Summary Plan Description

New York University
Choice Plus

Advantage Plan

Effective: January 1, 2022
Group Number: 175396
TABLE OF CONTENTS

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

SECTION 2 - INTRODUCTION .............................................................................................................. 3
   Eligibility ........................................................................................................................................ 3
   Cost of Coverage ............................................................................................................................ 3
   How to Enroll ................................................................................................................................. 4
   When Coverage Begins .................................................................................................................. 4
   Changing Your Coverage ................................................................................................................ 5

SECTION 3 - HOW THE PLAN WORKS ................................................................................................ 7
   Network and Non-Network Benefits .............................................................................................. 7
   Eligible Expenses ........................................................................................................................... 10
   Annual Deductible .......................................................................................................................... 14
   Copayment ................................................................................................................................... 14
   Coinsurance ................................................................................................................................... 14
   Out-of-Pocket Maximum .............................................................................................................. 14

SECTION 4 - PERSONAL HEALTH SUPPORT and PRIOR AUTHORIZATION ................................. 16
   Care Management .......................................................................................................................... 16
   Prior Authorization ....................................................................................................................... 17
   Special Note Regarding Medicare ............................................................................................... 18

SECTION 5 - PLAN HIGHLIGHTS ....................................................................................................... 19
   Schedule of Benefits .................................................................................................................... 21

SECTION 6 - ADDITIONAL COVERAGE DETAILS ............................................................................. 31
   Acupuncture Services .................................................................................................................... 31
   Ambulance Services - Emergency only ......................................................................................... 31
   Ambulance Services - Non-Emergency ........................................................................................ 31
   Cellular and Gene Therapy .......................................................................................................... 32
   Clinical Trials ............................................................................................................................... 32
   Congenital Heart Disease (CHD) Surgeries .................................................................................... 34
   Dental Services - Accident Only .................................................................................................... 35
   Diabetes Services .......................................................................................................................... 36
   Durable Medical Equipment (DME) ............................................................................................. 36
   Emergency Health Services - Outpatient ...................................................................................... 38
<table>
<thead>
<tr>
<th>Service</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enteral Nutrition</td>
<td>38</td>
</tr>
<tr>
<td>Eye Examinations</td>
<td>39</td>
</tr>
<tr>
<td>Gender Dysphoria</td>
<td>40</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>42</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>42</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>43</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>43</td>
</tr>
<tr>
<td>Infertility Services and Fertility Solutions (FS) Program</td>
<td>44</td>
</tr>
<tr>
<td>Injections received in a Physician's Office</td>
<td>46</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>47</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>48</td>
</tr>
<tr>
<td>Neurobiological Disorders - Autism Spectrum Disorders</td>
<td>50</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>52</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>53</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>53</td>
</tr>
<tr>
<td>Outpatient Surgery, Diagnostic and Therapeutic Services</td>
<td>53</td>
</tr>
<tr>
<td>Physician's Office Services - Sickness and Injury</td>
<td>55</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>56</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>57</td>
</tr>
<tr>
<td>Professional Fees for Surgical and Medical Services</td>
<td>57</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>57</td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td>57</td>
</tr>
<tr>
<td>Rehabilitation Services - Outpatient Therapy</td>
<td>58</td>
</tr>
<tr>
<td>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td>60</td>
</tr>
<tr>
<td>Spinal Treatment</td>
<td>61</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>61</td>
</tr>
<tr>
<td>Temporomandibular Joint (TMJ) Services</td>
<td>62</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>62</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>64</td>
</tr>
<tr>
<td>Urinary Catheters</td>
<td>64</td>
</tr>
<tr>
<td>Virtual Care Services</td>
<td>64</td>
</tr>
<tr>
<td>Wigs</td>
<td>64</td>
</tr>
<tr>
<td>Wisdom Teeth</td>
<td>65</td>
</tr>
</tbody>
</table>
# Table of Contents

## SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Solutions and Self-Service Tools</td>
<td>66</td>
</tr>
<tr>
<td>Disease Management Services</td>
<td>68</td>
</tr>
<tr>
<td>Complex Medical Conditions Programs and Services</td>
<td>69</td>
</tr>
<tr>
<td>Women's Health/Reproductive</td>
<td>73</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Treatments</td>
<td>75</td>
</tr>
<tr>
<td>Comfort or Convenience</td>
<td>75</td>
</tr>
<tr>
<td>Dental</td>
<td>76</td>
</tr>
<tr>
<td>Drugs</td>
<td>77</td>
</tr>
<tr>
<td>Experimental or Investigational Services or Unproven Services</td>
<td>77</td>
</tr>
<tr>
<td>Foot Care</td>
<td>77</td>
</tr>
<tr>
<td>Gender Dysphoria</td>
<td>78</td>
</tr>
<tr>
<td>Medical Supplies and Appliances</td>
<td>78</td>
</tr>
<tr>
<td>Mental Health, Neurobiological Disorders - Autism Spectrum Disorder</td>
<td>79</td>
</tr>
<tr>
<td>Use Disorder Services</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>80</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td>80</td>
</tr>
<tr>
<td>Providers</td>
<td>80</td>
</tr>
<tr>
<td>Reproduction</td>
<td>81</td>
</tr>
<tr>
<td>Services Provided under Another Plan</td>
<td>82</td>
</tr>
<tr>
<td>Transplants</td>
<td>82</td>
</tr>
<tr>
<td>Travel</td>
<td>82</td>
</tr>
<tr>
<td>Vision</td>
<td>83</td>
</tr>
<tr>
<td>All Other Exclusions</td>
<td>83</td>
</tr>
</tbody>
</table>

## SECTION 9 - CLAIMS PROCEDURES

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Benefits</td>
<td>86</td>
</tr>
<tr>
<td>Non-Network Benefits</td>
<td>86</td>
</tr>
<tr>
<td>How To File Your Claim</td>
<td>86</td>
</tr>
<tr>
<td>Health Statements</td>
<td>88</td>
</tr>
<tr>
<td>Explanation of Benefits (EOB)</td>
<td>88</td>
</tr>
<tr>
<td>Claim Denials and Appeals</td>
<td>88</td>
</tr>
<tr>
<td>External Review Program</td>
<td>90</td>
</tr>
</tbody>
</table>
Statement of Rights under the Newborns' and Mothers' Health Protection Act ........145

ATTACHMENT III – Nondiscrimination and Accessibility Requirements ........................................146

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS ................................148
SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Administrator: (800) 214-1736;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, Georgia 30374-0800; and

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 Employee Health & Welfare Benefit Plan. It includes summaries of:

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

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

IMPORTANT

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

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. 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 Employee Welfare Benefit Plan works. If you have questions, contact the PeopleLink Department 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 for request printed copies by contacting PeopleLink.
- Capitalized words in the SPD have special meanings and are defined in Section 14, Glossary.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, Glossary.
- 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; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you meet the eligibility rules as determined by The Plan Sponsor. Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse or Domestic Partner as defined in Section 14, Glossary;
- your or your Spouse’s or Domestic Partner’s child, through the end of the month in which age 26 is attained, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

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

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

Cost of Coverage

You and 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.

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

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

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

You can obtain current contribution rates by calling PeopleLink or logging onto the Benefits Resource Center which can be found under the Work tab in NYUHome.

**How to Enroll**

To enroll, you will need to log onto the Benefits Resource Center within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Annual Enrollment to make your benefit elections.

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

**Important**

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must make your election via the Benefits Resources Center, NYU's secure benefits portal, within 31 days of the event. Documentation may be required as a result of your elections. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

**When Coverage Begins**

Once you have completed your enrollment, coverage will begin on the date identified by the Plan Administrator. 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 the family status change provided you make your election within 31 days from the change. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you make your election within 31 days of the marriage, birth, adoption, or placement.

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

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

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

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

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

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

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

Change in Family Status - Example

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

What this section includes:
- Network Benefits (In-Network Benefits)
- Non-Network Benefits (Out-of-Network Benefits);
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

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

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

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

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, Plan Highlights. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits, also referred to as In-Network Benefits, apply to Covered Health Services that are provided by a Network Physician or other Network provider.

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

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.

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

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

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

Health Services from Non-Network Providers Paid as Network Benefits
If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

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

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

Network providers are independent practitioners and are not employees of New York University or UnitedHealthcare.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the number on your ID card to request a copy. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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

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

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

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

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

**Possible Limitations on Provider Use**

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

**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 Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For Non-Network Benefits, 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 Claims Administrator 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 this 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 this 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 which is based on the Recognized Amount as defined in the SPD.

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

**Designated Network Benefits and Network Benefits**

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our 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 the Claims Administrator 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.

**Non-Network Benefits**

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 Expense is based on one of the following in the order listed below as applicable:
- 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, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service 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 one of the following in the order listed below as applicable:

- 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 one of the following in the order listed below as applicable:

- 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 which is based on the Recognized Amount as defined in the SPD.

■ When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined, based on one of the following:
- 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:
  
  ♦ Eligible Expenses are determined based on 190% 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 an available gap methodology to determine a rate for the service as follows:

    - For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become 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](http://www.myuhc.com) for information regarding the vendor that provides the applicable gap fill relative value scale information.

    - For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

    - When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.

    - When a rate for all other services is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider’s billed charge.

The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

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

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

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

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

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

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 90% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance.

Out-of-Pocket Maximum
The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximaums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.
The 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 Network Out-of-Pocket Maximum?</th>
<th>Applies to the Non-Network Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Payments toward the Annual Deductible</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Charges for non-Covered Health Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses or the Recognized Amount when applicable.</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

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

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.

- **Inpatient care management** - If you are hospitalized, a Personal Health Support Nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment,
follow-up services are in place. The Personal Health Support Nurse will also share
important health care information, reiterate and reinforce discharge instructions, and
support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex
  conditions, this program addresses such health care needs as access to medical
  specialists, medication information, and coordination of equipment and supplies.
  Participants may receive a phone call from a Personal Health Support Nurse to discuss
  and share important health care information related to the participant's specific chronic
  or complex condition.

- **Cancer Management** - You have the opportunity to engage with a nurse that
  specializes in cancer, education and guidance throughout your care path.

- **Kidney Management** - You have the opportunity to engage with a nurse that
  specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD
  throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit
from any of these programs, please call the number on your ID card.

**Prior Authorization**

UnitedHealthcare requires prior authorization for certain Covered Health Services.
Network Primary Physicians and other Network providers are responsible for obtaining
prior authorization before they provide these services to you.

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

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

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

The utilization review process is a set of formal techniques designed to monitor the use of,
or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care
services, procedures or settings. Such techniques may include ambulatory review, prospective
review, second opinion, certification, concurrent review, case management, discharge
planning, retrospective review or similar programs.
Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

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

Services for which you are required to obtain prior authorization are identified in Section 6, Additional Coverage Details, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

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

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>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Emergency Health Services</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>■ Partial Hospitalization/Intensive</td>
<td>$30</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>■ Physician's Office Services – Primary Physician</td>
<td>$30</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>■ Physician's Office Services – Specialist</td>
<td>$40</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>■ Physician’s Office Services – Primary Physician</td>
<td>$0</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>■ Urgent Care Center Services</td>
<td>$35</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>■ Rehabilitation Services - Outpatient Therapy</td>
<td>$40</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Individual</td>
<td>$400</td>
<td>$2,600</td>
</tr>
<tr>
<td>■ Family (not to exceed the applicable Individual</td>
<td>$800</td>
<td>$5,200</td>
</tr>
<tr>
<td>■ Individual amount per Covered Person)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

<p>| Annual Out-of-Pocket Maximum&lt;sup&gt;2&lt;/sup&gt;       |            |                |
|■ Individual                                     | $2,000     | $8,000         |
|■ Family (not to exceed the applicable Individual | $5,000     | $15,000        |
|■ Individual amount per Covered Person)          |            |                |</p>
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<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>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td><em>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit a non-Network provider.

2The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

5Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
Schedule of Benefits

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

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</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td><strong>Office visit:</strong> 100% after you pay a $30 Copay or a $40 Specialist Copay</td>
</tr>
<tr>
<td></td>
<td><strong>Non-office:</strong> 90%</td>
</tr>
<tr>
<td><strong>Ambulance Services - Emergency Only</strong></td>
<td><strong>Ground Transportation</strong> 90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Air Transportation</strong> 90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Ambulance Services - Non-Emergency</strong></td>
<td><strong>Ground Transportation</strong> 90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Air Transportation</strong> 90% after you meet the Annual Deductible</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></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Cellular and Gene Therapy</strong></td>
<td><em>Designated Network</em></td>
</tr>
<tr>
<td></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><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Hospital Inpatient Stay</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Dental Services - Accident Only</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</td>
<td></td>
</tr>
<tr>
<td>Diabetes Self-Management Items</td>
<td></td>
</tr>
<tr>
<td>■ diabetes equipment</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ diabetes supplies</td>
<td>100% after you pay a $30 per visit Copay</td>
</tr>
</tbody>
</table>

*See Durable Medical Equipment in Section 6, Additional Coverage Details, for limits*
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>See Section 6, <em>Additional Coverage Details</em> for limits.</td>
</tr>
<tr>
<td>Emergency Health Services</td>
<td>100% after you pay a $75 Copay</td>
</tr>
<tr>
<td></td>
<td>Copay waved if admitted to the Hospital</td>
</tr>
<tr>
<td>■ If non-Emergency</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay, 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. 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>
</tr>
<tr>
<td>Enteral Nutrition</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Fertility Preservation for Iatrogenic Infertility</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Eye Examinations</td>
<td>100% after you pay a $30 per visit Copay or $40 Specialist Copay</td>
</tr>
<tr>
<td></td>
<td>See Section 6, <em>Additional Coverage Details</em>, for limits</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>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>Hearing Aids</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Up to 200 visits per calendar year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Infertility Services and Fertility Solutions (FS) Program</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Hospital – Inpatient Stay</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient services at a Hospital or Alternate Facility</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>■ Physician’s Office Services</td>
<td>100% after you pay a $30 Copay per visit or $40 per Specialist visit</td>
</tr>
<tr>
<td>■ Injections received in a Physician's Office</td>
<td>100% after you pay a $30 per visit Copay (except for immunization)</td>
</tr>
<tr>
<td>■ Maternity Services</td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section. No Copayment applies to Physician office visits for prenatal care after the first visit.</td>
</tr>
<tr>
<td>■ Mental Health Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Inpatient</td>
<td>100% after you pay a $30 per visit Copay</td>
</tr>
<tr>
<td>■ Outpatient</td>
<td>100% for Partial Hospitalization/Intensive Outpatient Treatment after you pay a Copayment of $30 per session</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Neurobiological Disorders - Autism Spectrum Disorder Services</td>
<td></td>
</tr>
<tr>
<td>■ Inpatient</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient</td>
<td>100% after you pay a $30 per visit Copay</td>
</tr>
<tr>
<td></td>
<td>100% for Partial Hospitalization/Intensive Outpatient Treatment after you pay a Copayment of $30 per session</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>100% after you pay a $30 Primary Physician or a $40 Specialist Copay per visit</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td></td>
</tr>
<tr>
<td>■ Physician’s Office Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Professional Fees for Surgical and Medical Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Hospital - Inpatient Stay</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient Surgery</td>
<td>90% after you meet the Annual Deductible</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>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Outpatient Diagnostic Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Outpatient Diagnostic/Therapeutic Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>- CT scans, PET scans, MRI and Nuclear</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapeutic Treatments</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

See Section 6, Additional Coverage Details for limits

| Ostomy Supplies                             | 90% after you meet the Annual Deductible            |
|                                             | 60% after you meet the Annual Deductible            |

Outpatient Surgery, Diagnostic and Therapeutic Services

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Outpatient Diagnostic Services</td>
<td></td>
</tr>
<tr>
<td>- Preventive Lab and radiology/X-ray</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>- Mammography testing and breast ultrasound</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>- Sickness and Injury related diagnostic</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>services</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Outpatient Diagnostic/Therapeutic Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>- CT scans, PET scans, MRI and Nuclear</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapeutic Treatments</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
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<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Physician's Office Services - Sickness and Injury</strong></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Primary Physician Office Visit:</strong></td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $30 per visit Copay</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist Office Visit:</strong></td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $40 per visit Copay</td>
</tr>
<tr>
<td></td>
<td><strong>Designated Network</strong></td>
</tr>
<tr>
<td></td>
<td>100% per Primary Physician visit or OBGYN visit</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Breast Pumps</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td><strong>90% after you meet the Annual Deductible</strong></td>
</tr>
<tr>
<td>Benefits are provided for home skilled nursing only.</td>
<td></td>
</tr>
<tr>
<td><strong>Professional Fees for Surgical and Medical Services</strong></td>
<td><strong>90% after you meet the Annual Deductible</strong></td>
</tr>
<tr>
<td>Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, How the Plan Works, under Eligible Expenses.</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services ¹</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Reconstructive Procedures</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>Rehabilitation Services - Outpatient</td>
<td>100% after you pay a $40 Copay</td>
</tr>
<tr>
<td>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Spinal Treatment</td>
<td>100% after you pay a $40 Copay</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>⁰ Inpatient</td>
<td>100% after you after you pay a $30 Copay</td>
</tr>
<tr>
<td>⁰ Outpatient</td>
<td>100% for Partial Hospitalization/Intensive Outpatient Treatment after you pay a Copayment of $30 per session</td>
</tr>
</tbody>
</table>

¹ See Section 6, Additional Coverage Details, for visit limits.
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ)</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td></td>
</tr>
<tr>
<td>For Network Benefits, transplantation services must be received by a Designated Provider. The Claims Administrator does not require that cornea transplants be performed by a Designated Provider in order for you to receive Network Benefits.</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>100% after you pay a $35 Copay per visit</td>
</tr>
<tr>
<td>Urinary Catheters</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Virtual Care Services</td>
<td></td>
</tr>
<tr>
<td>Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card.</td>
<td>100% after you pay a $30 Copay</td>
</tr>
<tr>
<td>Wigs</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Wisdom Teeth</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

1 Please obtain prior authorization before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*. 

_Section 5 - Plan Highlights_
SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

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

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

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

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

Acupuncture services for pain therapy when the service is performed by a provider in the provider's office.

Non-Network Benefits are limited to 14 visits per calendar year.

Did you know…

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

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.

Ambulance Services - Non-Emergency

Transportation by professional ambulance (not including air ambulance) between medical facilities.

Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.
Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Non-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization from the Claims Administrator, Benefits will be subject to a $400 reduction.

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.

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

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

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

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

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

■ Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

    ♦ comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
NEW YORK UNIVERSITY MEDICAL CHOICE PLUS ADVANTAGE PLAN

♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.

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 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 Provider, the Plan pays Benefits as described under:

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

**Prior Authorization Requirement**

For Covered Health Services required to be received by a Designated Provider, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization and if, as a result, the CHD surgeries are not received at a Designated Provider, Non-Network Benefits will apply. For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.

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

**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.

**Dental Services - Accident Only**

Dental services when all of the following are true:

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

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

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

Dental services for final treatment to repair the damage must be both of the following:

- started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan;
- completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

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

**Diabetes Services**

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

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

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

*Diabetic Self-Management Items*

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

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

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

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

**Durable Medical Equipment (DME)**

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
not consumable or disposable; and
not of use to a person in the absence of a disease or disability.

If more than one piece of DME can meet your functional needs, Benefits are available only for the most Cost-Effective piece of equipment.

Examples of DME include but are not limited to:

- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;
- oxygen concentrator units and the rental of equipment to administer oxygen;
- delivery pumps for tube feedings;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section;
- braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

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.

**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

**Emergency Health Services - Outpatient**
The Plan pays for services that are required to stabilize or initiate treatment in an Emergency. Emergency health services must be received on an outpatient basis at a Hospital or Alternate Facility.

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

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

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

**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.

**Eye Examinations**

The Plan pays Benefits for eye examinations received from a health care provider in the provider’s office or outpatient facility.

Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider each calendar year. Refractive exams are not covered out-of-network.

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

**Fertility Preservation for Iatrogenic Infertility**

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Injections in a Physician’s Office* in this section.

Benefits are not available embryo transfer.

Benefits are not available for long-term storage costs (greater than one year.)
Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan.

**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)
  - Orchietectomy (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)
  - Vulvectomv (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.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises.

If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay.

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.
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.

Coverage for hearing aids is per ear (binaural) every 36 months. Coverage includes dispensing fees. The limit does not apply to hearing testing.

Home Health Care

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

- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

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

Benefits for Home Health Agency services include private duty nursing.

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

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

Any combination of Network Benefits and Non-Network Benefits is limited to 200 visits per calendar year. One visit equals four hours of Skilled Care services.

**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

**Hospice Care**
The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

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

**Hospital - Inpatient Stay**
Hospital Benefits are available for:

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

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

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

Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.

- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 reduction.

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

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**Infertility Services and Fertility Solutions (FS) Program**

Therapeutic services are covered for the treatment of infertility when provided by or under the direction of a Physician.

Benefits under this section are limited to the following procedures:

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

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the SPD. Benefits for diagnostic tests are described under, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits.*
Benefits for certain Pharmaceutical Products, including specialty Pharmaceutical Products, for the treatment of Infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under Injections in a Physician’s Office.

**Enhanced Benefit Coverage**

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

**Fertility Preservation for Medical Reasons** - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

**Criteria to be eligible for Benefits**

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

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

- You are a female:
  - under age 44 and using own oocytes (eggs).
  - under age 55 and using donor oocytes (eggs).
  - Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- You have Infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

- You are not a Child Dependent.

The waiting period may be waived when you have a known male or female Infertility factor, including but not limited to: congenital malformations, abnormal sperm, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.
Artificial insemination with donor sperm is not subject to medical diagnosis criteria. Artificial insemination using donor sperm is limited to not more than 12 inseminations for females less than 35 years of age and not more than 6 inseminations for females 35 years of age and older. In this context, ovarian stimulation is not indicated, the insemination being performed in a natural cycle.

Certain criteria to be eligible for Benefits may be waived for Fertility Preservation for medical reasons.

Any combination of Network Benefits and Non-Network Benefits is limited to $10,000 per Covered Person during the entire period he or she is covered under the Plan.

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

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

*Fertility Solutions Program*

For Designated Network Benefits, you must enroll in the Fertility Solutions Program to receive services from a Designated Provider. To enroll you can call the telephone number on your ID card or you can call the *Fertility Solutions Program Nurse Team* at 1-866-774-4626.

*Injections received in a Physician's Office*

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

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 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, Network Benefits are not available for that Pharmaceutical Product.

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

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

Maternity Services

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

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

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

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Mental Health Services

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

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

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

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

Prior Authorization Requirement

Please remember for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator five business days before admission.

- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.
In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management;

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $400 reduction.

Mental Health Services for Children with Serious Emotional Disturbances - Inpatient and Intermediate

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 and include the conditions that are listed in the definition of Biologically Based Mental Illness in Glossary of Defined Terms. 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.

The Mental Health / Substance Abuse Designee, 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. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day.

Network Benefits for Mental Health Services for Biologically Based Mental Illness must be provided by or under the direction of the Mental Health / Substance Abuse Designee. For Network Benefits, referrals to a Mental Health provider are at the sole discretion of the Mental Health / Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health / Substance Abuse Designee regarding Benefits for inpatient / intermediate Mental Health Services for Biologically Based Mental Illness.

Inpatient Pre-Service Notification Requirement

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

If you fail to obtain prior authorization as required, $400 penalty will apply.

For Network Benefits authorization is obtained by the provider.

Outpatient Pre-Service Notification Requirement

Authorization is required before the following services are received: intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended
outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

For Network Benefits authorization is obtained by the provider.

For Non-Network Benefits you must obtain prior authorization before the services are received.

**Neurobiological Disorders - Autism Spectrum Disorders**

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

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

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

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.
The Mental Health/Substance-Related and Addictive Disorder Administrator provides administrative services for all levels of care.

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

**Prior Authorization Requirement**

Please remember for Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator five business days before the admission.

- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $400 reduction.

**Mental Health Services for Biologically Based Mental Illness and for Children with Serious Emotional Disturbances - Inpatient and Intermediate**

Benefits for the treatment of certain Mental Illnesses are covered on the same basis as Benefits provided for the treatment of physical illnesses.

Benefits are provided for the treatment of Biologically Based Mental Illness and for Children with serious Emotional Disturbances received on an inpatient or intermediate basis in a Hospital or an Alternate Facility.

The Mental Health / Substance Abuse Designee, 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. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day.

Network Benefits for Mental Health Services for Biologically Based Mental Illness and for Children with serious Emotional Disturbances must be provided by or under the direction of the Mental Health / Substance Abuse Designee. For Network Benefits, referrals to a Mental Health provider are at the sole discretion of the Mental Health / Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health / Substance Abuse Designee regarding Benefits for inpatient / intermediate Mental Health Services for Biologically Based Mental Illness and Children with serious Emotional Disturbances.
Authorization Required
Please remember that you must call to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. If you don't obtain authorization a $400 penalty will apply.

Biologically Based Mental Illness and Children with Serious Emotional Disturbances– Outpatient

Benefits for the treatment of certain Mental Illnesses are covered on the same basis as Benefits provided for the treatment of physical illnesses.

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.

For Network Benefits, referrals to a Mental Health provider are at the sole discretion of the Mental Health / Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health / Substance Abuse Designee regarding Network Benefits for outpatient Mental Health Services for Biologically Based Mental Illness and Children with serious Emotional Disturbances.

Nutritional Counseling

Nutritional counseling services provided by a dietician (a licensed health professional) to develop a dietary treatment plan to treat and/or manage conditions such as diabetes, heart failure, kidney failure, high cholesterol, anorexia, bulimia, etc. are Covered Heath Services (including all diagnostic codes) when both of the following are true:

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

When nutritional counseling services are billed as a preventive care service, these services will be paid as Preventive Care Services.
When provided in an office place of service, the benefit is under the *Physician’s Office Services – Sickness and Injury*. When provided in an outpatient Hospital or facility place of service, the benefit is under the *Outpatient Therapeutic Treatments* benefit.

**Obesity Surgery**

The Plan covers surgical treatment of morbid obesity provided by or under the direction of a Physician based on Care Coordination determination.

Bariatric and Lap Band Surgery are covered.

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.

<table>
<thead>
<tr>
<th>Prior Authorization Requirement</th>
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<tbody>
<tr>
<td>For Non-Network Benefits you must obtain prior authorization as soon as the possibility of obesity surgery arises.</td>
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<tr>
<td>If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.</td>
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<tr>
<td>In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay.</td>
</tr>
<tr>
<td>It is important that you provide notification regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.</td>
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**Ostomy Supplies**

Benefits for ostomy supplies are limited to:

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

Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.

**Outpatient Surgery, Diagnostic and Therapeutic Services**

**Outpatient Surgery**

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.
Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under Professional Fees for Surgical and Medical Services.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

### Prior Authorization Requirement
For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization, electrophysiology implant and sleep apnea surgery you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.

### Outpatient Diagnostic Services
The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab and radiology/X-ray.
- Mammography testing.

Benefits under this section 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.

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

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

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

This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicines, which are described immediately below.

### Prior Authorization Requirement
For Non-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.
**Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine**

The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator for CT, PET scans, MRI, MRA, nuclear medicine, including nuclear cardiology, five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $400 reduction.

**Outpatient Therapeutic Treatments**

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under **Physician's Office Services** below.

**Prior Authorization Requirement**

For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, Benefits will be subject to a $400 reduction.

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

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

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

Benefits include botox for treatment of hyperhidrosis when clinically necessary.

Benefits for preventive services are described under **Preventive Care Services** in this section.
Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Preventive Care Services

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

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

Travel immunizations are covered.

Note. Preventive Care Services include fecal deoxyribonucleic acid (DNA) testing for the screening of colon cancer (example: Cologuard®).

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

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

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition;

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

For questions about your preventive care Benefits under this Plan call the number on your ID card.
Private Duty Nursing
The Plan pays for Covered Health Services for Private Duty Nursing care (home skilled nursing care only) given on an outpatient basis when provided by a licensed nurse (R.N., L.P.N., or L.V.N.).

Professional Fees for Surgical and Medical Services
The Plan pays for professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility or Physician house calls.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

Prosthetic Devices
External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be subject to a $400 reduction.

Reconstructive Procedures
Reconstructive Procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a
Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical 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.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the 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 Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled reconstructive procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled reconstructive procedure is performed;

- A non-scheduled reconstructive procedure you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 reduction.

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

Rehabilitation Services - Outpatient Therapy
The Plan provides short-term outpatient rehabilitation services for:

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

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician (when required by state law). Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Benefits are available only for rehabilitation services that are expected
to result in significant physical improvement in your condition within two months of the start of treatment. Rehabilitative services provided in a Covered Person’s home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person’s home other than by a Home Health Agency are provided as described under this section.

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

Benefits are limited to:

■ 60 visits per calendar year for physical therapy;
■ 60 visits per calendar year for occupational therapy;
■ 60 visits for Post-cochlear implant aural therapy.
■ 60 visits per calendar year for speech therapy (unlimited for children under 3);
■ unlimited for pulmonary rehabilitation therapy; and
■ unlimited for cardiac rehabilitation therapy.

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

**Habilitative Services**

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

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

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

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:
■ The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.

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

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

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, 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, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

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

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

The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

■ services and supplies received during the Inpatient Stay; and

■ room and board in a Semi-private Room (a room with two or more beds).

Any combination of Network Benefits and Non-Network Benefits is limited to 365 days per confinement.

Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

**Prior Authorization Requirement**

Please remember for Non-Network Benefits for:

■ A scheduled admission, you must obtain prior authorization five business days before admission;

■ A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.
If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 reduction.

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

**Spinal Treatment**

Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider’s office.

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

Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 60 visits per calendar year.

**Substance Use Disorder Services**

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider’s office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.
The Mental Health/Substance-Related and Addictive Disorder Administrator provides administrative services for all levels of care.

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

### Prior Authorization Requirement

Please remember, for Non-Network Benefits for:

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

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

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $400 reduction.

### Temporomandibular Joint (TMJ) Services

The Plan pays for Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Benefits are not available for charges or services that are dental in nature.

TMJ appliances are not covered.

### Transplantation Services

Covered Health Services for organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Provider. Transplantation services provided at a non-Designated Provider will be covered as Non-Network Benefits. Benefits are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

Authorization is required for all transplant services.

The Copayment and Annual Deductible will not apply to Network Benefits when a transplant listed below is received at a Designated Provider.
Examples of transplants for which Benefits are available include but are not limited to:

- bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Provider.
- CAR-T cell therapy for malignancies.
- heart transplants;
- heart/lung transplants;
- lung transplants;
- kidney transplants;
- kidney/pancreas transplants;
- liver transplants;
- liver/small bowel transplants;
- pancreas transplants; and
- small bowel transplants.

Benefits for cornea transplants that are provided by a Network Physician at a Network Hospital are paid as if the transplant was received at a Designated Provider. Cornea transplants are not required to be performed at a Designated Provider. Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

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

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

If you don't obtain prior authorization from the Claims Administrator, as required, Benefits will be subject to a $400 reduction.
In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

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

Urinary Catheters
Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Care Services
Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

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

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (CMS defined originating facilities).

Wigs
The Plan pays Benefits for wigs only when temporary loss of hair results from the treatment of a malignancy or permanent hair loss from accidental injury.
Wisdom Teeth

Benefits are provided for the removal of partially or fully impacted wisdom teeth.
SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

■ Consumer Solutions and Self-Service Tools;
■ Disease Management Services; and
■ Complex Medical Conditions Programs and Services.
■ Women’s Health/Reproductive.

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; and
■ navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and 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.

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

■ mammograms for women;
■ pediatric and adolescent immunizations;
■ cervical cancer screenings for women;
■ comprehensive screenings for individuals with diabetes; and
■ influenza/pneumonia immunizations for enrollees.

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

**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 health care information.
■ Support by a nurse to help you make more informed decisions in your treatment and care.
■ Expectations of treatment.
■ Information on 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.

**UnitedHealth Premium® Designation Program**

To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality. The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.
For details on the UnitedHealth Premium designation program including how to locate a Premium Care Physician, log onto www.myuhc.com or call the number on your ID card.

**www.myuhc.com**

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

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

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

**Disease 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.

Comprehensive Kidney Solution (CKS) program
For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a “best practices” approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

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. If you decide to no longer participate in the program, please contact CKS about your decision.

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](http://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](http://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.

- Each of the cancer, congenital heart disease and transplant programs offer a 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.
- Trains.
- Boat.
- Bus.
- Tolls.

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.
**Fertility Solutions**

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

- Specialized clinical consulting services to Participants and Enrolled Dependents to educate on infertility treatment options.

- Access to specialized Network facilities and Physicians for infertility services.

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

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

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.

- Call the telephone number on your ID card.

- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).
SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
• Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, Additional Coverage Details.

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

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

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

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

Comfort or Convenience
1. television;
2. telephone;
3. beauty/barber service;
4. guest service;
5. supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - air conditioners;
   - air purifiers and filter;
   - batteries and battery chargers;
   - dehumidifiers;
   - humidifiers.
   - 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 (DME) in Section 6, Additional Coverage Details.

Dental

1. dental care, except as described in Section 6, Additional Coverage Details under the headings Dental Services - Accident only and Wisdom Teeth.

2. preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   - extraction, restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions;
   - services to improve dental clinical outcomes.
   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and under Wisdom Teeth in Section 6, Additional Coverage Details.

3. dental implants.

4. dental braces.

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - transplant preparation;
   - initiation of immunosuppressives;
   - the direct treatment of acute traumatic Injury, cancer or cleft palate.
   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, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.
Drugs

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

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

3. non-injectable medications given in a Physician's office except as required in an Emergency;

4. over the counter drugs and treatments;

5. 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.

6. compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational Services or Unproven Services

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

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

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:

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

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

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. shoe orthotics.

**Gender Dysphoria**

1. Cosmetic Procedures, including the following:
   - abdominoplasty;
   - blepharoplasty;
   - breast enlargement, including augmentation mammoplasty and breast implants;
   - body contouring, such as lipoplasty;
   - brow lift;
   - calf implants;
   - cheek, chin, and nose implants;
   - injection of fillers or neurotoxins;
   - face lift, forehead lift, or neck tightening;
   - facial bone remodeling for facial feminizations;
   - hair removal;
   - hair transplantation;
   - lip augmentation;
   - lip reduction;
   - liposuction;
   - mastopexy;
   - pectoral implants for chest masculinization;
   - rhinoplasty;
   - skin resurfacing;
   - thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple);
   - voice modification surgery; and
   - voice lessons and voice therapy.

**Medical Supplies and Appliances**

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - elastic stockings;
   - ace bandages;
   - gauze and dressings;

3. orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *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.

4. tubings and masks are not covered except when used with *Durable Medical Equipment* as described in Section 6, *Additional Coverage Details* under the heading *Durable Medical Equipment*.

5. Powered and non-powered exoskeleton devices.

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

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

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

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

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

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

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*. 
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services.


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. Megavitamin and nutrition based therapy;

2. 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*.

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

**Physical Appearance**

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Pharmacological regimens, nutritional procedures or treatments;
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - Sclerotherapy treatment of veins;
   - Skin abrasion procedures performed as a treatment for acne;

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation;

4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded;

**Providers**

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
2. services performed by a provider with your same legal residence;

3. services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

- has not been actively involved in your medical care prior to ordering the service; or
- is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. The following 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.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

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

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

4. The reversal of voluntary sterilization.

5. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.
6. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

7. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

8. Infertility treatment following unsuccessful reversal of voluntary sterilization.

9. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

**Services Provided under Another Plan**

1. health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you;

3. health services while on active military duty.

**Transplants**

1. health services for organ, multiple organ and tissue transplants, except as described in Transplantation Services in Section 6, Additional Coverage Details unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.);

3. health services for transplants involving animal organs;

4. any solid organ transplant that is performed as a treatment for cancer.

**Travel**

1. travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in Section 6, Additional Coverage Details. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 6, Additional Coverage Details.
Vision
1. purchase cost of eye glasses or contact lenses;
2. fitting charge for eye glasses or contact lenses;
3. eye exercise or vision therapy;
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

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

   This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.
2. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - required solely for purposes of career, education, sports or camp, employment, insurance, marriage or adoption;
   - related to judicial or administrative proceedings or orders;
   - conducted for purposes of medical research;
   - required to obtain or maintain a license of any type;
3. health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
4. health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;
5. health services 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 the Plan;
6. in the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or the Annual Deductible are waived;
7. charges in excess of Eligible Expenses or in excess of any specified limitation;
8. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

9. non-surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 35);

10. growth hormone therapy;

11. custodial Care;

12. domiciliary care;

13. private duty nursing received on an inpatient basis;

14. respite care;

15. rest cures;

16. psychosurgery;

17. panniculectomy, abdominoplasty, thighplasty, brachioplasty, and mastopexy, unless they are Medically Necessary when considered reconstructive in nature and meet the clinical guidelines for coverage. This exclusion does not apply to breast reconstruction following a mastectomy as described under Reconstructive Procedures in Section 6, Additional Coverage Details;

18. 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 Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 6 Additional Coverage Details;

19. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;

20. oral appliances for snoring;

21. speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly;

22. any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;

23. any charge for services, supplies or equipment advertised by the provider as free;

24. any charges prohibited by federal anti-kickback or self-referral statutes.
25. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

26. Intracellular micronutrient testing.
SECTION 9 - CLAIMS PROCEDURES

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

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

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

Non-Network Benefits
If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on 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 or contacting PeopleLink. 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; and
   - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).
Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

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

**Payment of Benefits**

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 10: Coordination of Benefits.
Form of Payment of Benefits
Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. 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. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

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

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

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

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

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

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

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

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

### Types of claims

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

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

### 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; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.
Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

**Filing a Second Appeal**

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

**Note:** Upon written request and free of charge, any Covered Persons may examine 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.

**External Review Program**

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

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

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

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

An external review request should include all of the following:

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

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

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

**Standard External Review**

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

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

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

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

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

The IRO will notify you in writing of the request’s eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO’s request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

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

**Expedited External Review**

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

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

- an adverse benefit determination of a claim or appeal if the adverse benefit
determination involves a medical condition for which the time frame for completion of
an expedited internal appeal would seriously jeopardize the life or health of the
individual or would jeopardize the individual's ability to regain maximum function and
you have filed a request for an expedited internal appeal; or

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

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

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

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

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

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

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

**Timing of Appeals Determinations**

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

- **Urgent Care request for Benefits** - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- **Pre-Service request for Benefits** - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- **Post-Service** - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

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

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

The tables below describe the time frames which you and UnitedHealthcare are required to follow.
### Urgent Care Request for Benefits*

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

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must 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 decision</td>
</tr>
</tbody>
</table>

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

### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 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>
<td>30 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>30 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>30 days 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 10 - 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 or covering the person as a dependent of 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 is covered at least in part by one of the health benefit plans covering you.

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

**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 11 - SUBROGATION AND REIMBURSEMENT

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

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly 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; or

■ advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.
Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

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

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

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

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

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

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

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

Coverage for your eligible Dependents will end on the earliest of:
- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from New York University to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage
The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.
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; and
- 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 Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, Glossary.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if 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; or
- a Participant's former Spouse.

**Qualifying Events for Continuation Coverage under COBRA**

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

<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>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>New York University files for bankruptcy under Title 11, United States Code.²</td>
<td>36 months</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.

<table>
<thead>
<tr>
<th>If Dependent Coverage Ends When:</th>
<th>You May Elect COBRA Dependent Coverage For Up To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You become entitled to Medicare and don't experience any additional qualifying events</td>
<td>18 months</td>
</tr>
<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>
<tr>
<td>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</td>
<td>36 months</td>
</tr>
</tbody>
</table>

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

**Notification Requirements**

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

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

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

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

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

**Notification Requirements for Disability Determination**

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide 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 15, Important Administrative Information: ERISA. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

**Trade Act of 2002**

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

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

When COBRA Ends

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

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to 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 13 - 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; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

Your Relationship with UnitedHealthcare and 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:

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

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, SMMs and/or Amendments; and
- 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 7, 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 Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the 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.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, Coordination of Benefits, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.
If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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 14 - GLOSSARY

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

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

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

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; or
■ rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health 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 you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

**Annual 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 Annual Enrollment period.

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

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

**Body Mass Index (BMI)** – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

**BMI** – see Body Mass Index (BMI).

**Cancer Resource Services (CRS)** – a program administered by UnitedHealthcare or its affiliates made available to you by 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; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

**Cellular Therapy** - administration of living whole cells into a patient for the treatment of disease.

**Claims Administrator** – UnitedHealthcare (also known as UnitedHealthcare Service L.L.C.) 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.

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

Copayment (or Copay) – the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

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

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

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, Plan Highlights and Section 6, Additional Coverage Details.
Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 2, Introduction.

Not otherwise excluded in this SPD under Section 8, Exclusions and Limitations.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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 Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, Plan Highlights, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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 or the telephone number on your ID card.

**Designated Virtual Network Provider** - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Services via interactive audio and video modalities.

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

**Domestic Partner** – an individual of the same 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:
used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;

not disposable;

not of use to a person in the absence of a Sickness, Injury or their symptoms;

durable enough to withstand repeated use;

not implantable within the body; and

appropriate for use, and primarily used, within the home.

**Eligible Expenses** – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by 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 medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

- Serious impairment to bodily functions.

- Serious dysfunction of any bodily organ or part.

**Emergency Health Services** – with respect to an Emergency:

- 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 UnitedHealthcare 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:

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

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

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

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

**Fertility Solutions (FS)** – a program administered by UnitedHealthcare or its affiliates made available to you by New York University. The FS program provides:

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

**FS** – see Fertility Solutions (FS).

**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*. 
Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

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

Hospital – an institution, operated as required by law, which is:

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

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

Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

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 Behavioral Therapy (IBT)** – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI)*.

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

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

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

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

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

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.
Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

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

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

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

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

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

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

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

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

Network Benefits (also referred to as In-Network Benefits) - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, Plan Highlights for details about how Network Benefits apply.

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

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

Non-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.
Non-Network Benefits (also referred to as Out-of-Network Benefits) - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, Plan Highlights for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, Plan Highlights for the Out-of-Pocket Maximum amount. See Section 3, How the Plan Works for a description of how the Out-of-Pocket Maximum works.

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.

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

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

Pharmaceutical Product(s) – U.S. Food and Drug Administration (FDA)-approved prescription 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 Administrator – New York University or its designee.

Plan Sponsor – New York University.

Pregnancy – includes prenatal care, postnatal care, childbirth, and 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 a 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** – treatment in a facility which provides Mental Health Services or Substance Use Disorder Services treatment. The facility meets all of the following requirements:

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

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

**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; and

■ they are not Custodial Care, as defined in this section.

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

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

**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.

**Therapeutic Donor Insemination (TDI)** - Insemination with a donor sperm sample for the purpose of conceiving a child.

**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; or

- supervised living arrangements which are residences such as 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** – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

**Urgent Care Center** – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.
SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

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

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

Plan Sponsor and Administrator
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
105 East 17th Street, Benefits Office
1st Floor
New York, NY 10003
(212) 992-5465

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
105 East 17th Street, Benefits Office
1st Floor
New York, NY 10003
(212) 992-5465

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>
<td>Plan Number</td>
<td>501</td>
</tr>
<tr>
<td>Employer ID</td>
<td>13-5562308</td>
</tr>
<tr>
<td>Plan Type</td>
<td>Welfare benefits plan</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 – December 31</td>
</tr>
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<td>Plan Administration</td>
<td>Self-Insured</td>
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<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; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.
In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

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

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

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

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

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

The Plan's Benefits are administered by 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, whether provided by a Network or non-Network provider. UnitedHealthcare and New York University are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.
ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices
The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.
ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.
ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service LLC, on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

<table>
<thead>
<tr>
<th>Claims Administrator Civil Rights Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Service LLC Civil Rights Coordinator</td>
</tr>
<tr>
<td>UnitedHealthcare Civil Rights Grievance</td>
</tr>
<tr>
<td>P.O. Box 30608</td>
</tr>
<tr>
<td>Salt Lake City, UT 84130</td>
</tr>
<tr>
<td>The toll-free member phone number listed on your health plan ID card, TTY 711</td>
</tr>
<tr>
<td><a href="mailto:UHC_Civil_Rights@UHC.com">UHC_Civil_Rights@UHC.com</a></td>
</tr>
</tbody>
</table>

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.
You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translated Taglines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Albanian</td>
<td>Ju keni të drejti të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.</td>
</tr>
<tr>
<td>2. Amharic</td>
<td>ያለምንምክፍያበቋንትዎእርዳታናመረጃየማግኘትመብትአላችሁ።አስተርጓሚእንዲቀርבלዎፈለጉበጤናዎትባለውበተጻመስመርስልክቁጥርማረጋገጥ0ንጫኑ።TTY711</td>
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<td>3. Arabic</td>
<td>للاوْجِيْدُ فُسَّي لِحَجِّصِ وُلْعِيْلِ لِلنَّسَاء عَدَةٌ وَهُنَّ نَافِعٌ بَيْنَهَا دُوَّرُ ثلْثَاءٍ َثُلْثَاءٌ وَتَلْبِيْنَ فِيْهِ تَمْهِدُونَ لِلْفُهْمِ وَتَلْبِيْنَ بِتَكُونُ آنَاً آنَاً أَلْبَارَ بِذَلِكَ فِيْهِ تَمْهِدُونَ َثُلْثَاءٌ وَتَلْبِيْنَ فِيْهِ تَمْهِدُونَ َثُلْثَاءٌ وَتَلْبِيْنَ   TTY 711</td>
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<td>Թարգմանիչ պահանջէլու համար, զանգահարե՛ք Ձեր առողջապահության (ID) տոմսի վրա նշված անվճար Անդամնէրի համար, պետք է շեղչիIBUTES, սեղմե՛ք 0: TTY 711</td>
</tr>
<tr>
<td>5. Bantu-Kirundi</td>
<td>Urafise uburenganzira bwo konkera ubufasha n’amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y’ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k’umusemuzi wawe w’ubuzima, fyonda 0. TTY 711</td>
</tr>
<tr>
<td>6. Bisayan-Visayan (Cebuano)</td>
<td>Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711</td>
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<td>অনুবাদকের অনুরোধ থাকলে, আপনার ব্যাপার পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূন্য চাপুন। TTY 711</td>
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<td>8. Burmese</td>
<td>အနော်တွင်အနိုင်ရှိသို့မဟုတ်၊ အပုံးအားဖြင့် လက်ရှိလိုအပ်သော အကြောင်းကြားနှစ်သက်မှုများကို အတိုက်တွင်မဟုတ် မျှဝေနိုင်သည်။ (0) မိမိမှ မြန်ကြားမည်။ TTY 711</td>
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<td>10. Cherokee</td>
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<tr>
<td>11. Chinese</td>
<td>您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言障礙服務專線 711</td>
</tr>
<tr>
<td>12. Choctaw</td>
<td>Chim anumpa ya, apela micha nana aijama yvt nan aivli keyu ho ish isha hinla kvt chim aivhilpesa. Tosholi ya asilhha chi hokmvnt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i payday cha 0 ombetipa. TTY 711</td>
</tr>
<tr>
<td>13. Cushite-Oromo</td>
<td>Kaffaltii male afan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaama gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711</td>
</tr>
<tr>
<td>14. Dutch</td>
<td>U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711</td>
</tr>
<tr>
<td>15. French</td>
<td>Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711</td>
</tr>
<tr>
<td>16. French Creole-Haitian Creole</td>
<td>Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711</td>
</tr>
<tr>
<td>17. German</td>
<td>Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711</td>
</tr>
<tr>
<td>18. Greek</td>
<td>Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνεία, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711</td>
</tr>
<tr>
<td>Language</td>
<td>Translated Taglines</td>
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</tr>
<tr>
<td>19. Gujarati</td>
<td>તમને વિના મૂલય માટે મદદ અને તમારી ભાષામા માહિતી મેળિિાનો અવિકાર છે. દુભાષજ્ઞ માટે બીનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાઉન્ટ પરની સફળી અલેટ ટ૊લ-ફ્રી મેમ્બર ડીલ નબર ઉપર ડોલ કરો, 0 દરખાબો. TTY 711</td>
</tr>
<tr>
<td>20. Hawaiian</td>
<td>He pono ke kōkua ‘ana aku iā ‘oe ma ka maopopo ‘ana o kēia ‘ike ma loko o kāu ‘ōlelo pono ‘i me ka uku ‘ole ‘ana. E kama’ilio ‘oe me kekahī kanaka unuhi, e kāhca i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.</td>
</tr>
<tr>
<td>21. Hindi</td>
<td>आप के पास अपनी भाषा में सहायता एवं जानकारी निषेधक प्राप्त करने का अधिकार है। दुभाषित के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID काउंट पर सूचिबद्ध टोल-फ्री नंबर पर फ़ोन करे, 0 दराएं। TTY 711.</td>
</tr>
<tr>
<td>22. Hmong</td>
<td>Koj muaj cai tau kev pav thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tsawv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqj kho mob, nias 0. TTY 711.</td>
</tr>
<tr>
<td>23. Ibo</td>
<td>Inwere ikike inweta enyemaka nakwa ịmụta aspect ị n’efu n’akwughị ụgwọ. Maka ikpotụrụ onye nụgharị okwu, kpọọ akara ekwentị nke dj nàkwụkwọ nijirimara ịgị nke emere maka ahụike ịgị, pia 0. TTY 711.</td>
</tr>
<tr>
<td>24. Ilocano</td>
<td>Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711</td>
</tr>
<tr>
<td>25. Indonesian</td>
<td>Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711</td>
</tr>
<tr>
<td>26. Italian</td>
<td>Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711</td>
</tr>
<tr>
<td>Language</td>
<td>Translated Taglines</td>
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</tr>
<tr>
<td>27. Japanese</td>
<td>ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。</td>
</tr>
<tr>
<td>28. Karen</td>
<td>귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711</td>
</tr>
<tr>
<td>29. Korean</td>
<td>니가 쿠데를 바탕 위로 재원 남편에게 해드비를 더하기 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 니가의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711</td>
</tr>
<tr>
<td>30. Kru- Bassa</td>
<td>Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu l ticket l docta l nan, bep 0. TTY 711</td>
</tr>
<tr>
<td>31. Kurdish-Sorani</td>
<td>ئەف دەبەت دەوەکە لەر، ئەرەچەوە، دەزەرەچەوە، دەوێتە، دەوێتە بە دەوەکەزی وەکو. ئەوەی کە دەتەوەکەوەی، دەزەرەچە ئەوەی دەتوانیتە ئەوەی دەتوانیتە دەتوانیتە خۆت وەکو. ئەوەی دەتوانیتە خۆت 0 گەرە. TTY 711</td>
</tr>
<tr>
<td>32. Laotian</td>
<td>ການມັນທີ່ຈະຕັດເຖິງການອາງອະນາຄອງແຮງຮ່ວມການທັງໝັ້ນທັງໝັ້ນຈັດການຕັດສັກສາທາງສໍາລັບການຈາກການທັງໝັ້ນທັງໝັ້ນໃຊ້ເບິ່ງໂທລະສັບສະມາຊິກທີ່ຈະໃຊ້ເບິ່ງໂທລະສັບສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711</td>
</tr>
<tr>
<td>33. Marathi</td>
<td>आपल्यांच्या आपल्या भाषेत चिन्हांवून माहीती मिळून आहेत. दूरभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना अधिकारी सुचीबद्ध केलेल्या सदस्यांना चिन्हांवून फोन नंबर संपर्क करण्यासाठी दाबा 0. TTY 711</td>
</tr>
<tr>
<td>34. Marshallese</td>
<td>Eor am maroñ ñan bok jipañ im melele ilo kajin eo am ilo ejelōk wōŋānān. Ñan kajitōk ñan juon ri-ukok, kūrōk nōmba eo emōj an jeje ilo kaat in ID in ājmour eo am, jiped 0. TTY 711</td>
</tr>
<tr>
<td>35. Micronesian- Pohnpeian</td>
<td>Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasandi en kehl, padik 0. TTY 711</td>
</tr>
<tr>
<td>36. Navajo</td>
<td>T’āa jiik’eh doo bājḥ ‘alinigōo bee baa hane’igii t’āa ni nizāăd bee nikā’e’eyego bee nā’ahoot’i’. ’Ata’ halne’i ła yinikeedgo, ninaaltsos niit’iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77</td>
</tr>
<tr>
<td>Language</td>
<td>Translated Taglines</td>
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</tr>
<tr>
<td>Nepali</td>
<td>तपाईले आफ्नो भाषामा नृ:शुल्क सहयोग र जानकारी प्राप्‌त गर्ने अधिकार तपाईसँग छ। अनुसूचक प्राप्‌त गरीपाई भनी अनुरोध गर्न, तपाईले स्वास्थ्य योजना परिचय काउमा सूचीबाट टोल-फ्री सहयोग नबदगमा सम्पन्न गन्नहोस्। 0 थिनुहोस्। TTY 711</td>
</tr>
<tr>
<td>Nilotic-Dinka</td>
<td>Yin ǹəŋ lông bë yi kuunya nê wêrêyic de thòŋ du abac ke cîn wëu tāâu ke piny. Àćān bâ ran yê kóc ger thok thiêëc, ke yìn cöl nàmba yene yup abac de ran tòŋ ye kóc wäär thok tō nê ID kat duön de pânakim yic, thány 0 yic. TTY 711.</td>
</tr>
<tr>
<td>Norwegian</td>
<td>Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Du hoscht die Recht fer Hilf unn Information in deine Schprooch grieye, fer nix. Wann du en Iwizerseter hawwe willscht, kannsecht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711</td>
</tr>
<tr>
<td>Persian-Farsi</td>
<td>شما حق دارید کمک و اطالعات بە زبان خود را بە طور رایگان دریافت نمایید. شما حق شناسایی کارت در شده قید رایگان تلفن برای درخواست مترجم شفاهی با شماره خود بهداشتی برنامه‌ی ID کارت کردن و 0 را بزنید. TTY 711</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਾਲੀ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਵਿਕਾਰ ਦੂਬਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਵਦ ਗਏ ਟਾਿੱਲ ਫ਼ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨਬਾਰ ਟੀਟੀ ਾਈ 711 ਤੇ ਕਾਿੱਲ ਕਰ, 0 ਬੋਧੀ</td>
</tr>
<tr>
<td>Polish</td>
<td>Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711</td>
</tr>
<tr>
<td>Romanian</td>
<td>Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711</td>
</tr>
<tr>
<td>Russian</td>
<td>Вы имеет право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711</td>
</tr>
</tbody>
</table>
| Samoan-Fa’asamoa | E iai lou aiā tatau e maau atu ai se fesoasoani ma fā’amatalaga i lau gagana e aunoa ma se toto. Ina ia
<table>
<thead>
<tr>
<th>Language</th>
<th>Translated Taglines</th>
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</thead>
<tbody>
<tr>
<td>fa’atalosagaina se tagata fa’aliliu, vili i le telefoni mo su i le toto gia o loo nisi atu i lau pele i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.</td>
<td></td>
</tr>
<tr>
<td>48. Serbo-Croatian</td>
<td>Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.</td>
</tr>
<tr>
<td>49. Spanish</td>
<td>Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentran en su tarjeta de identificación del plan de salud y presione 0. TTY 711</td>
</tr>
<tr>
<td>50. Sudanic-Fulfulde</td>
<td>Ɗum hakke maafa mballedaa kadin kebba habaru nder wolde maafa naa ma a yobii. To a yidi pirtoowo, noddu limgal mo telefoni caahu limtaa nder kaatiwol ID maafa ngol njamu, nyo”u 0. TTY 711.</td>
</tr>
<tr>
<td>51. Swahili</td>
<td>Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bare illyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711</td>
</tr>
<tr>
<td>52. Syriac-Assyrian</td>
<td>ܐܚܬܘܢ ܐܝܬܠܘܟܘܢ ܚܩܘܬܐ ܕܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ ܠܡܚܟܘܝܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܬܠܝՖܘܢ ܕܐܝܠܗ ܟܬܝܒܐ ܐܠܕ ܦܬܩܐ ܕܚܘܠܡܢܐ ܘܡܚܝ 0. TTY 711</td>
</tr>
<tr>
<td>53. Tagalog</td>
<td>May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711</td>
</tr>
<tr>
<td>54. Telugu</td>
<td>ఎల ాంటి ఖర్చులేక ాండా మీ భాషలో సాయాంబు మరియు సమ చార్ పాందడికి మీ హకు ఉాంది. ఒకవేళ దుబాషి కావాలాంటే, మీ హెల్తాండా పాన్ ఐడి కార్చి మీద జాబితా చయబడ్ టోల్త ఫ్రీ న ాంబర్చక  ఫన్ చేసి, 0 ప్రీస్ చేసు. TTY 711</td>
</tr>
<tr>
<td>55. Thai</td>
<td>คุณมีสทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอส่งภาษา โปรดโทรศัพท์มาทางโทรศัพท์ โปรดโทรศัพท์ที่มีหมายเหตุที่มีการส่งสารให้สิ่งที่คุณต้องการส่ง TTY 711</td>
</tr>
<tr>
<td>56. Tongan-Fakatonga</td>
<td>‘Oku ke ma’u ‘a e totonu ke ma’u’ a e tokoni mo e ‘u fakamatala i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a e ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711</td>
</tr>
<tr>
<td>57. Trukese (Chuukese)</td>
<td>Mi wor omw pwung om kopwe nounou ika amasou noom ekkewe aninis ika toropwen aninis nge epwe awewetiw non</td>
</tr>
<tr>
<td>Language</td>
<td>Translated Taglines</td>
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</tr>
<tr>
<td>Turkish</td>
<td>Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basinız. TTY (yazılı iletişim) için 711</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711</td>
</tr>
<tr>
<td>Urdu</td>
<td>آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمہ سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کیں جو آپ ہیلتھ پالن آئی ڈی کارڈ پر درج ہے، کے 0 دبائیں۔ TTY 711</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hỗ trợ được nêu trên the ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711</td>
</tr>
<tr>
<td>Yiddish</td>
<td>יער שפראך פריין איע אימאצפארנין אף אוהיל ןעמקובא ט צוכעי רט דאיר הא טמעטשער, רופאלן א דעגנלאן אפצאל. צו פארפוןלאט פעלער הייא ףיט אוייטס שמער וואונ ןעפאעלט מבערעמ עיימ טאל פרעד 711 TTY .0 , ID טקדרורטלקא</td>
</tr>
<tr>
<td>Yoruba</td>
<td>O ní ọtọ lati ọtọ lori iranwo ẹti išifōnīlẹ́ẹ́ gbà ní ìdò rè lāìsànwó. Láti bá ìgbúçó ṣẹ ńọ̀rọ̀, pè sórí nọmbá ọtọ ibánìsọ́rọ́ lāìsànwó ńbọ̀dè ti a tó sórí kádì ọdánímọ tí ètò ọlèrẹ́ rè, tẹ́ ‘0’. TTY 711</td>
</tr>
</tbody>
</table>