it is, you should use the
Caremark's Mail Service Pharmacy (see the next page for the instructions).

Step 2. If your prescription is for immediate or short-term use, ask your doctor to write a
prescription for up to a 30-day supply plus refills, when clinically appropriate.

Step 3. Take your prescription to a Caremark participating retail pharmacy.

Step 4. Present your Caremark ID card.

Step 5. Verify that the pharmacist has accurate information about you and your covered
dependents, including date of birth and gender.

Step 6. Pay the appropriate co-payment.

*There are no claim forms to file when you fill your prescription at a participating pharmacy.*

**Using a Non-Participating Pharmacy**

Since Caremark’s retail pharmacy network includes 98% of all walk-in pharmacies located
in the United States, you should not need to visit a non-participating pharmacy. In the event
you do go to a non-participating pharmacy, you will pay the full retail price for the
prescription. You will then need to submit a paper claim form, along with the original
prescription receipt(s) to Caremark for reimbursement. You'll be reimbursed for the
discounted cost of the prescription—the cost the plan would have paid if the prescription
had been filled at a Caremark participating pharmacy—less the applicable copayment. In
most cases, the discounted price will be less than the retail price, so you may end up paying
more when you use a non-participating pharmacy. The same applies in an emergency
situation. For example, if you paid $25 for a generic prescription drug at an out-of-network
pharmacy and the plan's discounted cost for the same drug at an in-network pharmacy is
$20, you'd be reimbursed for $15 ($20 minus your $5 copayment for a generic drug). The
same applies when you go to a participating pharmacy and do not show your Caremark
Prescription Drug ID Card or do not identify yourself to the pharmacist as a participant of the Caremark prescription drug program.

**Caremark’s Mail Service**
Pharmacy Maintenance drugs are drugs that are prescribed for certain ongoing or chronic conditions (like high blood pressure or hypothyroidism) and are generally taken for long periods of time. Your doctor can predict your regular need for this kind of maintenance medication in advance. Caremark’s Mail Service Pharmacy provides the lowest cost way to purchase such medications. Caremark’s Mail Service Pharmacy allows you to buy a 90-day quantity of medication for the same amount you would pay for a 60-day supply at a retail pharmacy. Caremark’s Mail Service Pharmacy should be your first choice when purchasing maintenance or long-term medications. (The number of times you can fill a maintenance prescription at a retail pharmacy is limited to two fills per calendar year. You will pay the full retail cost for a third and subsequent fills of your maintenance medication at a retail pharmacy. So you may want to save the allowance of two fills of a maintenance medication at a retail pharmacy in case of an emergency.) Call a Caremark Customer Service Representative at 1-800-421-5501 to find out if that prescription is considered “maintenance medication.”

**How to Use Caremark’s Mail Service Pharmacy**
For new maintenance medications, ask your doctor to write two prescriptions: one for up to a 90-day* supply plus refills, to be ordered through the Mail Service Pharmacy; the other, to be filled immediately at a Caremark participating retail pharmacy for use until you receive your prescription order from the Mail Service Pharmacy.

*Please Note: By law, Caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day limit. 30 days plus 2 refills does not equal one prescription written for 90 days

- Complete a Mail Service Order Form and send it to Caremark along with your original prescription(s) and the appropriate copayment for each prescription. Be sure to include your original prescription, not a photocopy.

- While checks and money orders are accepted, Caremark’s preferred method of payment is by credit card. For credit card payments, simply include your VISA, Discover, MasterCard, or American Express number and expiration date, in the space provided on the Mail Service Order Form.

- You can expect to receive your prescription within 14 days of Caremark’s receipt of your order. Your prescription will be delivered by First Class U.S. Mail or United Parcel Service (UPS).

- You will receive a new Mail Service Order Form and pre-addressed envelope with each shipment.

**Mail Service Refills are Easy**
Once you have processed a prescription through Caremark’s Mail Service Pharmacy, you can obtain refills using the Internet, phone, or mail. Order your refill three weeks in advance of
your current prescription running out. Suggested refill dates will be included on the prescription label you receive from Caremark.

- Internet: Visit www.caremark.com, your on-line prescription service, to order prescription refills or inquire about the status of your order. You will need to register on the site and log in.

- Phone: Call 1-800-421-5501 for Caremark's fully automated refill phone service.

- Mail: Attach the refill label provided with your last prescription order to a Mail Service Order Form. Enclose your payment with your order. Checks, money orders, and credit card payments are accepted. Do not send cash.

When you call or log in, be ready to provide: your ID number, your date of birth, your VISA, Discover, MasterCard or American Express, number with expiration date for your copayment.

Money Saving Tips
If you want to obtain the lowest out-of-pocket cost for your prescriptions, you may want to ask your doctor about generic and brand-name medications from Caremark's Primary Drug List that are suitable for you to take. If your doctor feels a different drug from the same therapeutic class can work for you, you should have your doctor write a new prescription for that drug. Brand-name products that are on Caremark's Primary Drug List will reduce the cost of your prescriptions.

- Give your healthcare provider a copy of Caremark's Primary Drug List, which is in the booklet that you'll receive in December. The list can also be printed from www.caremark.com. Ask that brand-name medications from the Primary Drug List be prescribed for you if it is medically appropriate to do so.

- Have your healthcare provider indicate —may substitute— on your prescription to receive a generic (less expensive) product.

- Ask your healthcare provider to write a prescription for a 90-day supply so that you can fill your prescription by mail.

3 Ways to Contact Caremark with Your Questions
Internet: Visit www.caremark.com

To enter the site you will be required to register and log in. You can do the following:

- Prescription Refills
- Order Status
- Pharmacy Locations
- Benefit Coverage
- Request Forms
- Frequently Asked Questions
- 13-month Drug History
• Additional Health Information

**Phone:** Call 1-800-421-5501 to speak to a Caremark Customer Service Representative. Monday through Friday 7:00 a.m. - 9:00 p.m. (CST) and Saturdays 8:00 a.m. - 12:00 p.m. (CST).

**E-mail:** E-mail Customer Service at customer service@caremark.com
ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.