SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Description
Effective: January 1, 2019
Group Number: 202970

A Summary Plan Description (SPD) was published effective January 1, 2018. The following are modifications and clarifications that are effective January 1, 2019 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

Section 2: Introduction

- Under the heading “Retired Employee Coverage” the existing content is replaced with the paragraph below in its entirety:

As permitted under your association’s personnel policy and approved by your Executive Director, Employees who retire at age 55 or over, with at least 10 years full-time YMCA service, may continue medical coverage for themselves and their eligible dependents subject to your YMCA’s continued participation with covered active employees of YMCA Employee Benefits. Coverage for retired Employees and Spouses will end at age 65, and coverage for Dependent Children will end at age 26, or the date a parent ceases to be covered under the Plan.

- Under the heading “Changing Your Coverage” remove the following bullet points:

  - 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
  - A change in your or your Spouse’s position or work schedule that impacts eligibility for health coverage
  - A strike or lockout involving you or your Spouse

Replace with the following bullet points in their entirety:

  - A change in your Dependent’s employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer’s plan
  - A change in your or your Dependent’s position or work schedule that impacts eligibility for health coverage
  - A strike or lockout involving you or your Dependent

Section 4, Personal Health Support: Covered Health Services Which Require Prior Authorization

The Plan is amended with the addition of Cellular and Gene Therapy to the prior authorization list.

The services that require prior authorization from the Claims Administrator are:

- Cellular and Gene Therapy
Section 5, Plan Highlights:
The Plan is amended with the addition of Cellular and Gene Therapy.

Schedule of Benefits Table

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<td>Non-Network Benefits are not available</td>
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<tr>
<td>Services must be received at a Designated Provider.</td>
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Section 6, Additional Coverage Details:
The Plan is amended with the addition of Cellular and Gene Therapy.

Cellular and Gene Therapy
Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.
Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

Prior Authorization Requirement
For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid.

The Plan is amended to replace the following benefit in its entirety:

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

If you require certain Pharmaceutical Products, 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.

**Lab, X-Ray and Diagnostic – Outpatient**

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.
  - Limited to 18 Presumptive Drug Tests per year.
  - Limited to 18 Definitive Drug Tests per year.

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

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

The Plan is amended to add the following provision to Section 6, Additional Coverage Details:

**Pharmaceutical Products - Outpatient**

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

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

The provision for Transplantation Services is replaced in its entirety with the following.

**Transplantation Services**

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

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.
Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

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

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

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

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

Section 7, Clinical Programs and Resources:

- Healthy Weight Program is removed.

Section 8, Exclusions and Limitations:

- The Plan is amended to add the following drug exclusion to the medical plan in its entirety:

  Drugs
  1. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by 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.

- The Plan is amended to replace the Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services exclusions in its entirety:

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

The Plan is amended to add the following habilitative exclusion under Procedures and Treatments:

15. Habilitative services for maintenance/preventive treatment.

Section 9: Claims Procedures

The Plan is amended to replace the Payment of Benefits section in its entirety:

Payment of Benefits

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

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (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.
Section 12, When Coverage Ends:

Under the heading “Coverage for your eligible Dependents will end on the earliest of:” the first bullet point is replaced with the following:

The date your coverage ends, unless you are eligible for Retired Employee coverage and your covered Dependents have not yet reached the limiting age (age 65 for a Spouse and age 26 for a dependent child, or the date an eligible parent ceases to be covered under the Plan).

Under the heading “Coverage for a Disabled Child” replace the last paragraph with the following: 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. Coverage for the Dependent child will end when they no longer have an eligible parent covered by the Plan.

Section 13, Other Important Information:

The Plan is amended to replace the following provision in its entirety.

Review and Determine Benefits in Accordance with the Claims Administrator’s Reimbursement Policies

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

- As shown 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 the Claims Administrator accepts.

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

The Claims Administrator 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, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to the Claims Administrator’s website at myuhc.com for information regarding the vendor that provides the applicable methodology.
The Plan is amended to replace the following provision in its entirety.

**Incentives to You**
Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but YMCA Employee Benefits 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.

**Section 14, Glossary**

The Plan is amended to replace the following definitions in their entirety.

**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 and Section 15, Outpatient Prescription Drugs.
- 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 or Section 15, Outpatient Prescription Drugs.

**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](http://www.myuhc.com) or by calling the number on your ID card, and to Physicians and other health care professionals on [www.UHCprovider.com](http://www.UHCprovider.com).

**Mental Health Services** - Covered Health 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 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.

**Retired Employee** - an Employee who retires under his or her Employer’s personnel policy, at or after the attainment of age 55 and completion of ten (10) years of full-time YMCA service, while covered under the Plan. Retired Employees are no longer eligible for coverage once they reach age 65.

**Substance-Related and Addictive Disorders Services** - Covered Health 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.

The Plan is amended to add the following definitions to the medical plan in their entirety.

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

**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.

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

**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.

**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.

**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.
Section 15, Outpatient Prescription Drugs:

The Plan is amended to add following program to the Outpatient Prescription Drug plan in their entirety.

Designated Pharmacies

*Smart Fill Program - Split Fill*

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, through the internet at www.myuhc.com or by calling the telephone number on your ID card.

The Plan is amended to replace the following provision to the Outpatient Prescription Drug plan in its entirety.

The Plan is amended to replace the following provision in the medical plan is in its entirety. Rebates and Other Discounts

UnitedHealthcare and YMCA Employee Benefits Plan may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan 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 Copayment and/or Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

The Plan is amended to replace the exclusion to the Outpatient Prescription Drug plan in its entirety.

14. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.
KNOW YOUR COVERAGE

YMCA EMPLOYEE BENEFITS

SUMMARY PLAN DESCRIPTION

HIGH DEDUCTIBLE HEALTH PLAN 2500

Effective: January 1, 2018
Group Number: 202970
SET 55

Administered by UnitedHealthcare
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SECTION 1 – WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support, and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) BEN-YMCA
- Claims submittal address: UnitedHealthcare – Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555
- Online assistance: www.myuhc.com

YMCA Employee Benefits 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 YMCA Employee Benefits 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
- 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. Due to YMCA Employee Benefits’ self-funded status, federal ERISA guidelines supersede state laws under the ERISA preemption clause.

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 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. YMCA Employee Benefits 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. Receipt of this SPD does not guarantee that the recipient is a participant under the Plan and/or otherwise eligible for benefits under the Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare’s goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare administers claims on behalf of the Plan. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The YMCA Employee Benefits Plan is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the YMCA Employee Benefits Plan works. If you have questions, contact your local Human Resources department or call the number on the back of 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 or request printed copies by contact Human Resources.
- 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.
- YMCA Employee Benefits is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.
SECTION 2 – INTRODUCTION

What this section includes:

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

Eligibility

As permitted under your association’s personnel policy and approved by your Executive Director, you may be eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan.

Please see your HR administrator for your specific eligibility requirements.

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

- Your Spouse, as defined in Section 14, Glossary
- You or your Spouse’s child to age 26, including natural child, a stepchild, a legally adopted child, a child placed for adoption, or a child for who you or your Spouse are the legal guardian; or
- An unmarried child who (i) is or becomes disabled; (ii) is dependent upon you for financial support; (iii) has had continuous coverage under the YMCA Employee Benefits Plan; and (iv) became disabled before reaching the limiting age under the Plan.

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

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the YMCA Employee Benefits Plan, you may each be enrolled as an Employee 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 YMCA Employee Benefits 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.

Your Contribution to Benefit Costs

The Plan may require you to contribute to the cost of coverage. Contact your Human Resources department for information about any part of this cost you may be responsible for paying.

Your contributions are subject to change from time to time.

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

You can obtain current contribution rates by calling Human Resources.
How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will generally need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election.

IMPORTANT

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. In addition, if you wish to enroll in medical benefits because you or a Dependent lose coverage under a State Children’s Health Insurance Program (CHIP) or Medicaid, or because you or a Dependent becomes eligible for premium assistance from a State towards the cost of Plan health coverage under Medicaid or CHIP, you must contact Human Resources within 60 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, the effective date of your coverage will vary and be determined by your individual YMCA location. 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 begins on the date of marriage, provided you notify Human Resources within 31 days of your marriage (if the Dependent stepchild is then eligible). Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You are Hospitalized When Your Coverage Begins

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

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. 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
- 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 Human Resources within 60 days of termination)
- You or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility)
- A strike or lockout involving you or your Spouse
- A court or administrative order
- You or your Dependent enrolls in Exchange coverage during an Exchange special enrollment period or open enrollment period; or
- If your work hours drop below 30 hours per week as a result of a change in employment status, you and your Dependents may drop coverage to enroll in another plan that provides minimum essential coverage under the Health Care Reform rule (examples include another employer’s plan, individual insurance coverage or Exchange coverage)

Unless otherwise noted above, if you wish to change your elections, you must notify Human Resources within 31 days of the change in family (60 days for loss of Medicaid or CHIP eligibility, or for eligibility for premium assistance under Medicaid or CHIP). Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the 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 Open Enrollment, she elects not to participate in the YMCA Employee Benefits medical plan, because her husband, Tom, has family coverage under his employer’s medical plan. In June, Tom loses his job as a 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 the YMCA Employee Benefits medical plan outside of annual Open Enrollment.

### Retired Employee Coverage

As permitted under your association’s personnel policy and approved by your Executive Director, Employees who retire at age 55 or over, with at least 10 years full-time YMCA service, may continue medical coverage for themselves and their eligible dependents subject to your YMCA’s continued participation with covered active employees of YMCA Employee Benefits.

### Survivor Benefits for Spouses and Dependents of Deceased Employees

As permitted under your association’s personnel policy and approved by your Executive Director, the covered Spouse and any covered Dependent children of an enrolled Participant who dies (prior to or after retirement) at age 55 or over, with at least 10 years full-time YMCA service, may continue medical coverage subject to your YMCA’s continued participation with covered active employees of YMCA Employee Benefits.
SECTION 3 – HOW THE PLAN WORKS

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

Accessing Benefits

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

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

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

- **Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider.

- **Non-Network Benefits** apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

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.

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.

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

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

**Looking for a Network Provider?**

In addition to other helpful information, [www.myuhc.com](http://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](http://www.myuhc.com) has the most current source of Network information. Use [www.myuhc.com](http://www.myuhc.com) to search for Physician’s 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 number on your ID card or log onto [www.myuhc.com](http://www.myuhc.com).

Network providers are independent practitioners and are not employees of YMCA Employee Benefits or UnitedHealthcare.

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

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

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

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

**Designated Providers**

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

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided 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 a referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

**Limitations on Selection of Providers**

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

**Eligible Expenses**

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

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for
any amount bile that is greater than the amount UnitedHealthcare determines to be an Eligible Expenses as described below.

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

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

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

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare’s vendors, affiliates or subcontractors, at UnitedHealthcare’s discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following:
      - 50% of CMS for the same or similar laboratory service.
      - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
    - When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the services as follows:
      - For services other than pharmaceutical products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk, and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare’s website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
      - For pharmaceutical products, UnitedHealthcare 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 is not published by CMS for the service and gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider’s billed charge.

UnitedHealthcare 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.
Annual Deductible

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

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, Outpatient Prescription Drugs.

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

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Coinsurance

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

<table>
<thead>
<tr>
<th>Coinsurance - Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let’s assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 100% after you meet the Annual Deductible, you are responsible for paying the other 0%. This 0% is your Coinsurance.</td>
</tr>
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Out-of-Pocket Maximum

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

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, Outpatient Prescription Drugs.

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

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

<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>Payments towards the Annual Deductible</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments, including those for Covered Health Services available in Section 15, Outpatient Prescription Drugs</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 from Personal Health Support</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION 4 – PERSONAL HEALTH SUPPORT – TOTAL POPULATION

What this section includes:
- An overview of the Personal Health Support program
- Covered Health Services which require Prior Authorization

Care Management

UnitedHealthcare provides a program called Personal Health Support-Total Population (PHS-TP) that delivers comprehensive, personalized care and services to you and your covered Dependents. You can engage with your PHS-TP care team by calling the toll-free number listed on the back of your ID card.

PHS-TP Nurses and Coaches 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 health and wellness services available.

If you are living with a chronic condition, dealing with complex health care needs, would like help improving your health or simple have questions, you can work with a nurse or wellness coach who will guide you through your healthcare journey. The nurse or coach will answer questions, explain options, identify your needs, and may refer you to specialized care programs. When you work with a nurse or coach, they will provide you with their telephone number, so you can call them with questions about your conditions, or your overall health and well-being.

PHS-TP provides a comprehensive set of services to help you and your covered family members access information and receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the programs include, but is not limited to, items such as:

- **Admission Counseling**: PHS-TP Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient Care Management**: If you are hospitalized, a 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 a 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 PHS-TP Nurse to confirm that medications, needed equipment, or follow-up services are in place. The PHS-TP 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 PHS-TP Nurse to discuss and share important health care information related to the participant’s specific chronic or complex condition.

If you do not receive a call from a PHS-TP Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

**Note**: If you have a medical emergency, call 911 instead of calling your PHS-TP care team.
Prior Authorization

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

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they 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 the back of your ID card.

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

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

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

Covered Health Services Which Require Prior Authorization

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

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

The services that require prior authorization from the Claims Administrator are:

- Ambulance – non-emergent
- Clinical Trials
- Congenital heart disease surgery
- Durable Medical Equipment: for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes.
- Genetic testing – BRCA
- Gender Dysphoria
- Home health care for skilled nursing and Private Duty Nursing
- Hospice care – inpatient
- Hospital Inpatient Stay: all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery
- Infertility services
- Lab, X-ray, and Diagnostics – Outpatient: sleep studies, stress echocardiography and transthoracic echocardiogram
- Lab, X-ray, and Major Diagnostics: CT, PET scans, MRI, MRA, nuclear medicine, including nuclear cardiology
- Mental Health Services: inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive outpatient program treatment; outpatient electro-convulsive treatment;
psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management

- Neurobiological Disorders: Autism Spectrum Disorder Services – inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; 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; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA)

- Obesity Surgery

- Prosthetic Devices: for items that will cost more that $1,000 to purchase or rent

- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery

- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

- Substance-Related and Addictive Disorders Services: inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; 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; medication assisted treatment programs for Substance-Related and Addictive Disorders

- Surgery: blepharoplasty, uvulopalatoparagolosophy, vein procedures, sleep apnea surgeries, cochlear implant, orthognathic surgeries, cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant

- Therapeutics: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy, and MR-guided focused ultrasound

- Transplants

Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For prior authorization time frames and any reductions in Benefits that apply if you do not obtain prior authorization from the Claims Administrator or contact Personal Health Support, see Section 6, Additional Coverage Details.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID Card.

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 the secondary payer as described in Section 10, Coordination of Benefits. You are not required to obtain authorization before receiving Covered Health Services.
SECTION 5 – PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features
- Schedule of Benefits

Payment Terms and Features

The table below outlines the Plan’s Annual Deductible and Out-of-Pocket Maximum.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network Amounts</th>
<th>Non-Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family (cumulative Annual Deductible)</td>
<td>$5,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

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

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, Outpatient Prescription Drugs.

| Annual Out-of-Pocket Maximum              |                 |                     |
| Individual                                 | $2,500          | $7,500              |
| Family (cumulative family Out-of-Pocket Maximum) | $5,000          | $15,000              |

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

The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, Outpatient Prescription Drugs.

| Lifetime Maximum Benefit                  |                 |                     |
|                                          |                 | Unlimited           |

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.

Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:
- Ambulatory patient services;
- Emergency services, hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services (including behavioral health treatment);
- Prescription drug products;
- 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.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits</td>
<td>Ground and/or Air Ambulance 100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Ambulance Services – Emergency Only</strong></td>
<td>Ground and/or Air Ambulance 100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Ambulance Services – Non-Emergency</strong></td>
<td>Ground and/or Air Ambulance 100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Ground or Air Ambulance, as the Claims Administrator determines appropriate</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>Cancer Services</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section</td>
</tr>
<tr>
<td>Network benefits are available for patients who receive care at a Designated Cancer Resource Services Network facility. Participation in this program is voluntary; you are not required to visit a Designated Provider to receive Benefits for a cancer-related treatment</td>
<td>See Cancer Resource Services (CRS) in Section 6, Additional Coverage Details</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Depending on 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>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</td>
<td></td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services – Accident Only</strong></td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits</td>
<td></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>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section</td>
</tr>
<tr>
<td>Covered Health Service</td>
<td>Benefit</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diabetes Self-Management Items</td>
<td>Depending upon where the covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment in this section and in Section 15, Outpatient Prescription Drugs</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Emergency Health Services – Outpatient</td>
<td>100% after you meet the Non-Network Annual Deductible</td>
</tr>
<tr>
<td>Non-Emergency Health Services – Outpatient</td>
<td>70% after you meet the Non-Network Annual Deductible</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 and in Section 15, Outpatient Prescription Drugs</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Hospital – Inpatient Stay</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Infertility Services and Fertility Solutions Program</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section</td>
</tr>
<tr>
<td>Kidney Resource Services</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section</td>
</tr>
<tr>
<td>Lab, X-ray, and Diagnostics – Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Lab Testing – Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>X-ray and Other Diagnostic Testing – Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Lab, X-ray, and Major Diagnostics: CT, PET, MRI, MRA, and Nuclear Medicine – Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Service¹</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Neonatal Resource Services (NRS)</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>See Neonatal Resource Services (NRS) in Section 6, Additional Coverage Details</td>
<td></td>
</tr>
<tr>
<td>Neurobiological Disorders – Autism Spectrum Disorder Services</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Nutritional Coaching</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td></td>
</tr>
<tr>
<td>Bariatric services must be received at a Designated Provider</td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits</td>
<td></td>
</tr>
<tr>
<td>Physician Fees for Surgical and Medical Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Physician’s Office Services – Sickness and Injury</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Pregnancy – Maternity Services</td>
<td></td>
</tr>
<tr>
<td>A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother’s length of stay</td>
<td></td>
</tr>
<tr>
<td>Covered Health Service</td>
<td>Benefit</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>(The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td></td>
</tr>
<tr>
<td>Physician Office Services</td>
<td>100%</td>
</tr>
<tr>
<td>Lab, X-ray, or Other Preventive Tests</td>
<td>100%</td>
</tr>
<tr>
<td>Breast Pumps</td>
<td>100%</td>
</tr>
<tr>
<td>Private Duty Nursing – Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for limits</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>100% 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 Therapy</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for visit limits</td>
<td></td>
</tr>
<tr>
<td>Scopic Procedures – Outpatient Diagnostic and Therapeutic</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, <em>Addition Coverage Details</em>, for limits</td>
<td></td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders Services</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>100% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Surgery – Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Temporomandibular Join Dysfunction (TMJ)</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>See Section 6, <em>Additional Coverage Details</em>, for limits</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Treatments – Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Transplantation Services</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>Covered Health Service¹</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Travel and Lodging</td>
<td>For Patient and companion(s) of patient undergoing cancer treatment, Congenital Heart Disease treatment, obesity surgery, or transplant procedures</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Virtual Visits</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Vision Examinations</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Wigs</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

¹ In general, your Network provider must obtain prior authorization from the Claims Administrator or Personal Health Support, as described in Section 4, Personal Health Support, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization from the Claims Administrator or Personal Health Support. See Section 6, Additional Coverage Details, for further information.
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 as required. The Covered Health Services in this section appear in the same order as the do in the table for easy reference. Services that are not covered are described in Section 8, Exclusions and Limitations.

Acupuncture Services

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

Ambulance Services – Emergency Only

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

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

Ambulance Services – Non-Emergency

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:
- From a non-Network Hospital to a Network Hospital
- To a Hospital that provides a higher level of care that was not available at the original Hospital
- To a more cost-effective acute care facility
- From an acute facility to a sub-acute setting

Did you know...
You generally pay less out-of-pocket when you use a Network provider?
**Prior Authorization Requirement**

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

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**Cancer Resource Services (CRS)**

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

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

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse
- Call CRS at 1-866-936-6002
- Visit [www.myoputmhealthcomplexmedical.com](http://www.myoputmhealthcomplexmedical.com)

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

- Physician’s Office Services – Sickness and Injury
- Physician Fees for Surgical and Medical Services
- Scopic Procedures – Outpatient Diagnostic and Therapeutic
- Therapeutic Treatments – Outpatient
- Hospital – Inpatient stay
- Surgery – Outpatient

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

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**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
- Other diseases or disorders which are not life-threatening for which, as UnitedHealthcare determines, a Clinical Trial meeting 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 Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exception to this are:
  - Certain Category B devices
  - Certain promising interventions for patients with terminal illnesses
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare’s medical and drug policies
- Items and services provided solely to satisfy data collection and analysis needs 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
- 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, 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
  - 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
    - 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 investigation 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.

• 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**

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

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**Congenital Heart Disease (CHD) Services**

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of Fallot, transportation of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing
- Evaluation
- Surgical intervention
- Interventional cardiac catheterizations (insertion of a tubular device in the heart)
- Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology)
- Approved fetal interventions

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at [www.myoputmhealthcomplexmedical.com](http://www.myoputmhealthcomplexmedical.com).

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
- Surgery – Outpatient

*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 are covered by the Plan when all of the following are true:

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

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

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

- Dental services related to medical transplant procedures
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system)
- Direct treatment of acute traumatic Injury, cancer, or cleft-palate

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

- Has no decay
- Has no filling on more than two surfaces
- Has no gum disease associated with bone loss
- Has no root canal therapy
- Is not a dental implant
- Functions normally in chewing and speech

Dental services for final treatment to repair the damage must be started within 3 months of the accident, or if not a Covered Person at the time of the accident, within the first 3 months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

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 and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips and tablets, and lancets and lancet devices are covered under the medical plan and the Outpatient Prescription Drug Plan.

### 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 $500 reduction.

### Durable Medical Equipment (DME)

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

- Ordered or provided by a Physician for outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a Sickness, Injury or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home

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

Examples of DME include but are not limited to:

- Equipment to administer oxygen
- Equipment to assist mobility, such as a standard wheelchair
- Hospital beds
- Delivery pumps for tube feedings
- Negative pressure wound therapy pumps (wound vacuums)
- Burn garments
- Insulin pumps and all related necessary supplies as described under Diabetes Services in this section
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy and Surgery – Outpatient in this section.
- Orthotic devices when prescribed by a Physician. This includes shoe inserts, arch supports, shoes (standard or custom), lifts and wedges, shoe orthotics, and cranial helmets.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part are considered Durable Medical Equipment and are a Covered Health Service. Braces to treat curvature of the spine and braces that straighten or change the shape of a body part are orthotic devices that 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)
Benefits also include speech aid devices and trachea-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and trachea-esophageal voice devices are available only after completing a required three-month rental period.

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

Benefits for speech aid devices and trachea-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.

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

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

Disposable Medical Supplies

Benefits for Disposable Medical Supplies include:

- Durable Medical Equipment and supplies that are necessary for the effective use of the item/device (e.g., oxygen tubing or mask, or tubing for a delivery pump; and
- Medical supplies such as catheters (non-ostomy); diabetic supplies, dressings, and surgical compression stockings

Any combination of Network Benefits and Non-Network Benefits for disposable supplies, including Ostomy supplies, is limited to $1,000 per calendar year.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization 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). To receive Network Benefits, you must purchase or rent the DME from the vendor the Claims Administrator or Personal Health Support identifies or purchase it directly from the prescribing network Physician. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Emergency Health Services – Outpatient

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

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under Eligible Expenses in Section 3, How The Plan Works.

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

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services in your SPD
• Cross-sex hormone therapy:
  o Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under Injections received in a Physician’s Office in your SPD.
  o Cross-sex hormone therapy dispensed from a pharmacy is provided as described in Section 15, Outpatient Prescription Drugs
• 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:

**Male to Female**
- Clitoroplasty (creations of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethralplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

**Female to Male**
- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

**Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements**

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

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  o Persistent, well-document Gender Dysphoria
  o Capacity to make a fully informed decision and to consent for treatment
  o Must be 18 years or older
  o 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.
  o Persistent, well-documented Gender Dysphoria
  o Must be 18 years or older
  o If significant medical or mental health concerns are present, they must be reasonably well controlled
  o Complete at least 12 months of successful continuous full-time real-life experience in the desired gender
  o 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 Non-Network Benefits you must obtain prior authorization as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises.

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

**Home Health Care**

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

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

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

Any combinations of network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization for skilled nursing and Private Duty Nursing from the Claims Administrator five business days before receiving services or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.
Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement

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

Hospital – Inpatient Stay

Hospital Benefits are available for:

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

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

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

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

Prior Authorization Requirement

For Non-Network Benefits, for:

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

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $500 reduction.

Infertility Services and Fertility Solutions Program

Therapeutic services for the treatment of infertility when provided by or under the direction of a Physician. The Plan pays Benefits for infertility when provided by Designated Providers participating in the Fertility Solutions program.

Note: Diagnostic services Benefits are covered as described under Physician’s Office Services – Sickness and Injury in this section.
Benefits under this section are limited to the following procedures:

- Ovulation induction and controlled ovarian stimulation
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI)
- Assisted Reproductive Technologies (ART): In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI)
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm
- Cryopreservation – embryos (storage is limited to 12 months)  
  **Note:** Long-term storage costs (anything longer than 12 months) are not covered under the Plan
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only
- Embryo transportation related network disruption
- Donor coverage – associated donor medical expenses, including collection and preparation of oocyte (egg) and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm.  
  **Note:** The Plan does not cover donor charges associated with compensation or administrative services.
- Fertility Preservation – when planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

To be eligible for Benefits, the Covered Person must:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35
- Have failed to achieve Pregnancy following twelve cycles (under age 35) or six cycles (age 35 or over) of donor insemination
- Have failed to achieve Pregnancy due to impotence/sexual dysfunction
- Have infertility that is not related to voluntary sterilization
- Have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm)
- Not a Child Dependent

The waiting period may be waived when Covered Person has a known infertility factor, including but not limited to: congenital malformations, known male factor, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.

Medical benefits are limited to $15,000 per Covered Person during the entire period you are covered under the Plan. In fertility medication benefits are limited to $5,000 per Covered Person during the entire period you are covered under the Prescription Drug Plan.

**Prior Authorization Requirement**

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


Fertility Solutions Program

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

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).

Covered Persons who do not live within a 60-mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network facility prior to starting treatment. For infertility services and supplies to be considered Covered Health Services, 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

Injections in a Physician’s Office

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

Kidney Resource Services (KRS)

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

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

- Prior to vascular access placement for dialysis
- Prior to any ESRD services

You or a Covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support
- Call KRS at 1-866-561-7518

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

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

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

Services for Sickness and Injury-related diagnostic purposes received on an outpatient basis at a Hospital or Alternate Facility or in a Physician’s office include:

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

Prior Authorization Requirement

For Non-Network Benefits for 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 $500 reduction.

Lab, X-ray, and Major Diagnostics – CT, PET Scans, MRI, MRA, and Nuclear Medicine – Outpatient

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

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 in this section under Physician Fees for Surgical and Medical Services.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator for 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 $500 reduction.

Mental Health Services

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

Benefits include the following levels of care:

- Inpatient Treatment
- Residential Treatment
- Partial Hospitalization/Day Treatment
• Intensive Outpatient Treatment
• Outpatient Treatment

Services include the following:
• Diagnostic evaluations, assessment and treatment planning
• Treatment and/or procedures
• Medication management and other associated treatments
• Individual, family, and group therapy
• Provider-based case management services
• Crisis intervention

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

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

Prior Authorization Requirement
For Non-Network Benefits for:
• A scheduled admission for Mental Health Services (including services at a Residential Treatment facility), you must obtain authorization prior to the admission.
• A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.
• Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; Outpatient electroconvulsive treatment; Psychological testing; Transcranial magnetic stimulation; Extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management, you must obtain prior authorization for Non-Network Benefits before services are received.

If you fail to obtain prior authorization from or provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be subject to a $500 reduction.

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

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

You or a Covered Dependent may also:
• Call the Claims Administrator or Personal Health Support
• Call NRS at 1-88-936-7246 and select the NRS prompt
To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician’s Office Services – Sickness and Injury
- Physician’s Fees for Surgical and Medical Services
- Scopic Procedures – Outpatient Diagnostic and Therapeutic
- Therapeutic Treatment – Outpatient
- Hospital – Inpatient Stay
- Surgery – Outpatient

**Neurobiological Disorders – Autism Spectrum Disorder Services**

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

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

Services include the following:

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

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

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

The Plan will pay for Covered Health Services for medical education services provided in a Physician’s office by an appropriately licensed healthcare professional when:

- 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

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

When nutritional counseling services are billed as a preventive care service these services will be paid as described under Preventive Care Services in this section.

Obesity Surgery

The Plan covers surgical treatment of morbid obesity provided all of the following are true:

- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4.
- You have a minimum Body Mass Index (BMI) of 40, or > 35 with at least 1 complicating comorbidity, directly related to, or exacerbated by morbid obesity, i.e.:
  - Type 2 diabetes
- Cardiovascular disease (e.g., stroke, myocardial infarction, or poorly controlled hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater) despite pharmacotherapy
- History of coronary artery disease with a surgical intervention such as cardiopulmonary bypass or percutaneous transluminal coronary angioplasty
- Cardiopulmonary problems (e.g., documented obstructive sleep apnea (OSA) confirmed on polysomnography with an AHI or RDI of \( \geq \) as defined by AASM Task Force. Sleep.1999; 22:667-89)
- History of cardiomyopathy
  - You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation
  - 6-month Physician supervised diet document within the last 2 years
  - You must enroll in the Optum Bariatric Resource Services (BRS) program
  - You must use an Optum Bariatric Center of Excellence (COE)

Services are limited to one surgery per lifetime unless there are complications. Repeat procedures for lap bands removed for noncompliance reasons will be handled on a case by case basis when the situation presents itself.

Excess skin removal post bariatric surgery is not covered, unless medically necessary.

**Bariatric Resource Services (BRS)**

Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurse help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation’s leading obesity surgery centers, known as Centers of Excellence. Access the Bariatric Resource Services Centers of Excellence program at 1-888-936-7246.

All authorization information and enrollment for bariatric surgery must be initiated through Optum’s Bariatric Resource Services (BRS) program. Covered participants seeking coverage for bariatric surgery should obtain prior authorization from Optum as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling Optum at 1-888-936-7246 to enroll in the program.

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

**Prior Authorization Requirement**

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

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.

**Ostomy Supplies**

Benefits for ostomy supplies are limited to:

- Pouches, face plates, and belts
- Irrigation sleeves, bags, and ostomy irrigation catheters
- Skin barriers

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Any combination of Network Benefits and Non-Network Benefits for disposable supplies, including Ostomy supplies, is limited to $1,000 per calendar year.
**Physician Fees for Surgical and Medical Services**

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

**Physician’s Office Services – Sickness and Injury**

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

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

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

Covered Health Services include genetic counseling. Benefits 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 for preventive services are described under Preventive Care Services in this section.

When a test is performed, or a sample is drawn in the Physician’s office and then sent outside the Physician’s office for analysis or testing, Benefits for lab, radiology/X-rays, and other diagnostic services that are performed outside the Physician’s office are described in Lab, X-ray, and Diagnostics – Outpatient.

**Prior Authorization Requirement**

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA. If authorization is not obtained as required, Benefits will be subject to a $500 reduction.

**Please Note**

Your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.
Pregnancy – Maternity Services

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

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

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

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

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

Due to the self-funded status of this Plan, please remember that we follow federal ERISA guidelines and newborns are not covered automatically. In order for the newborn to be covered, he/she must be added to the plan within 31 days of birth; coverage is not automatic. This may contradict your state laws.

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 $500 reduction.

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

Healthy moms and babies

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

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician’s office, an Alternate Facility, or a Hospital. Preventive care services encompass medical services that have been demonstrated by a 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.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided
by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to [www.myuhc.com](http://www.myuhc.com) or by call the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, Plan Highlights, under Covered Health Services.

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

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

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

There are guidelines for annual preventive care based on age and gender. You can find the list of preventive services that have a rating of “A” or “B” from the USPSTF by visiting [www.uhcpreventivecare.com](http://www.uhcpreventivecare.com). For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

### Private Duty Nursing – Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse, such as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN).

Any combination of Network Benefits and Non-Network Benefits is limited to $10,000 per Covered Person per calendar year.

### Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet, and hands
- Artificial face, 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.

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

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

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage, or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect, or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every five 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 $500 reduction.

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

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

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

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

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

Prior Authorization Requirement
For Non-Network Benefits for:

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

If authorization is not obtained from the Claims Administrator as required, or notification is not provided, Benefits will be subject to a $500 reduction.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical Therapy
- Occupational Therapy
- Manipulative Treatment
- Speech Therapy
- Vision Therapy
- Cognitive Rehabilitation Therapy following a post-traumatic brain injury or cerebral vascular accident
- Pulmonary Rehabilitation
- Cardiac Rehabilitation

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician’s office or on an outpatient basis at a Hospital or Alternate Facility.

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

Habilitative Services

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

The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person’s current condition or to prevent or slow further decline

- It is ordered by a Physician and provided and administered by a licensed provider
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively
- It is not Custodial Care

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of 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 for medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress,
the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

**Speech Therapy for Children Under Age Three**

Benefits are paid for services of a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions:

- Infantile autism
- Development delay or cerebral palsy
- Hearing impairment
- Major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate

Benefits are limited to:

- 30 visits per calendar year for physical therapy
- 30 visits per calendar year for occupational therapy
- 30 visits per calendar year for speech therapy
- 30 visits per calendar year for pulmonary rehabilitation therapy
- 30 visits per calendar year for cardia rehabilitation therapy
- 20 visits per adult Covered Person, or 30 visits per Dependent child during the entire period you or your Dependent children are covered under the Plan for vision therapy
- Unlimited visits per calendar year for cognitive rehabilitation therapy
- Unlimited visits per calendar year for Manipulative Treatment

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

**Scopic Procedure – Outpatient Diagnostic and Therapeutic**

The Plan pays for diagnostic and therapeutic Scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician’s office.

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

Benefits under this section include:

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

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Please note that Benefits under this section do not include surgical Scopic procedures, which are for the purpose of performing surgery. Benefits for surgical Scopic procedures are described under *Surgery – Outpatient*. Examples of surgical Scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*. 
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

Benefits are available only if both of the following are true:

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

Skilled 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 dressing, feeding, bathing, or transferring from a bed to a chair
- It requires clinical training in order to be delivered safely and effectively

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

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

Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification within 48 hours or as soon as is reasonably possible

If authorization is not obtained from the Claims Administrator as required, or notification is not provided, Benefits will be subject to a $500 reduction.
Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:
- Inpatient Treatment
- Residential Treatment
- Partial Hospitalization/Day Treatment
- Intensive Outpatient Treatment
- Outpatient Treatment

Services include the following:
- Diagnostic evaluations, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatment
- Individual, family, and group therapy
- Crisis intervention
- Provider-based case management services

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

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

Prior Authorization Requirement

For Non-Network Benefits for:
- A scheduled admission for Substance-Related and Addictive Disorders Services (including services at a Residential Treatment facility) you must obtain authorization prior to the admission
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible
- Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; Outpatient Electro-Convulsive Treatment; Psychological Testing; Extended Outpatient Treatment visits beyond 45-50 minutes in duration, with or without medication management, medication assisted treatment programs for substance-related and addictive disorders, you must obtain prior authorization before services are received.

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

Surgery – Outpatient

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

Benefits under this section include certain Scopic procedures. Examples of surgical Scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

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 in this section under Physician Fees for Surgical and Medical Services.

When these services are performed in a Physician’s office, Benefits are described under Physician’s Office Services – Sickness and Injury in this section.

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

Temporomandibular Joint Dysfunction (TMJ)
The Plan covers Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.
Diagnosis: Examination, radiographs, and applicable imaging studies and consultations.
Non-surgical treatment including clinical examinations, arthrocentesis, and trigger-point injections.
Benefits are provided for surgical treatment if the following criteria are met:
• There is clearly demonstrated radiographic evidence of significant joint abnormality
• Non-surgical treatment has failed to adequately resolve the symptoms
• Pain or dysfunction is moderate or severe

Benefits for surgical series include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.
Any combination of Network Benefits and Non-Network Benefits is limited to $1,500 per Covered Person during the entire period you are covered under the Plan.
Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under Hospital – Inpatient Stay and Physician Fees for Surgical and Medical Services, respectively.

Therapeutic Treatments – Outpatient
The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician’s office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy, and radiation oncology.
Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:
• Education is required for a disease in which patient self-management is an important component of treatment
• There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional

Benefits under this section include:
• The facility charge and the charge for related supplies and equipment
• Physician services for anesthesiologists, pathologists, and radiologists. Benefits for other Physician services are described in this section under Physician Fees for surgical and Medical Services.

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

**Transplantation Services**
Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel, and cornea.

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

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

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

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

**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**
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 and if, as a result, the services are not performed at a Designated Provider, you will be responsible for paying all charges and no Benefits will be paid.

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

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

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

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

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate
- The bariatric, cancer, congenital heart disease, and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures
- The Claims Administrator must receive valid receipts for such charged before you will be reimbursed. Reimbursement is as follows:
  - Lodging
    - A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital
    - A per diem rate up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child

Examples of items that are not covered:

- Groceries
- Alcoholic beverages
- Personal or cleaning supplies
- Meals
- Over-the-counter dressings or medical supplies
- Deposits
- Utilities and furniture rental, when billed separate from the rent payment
- Phone calls newspapers, or movie rentals
- Transportation:
  - Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider
  - Taxi fares (not including limos or car services)
  - Economy or coach airfare
  - Parking
  - Trains
  - Boat
  - Bus
  - Tolls
**Urgent Care Center Services**

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

**Virtual Visits**

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment 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 going to [www.myuhc.com](http://www.myuhc.com) or by call the telephone number on your ID card.

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

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

**Vision Examinations**

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider’s office (vision screenings do not include refractive examinations to detect vision impairment)
- One routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider’s office every calendar year.

**Wigs**

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent hair loss from accidental injury.
SECTION 7 – CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:
- Consumer Solutions and Self-Service Tools
- Disease and Condition Management Services
- Wellness Programs

YMCA Employee Benefits believes in giving you the tools you need to be an educated health care consumer. To that end, YMCA Employee Benefits has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:
- Take care of yourself and your family members
- Manage a chronic health condition
- Navigate the complexities of the health care system

Note
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and YMCA Employee Benefits 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 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 and your spouse are invited to learn more about the 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 health 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.

To find the health survey, log in to www.myuhc.com. After logging in, access your personalized Health & Wellness page. If you need any assistance with the online survey, please call the number on the back of your ID card.

NurseLineSM
NurseLineSM is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered may refer you to any additional resources that YMCA Employee Benefits has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:
- A recent diagnosis
- A minor Sickness or Injury
- Men’s, women’s, and children’s wellness
- How to take Prescription Drug Products safely
- Self-care tips and treatment options

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 YMCA Employee Benefits 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 seek professional medical care, or your choosing or not choosing specific treatment based on the text.
• Healthy living habits
• Any other health related topic

NurseLineSM is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it’s 1:00 AM. What do you do?
Call NurseLineSM any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help you answer your health questions.

With NurseLineSM, you also have access to nurses online. To use this service, log on to www.myuhc.com and click “Live Nurse Chat” in the top menu bar. You’ll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an emailed transcript of the conversation to us as a reference.

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

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

• Mammograms for women between the ages of 40 and 68
• Pediatric and adolescent immunizations
• Cervical cancer screening for individuals with diabetes
• Influenza/pneumonia immunizations for enrollees age 65 and older

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

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

This program offers:

• Access to accurate, objective, and relevant health care information
• Coaching by a nurse through decisions in your treatment and care
• Expectations of treatment
• Information on high quality providers and programs

Conditions for which this program is available under:

• Back pain
• Knee and 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 the back of your ID card.

**UnitedHealth Premium® Program**

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician, log on to [www.myuhc.com](http://www.myuhc.com) or call the number on your ID card.

**www.myuhc.com**

UnitedHealthcare’s member website, [www.myuhc.com](http://www.myuhc.com), provides information at your fingertips anywhere and anytime you have access to the Internet. [www.myuhc.com](http://www.myuhc.com) opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With [www.myuhc.com](http://www.myuhc.com) you can:

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

**Registering on www.myuhc.com**

If you have not already registered as a [www.myuhc.com](http://www.myuhc.com) subscriber, simply go to [www.myuhc.com](http://www.myuhc.com) and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit [www.myuhc.com](http://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](http://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 and Condition Management Services

Disease Management Services

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

These programs offer:

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

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

Cancer Support Program

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

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

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

Diabetes Prevention

UnitedHealthcare provides a program that identifies, assesses, and supports members over the age of 18 living with pre-diabetes. The program is designed to support members in preventing pre-diabetes from progressing to diabetes.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16-session lifestyle intervention that addresses diet, activity and behavior modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.
Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the DPP. If you think you may be eligible to participate or would like additional information regarding the programs, please contact the number on the back of your ID card.

**HealtheNotesSM**

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

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

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

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

**Wellness Programs**

**Healthy Back Program**

UnitedHealthcare provides a program that identifies, assesses, and supports members with acute and chronic back conditions. By participating in this program, you may receive free educational information through the mail and may even be called by a registered nurse who is a specialist in acute and chronic back conditions. This nurse will be a resource to advise and help you manage your condition.

This program offers:

- Education on back-related information and self-care strategies
- Management of depression related to chronic back pain
- Support in choosing treatment options

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

**Maternity Support Program**

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable education 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 post-partum to provide information on postpartum and newborn care, feeding, nutrition, immunizations, and more
• Post-partum depression counseling

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 the back of your ID card.

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

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

**Healthy Weight Program**

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. The program is designed to support you. This means that you may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

• Online self-help tools: health assessment, exercise tracking, meal planner, calorie counter, and educational content
• Education on weight management and self-care strategies
• Nutritional guidance and counseling by a health coach and registered dietician (if needed)
• Activity recommendations and encouragement by a health coach and exercise physiologist (if needed)

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

**Real Appeal Program**

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coach and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

• Online support and self-help tools: personal one-on-one coaching, group support sessions including integrated telephonic support, and mobile applications
• Education and training materials focused on goal setting, problem-solving skills, barriers, and strategies to maintain changes
• Behavioral guidance and counseling by a specially trained health coach for clinical weight loss

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7352). TTY users can dial 711 or visit [www.realappeal.com](http://www.realappeal.com)
SECTION 8 – EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

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

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

When Benefits are limited within any of Covered Health Services categories described in Section 5, Plan Highlights, those limits are stated in the corresponding Covered Health Service category in Section 6, Additional Coverage Details. 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 6, Additional Coverage Details. 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 limited 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

• Acupressure
• Aromatherapy
• Hypnotism
• Massage therapy
• Rolfing
• Art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, Additional Coverage Details.

Dental

• Dental care (which includes dental X-rays, supplies and appliances, and all associated expenses, including hospitalizations and anesthesia).
• This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 6, Additional Coverage Details.

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

• Transplant preparation
• Prior to the initiation of immunosuppressive drugs
• The direct treatment of acute traumatic Injury, cancer, or cleft palate
• Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication
• Endodontics, periodontal surgery, and restorative treatment are excluded
• Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums. Examples include:
  o Extractions (including wisdom teeth), restoration, and replacement of teeth
Medical or surgical treatments of dental conditions
Services to improve dental clinical outcomes

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

- Dental implants, bone grafts, and other implant-related procedures

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

- Dental braces (orthodontics)
- Treatment of congenitally missing, malpositioned, or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as a cleft lip or cleft palate
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) that are considered dental in nature and oral appliances

**Devices, Appliances, and Prosthetics**

- Devices used specifically as safety items or to affect performance in sports-related activities
- Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment* (DME) in Section 6, *Additional Coverage Details*
- Examples of excluded orthotic appliances and devices include but are not limited to, some type of braces, including orthotic braces available over-the-counter
- The following items are excluded, even if prescribed by a Physician:
  - Blood pressure cuff/monitor
  - Enuresis alarm
  - Non-wearable external defibrillator
  - Trusses
  - Ultrasonic nebulizers
- The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage, or gross neglect
- The replacement of lost or stolen prosthetic devices
- Devices and computers to assist in communication and speech, except for speech aid devices and tracheoesophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*
- Oral appliances for snoring
Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions.

- Prescription Drug Products for outpatient use that are filled by a prescription order or refill
- Self-injectable 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.
- Non-injectable medications given in a Physician’s office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician’s office
- Over-the-counter drugs and treatments
- Growth hormone therapy

Experimental or Investigational or Unproven Services

- 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

- Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, Additional Coverage Details. Routine foot care services that are not covered include:
  - Cutting or removal of corns and calluses
  - Nail trimming and cutting
  - Debriding (removal of dead skin or underlying tissue)
- Hygienic and preventive maintenance foot care. Example include:
  - 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 Sickness, Injury, or symptom involving the foot

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

- Treatment of flat feet
- Treatment of subluxation of the foot
- Shoe orthotics that are not prescribed by a Physician
Medical Supplies and Equipment

- Prescribed or non-prescribed medical supplies

This exclusion does not apply to:

- Disposable supplies for which Benefits are provided as described under Disposable Medical Supplies, Section 6, Additional Coverage Details
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Section 6, Additional Coverage Details
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 6, Additional Coverage Details
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details
- Tubings, nasal cannulas, connectors, and masks except when used with Durable Medical Equipment
- The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage, or gross neglect
- The replacement of lost or stolen Durable Medical Equipment
- Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in Section 6, Additional Coverage Details

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

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

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- 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
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- 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
- 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
- Transitional Living Services
Nutrition

- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals, or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). Nutritional therapy and food are covered under enteral nutrition

- Food of any kind. Foods that are not covered include:
  - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism, such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.
  - Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes
  - Oral vitamins and minerals
  - Meals you can order from a menu, for an additional charge, during an Inpatient Stay
  - Other dietary and electrolyte supplements

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

Personal Care, Comfort or Convenience

- Television
- Telephone
- Beauty/Barber service
- Guest service
- Supplies, equipment and similar incidentals for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters, and dehumidifiers
  - Batteries and battery chargers
  - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement
  - Car seats
  - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts, and recliners
  - Exercise equipment and treadmills
  - Hot tubs
  - Humidifiers
  - Jacuzzis
  - Medical alert systems
  - Motorized beds, non-Hospital beds, comfort beds, and mattresses
  - Music devices
  - Personal computers
  - Pillows
  - Radios
  - Saunas
  - Stairlifts and stair glides
  - Strollers
  - Safety equipment
  - Treadmills
- Vehicle modifications such as van lifts
- Video players
- Whirlpools

**Physical Appearance**

- 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 next 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
  - Voice lessons and voice therapy

- Replacement of an existing intact 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*

- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion of general motivation

- Wigs and other scalp hair prosthesis regardless of the reason for the hair loss except for loss of hair resulting from treatment of malignancy or permanent hair loss from accidental injury

- Treatment of benign gynecomastia (abnormal breast enlargement in males)

- Weight loss programs, whether or not they are under medical supervision or for medical reasons, even if for morbid obesity
Pregnancy and Infertility

- The following infertility treatment-related services:
  - Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue
  - Donor non-medical costs of oocyte or sperm donation (e.g., 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 cervical trauma
  - All costs associated with surrogate motherhood; non-medical costs associated with a gestational carrier
  - Ovulation predictor kits

- Surrogate parenting and host uterus
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes
- Infertility Services following a voluntary sterilization procedure
  
  **Note:** See eligibility requirements under Infertility Services and Fertility Solutions Program
- Oral contraceptive supplies, unless covered under Section 15, Prescription Drugs
- Services provided by a doula (labor aide)
- Parenting, pre-natal, or birthing classes

Procedures and Treatments

- Biofeedback
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Appliances for snoring are always excluded.
- Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term, or maintenance/preventive treatment
- Speech therapy to treat stuttering, stammering, or other articulation disorders
- Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment in Section 6, Additional Coverage Details
- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures call abdominoplasty or abdominal panniculectomy and brachioplasty
- Psychosurgery (lobotomy)
- Stand-alone, multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques, and medications to control cravings
- Chelation therapy, except to treat heavy metal poisoning
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter
- The following treatments for obesity
  - Non-surgical treatment of obesity, even if for morbid obesity
  - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in Section 6, Additional Coverage Details
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
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, and dental restorations

Breast reduction surgery that is determined to be a Cosmetic Procedure

This exclusion does not apply to breast reduction which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women’s Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 6, Additional Coverage Details

Providers

- Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent, or child. This may include any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence
- Services ordered or delivered by a Christian Science practitioner
- Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license
- 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
  - Is not actively involved in your medical care after the service is received

This exclusion does not apply to mammography

Services Provided Under Another Plan

Services for which coverage is available:

- Under another plan, except for Eligible Expenses payable as described in Section 10, Coordination of Benefits (COB)
- Under workers’ compensation, no-fault automobile coverage, or similar legislation if you could elect it or could have it elected for you
- While on active military duty
- For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you

Transplants

- Health services for organ and tissue transplants except as identified under Transplantation Services in Section 6, Additional Coverage Details unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare’s transplant guidelines
- Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor to become available)
- 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)
Travel

- Health services provided in a foreign country, unless required as Emergency Health Services
- 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

Types of Care

- Custodial Care or maintenance care as defined in Section 14, Glossary
- Domiciliary Care, as defined in Section 14, Glossary
- Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain
- Private Duty Nursing received on an inpatient basis
- Respite care
- This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provide as described under Hospice Care in Section 6, Additional Coverage Details
- Rest cures
- Services of personal care attendants
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work)

Vision and Hearing

- Implantable lenses used only to correct a refractive error (such as Intacs corneal implants)
- Purchase cost and associated fitting charges for eyeglasses or contact lenses
- Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA), and all other hearing assistive devices
- Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery, and radial keratotomy

All Other Exclusions

- Autopsies and other coroner services and transportation for a corpse
- Charges for:
  - Missed appointments
  - Room or facility reservations
  - Completion of claim forms
  - Record processing
- Charges prohibited by federal anti-kickback or self-referral statutes
- Diagnostic tests that are:
  - Delivered in other than a Physician’s office or health care facility
  - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests
• Expenses for health services and supplies:
  o That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country.
  o This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in a non-war zone
  o That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends
  o For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan
  o That exceed Eligible Expenses or any specified limitation in this SPD
  o For which a Non-Network provider waives the Copay, Annual Deductible, or Coinsurance amounts

• Foreign language and sign language services

• Long-term (more than 30 days) storage of blood, umbilical cord, or other material

• 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:
  o Medically Necessary
  o Described as a Covered Health Service in this SPD under Section 6, Additional Coverage Details and in Section 5, Plan Highlights
  o Not otherwise excluded in this SPD under this 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

• Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded.

• This exclusion does not apply to services the plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service

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

• Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:
  o Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption, or as a result of incarceration
  o Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details
  o Related to judicial or administrative proceedings or orders
  o Required to obtain or maintain a license of any type
SECTION 9 – CLAIMS PROCEDURES

What this section includes:
- How Network and Non-Network Claims work
- What to do if your claim is denied, in whole or part

Network Benefits

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

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

Non-Network Benefits

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

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:
- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it
- You pay a Copay and you believe that the amount of the copay was incorrect

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented, and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

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

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

When you assign your Benefits under the Plan to a Non-Network provider with UnitedHealthcare’s consent, and the Non-Network provider submits a claim for payment, you and the Non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

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

UnitedHealthcare will pay Benefits to you unless:

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

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

**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 payment, where the Plan has taken an assignment of other plans’ recovery rights for value.

**Health Statements**

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

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

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

<table>
<thead>
<tr>
<th>Important – Timely Filing of Non-Network Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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
- 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.
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 who is not a subordinate of the individual who made the initial benefit determination
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process

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

Filing a Second Appeal

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

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

Federal External Review Program

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

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

- Clinical reasons
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s)
- Rescission of coverage (coverage that was cancelled or discontinued retroactively)
- 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 number on your ID card or by sending 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
- Any new, relevant information that was not provided during the internal 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
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
- 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
- A decision by the IRO

Within the applicable time frame after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for who 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
- Has provided all the information and forms required so that UnitedHealthcare may process the request

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process. The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

- All relevant medical records
- All other documents relied upon by UnitedHealthcare
- 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 reach 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 is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

**Expedited External Review**

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.
You may make a written or verbal request for an expedited external review if you receive either of the following:

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

- 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 expedited external review.

**Timing of Appeals Determinations**

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

- Urgent care request for Benefits – a request for Benefits provided in connection with urgent care services

- Pre-Service request for Benefits – a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided

- 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 table below describes 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 a 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 a 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>15 days</td>
</tr>
<tr>
<td>If the initial request for Benefits is complete, within:</td>
<td>15 days</td>
</tr>
<tr>
<td>After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within</td>
<td>15 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>15 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>15 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

*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 Request for Benefits***

<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>
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<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>
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<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>
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</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>30 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

**Limitation of Action**

You cannot bring any legal action against YMCA Employee Benefits or the Claims Administrator to recover reimbursement until 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 YMCA Employee Benefits or the Claims Administrator, other than a breach of fiduciary duty claim, you must do so within the earliest of (a) 90 days after the final denial of the claim, (b) within 3 years after the date that the medical treatment at issue in the legal action was provided by a physician or other medical provider, or (c) the statutory deadline for filing a claim or lawsuit with respect to the Plan benefits at issue in the judicial proceeding as determined by applying the most analogous statute of limitations for the state of Illinois or you lost any rights to bring such an action against YMCA Employee Benefits or the Claims Administrator.

If any judicial or administrative proceeding is undertaken, the evidence presented will be strictly limited to the evidence timely presented to the Plan Administrator or designated Claims Administrator. Benefits will be paid under the Plan only if the Plan Administrator, or its delegate, determines in its discretion that the applicant is entitled to them. No action at law or in equity shall be brought to recover benefits under this Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.
SECTION 10 – COORDINATION OF BENEFITS (COB)

What this section includes:
- How your Benefits under this Plan coordinate with other medical plans
- How coverage is affected if you become eligible for Medicare
- Procedures in the event the Plan overpays Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:
- Another employer sponsored health benefits plan
- A medical component of a group long-term care plan, such as skilled nursing care
- No-fault or traditional “fault” type medical payment benefits or personal injury protection benefits under an auto insurance policy
- Medical payment benefits under any premises liability or other types of liability coverage
- Medicare or other governmental health benefits

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

Don’t forget to update your Dependents’ Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent’s medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent’s other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

- If you are covered by two or more plans, the benefit payment follows the rules below in this order:
- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first
- Your dependent children will receive primary coverage from the parent whose birthdate occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated
  - A court decree awards joint custody without specifying that one part has the responsibility to provide health care coverage
• If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  o The parent with custody of the child; then
  o The Spouse of the parent with custody of the child; then
  o The parent not having custody of the child; then
  o The Spouse of the parent not having custody of the child

• Plans for active employees pay before plans covering laid-off or retired employees
• The plan that has covered the individual claimant the longest will pay first
• Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

**Determining Primary and Secondary Plan – Examples**

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

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

**When This Plan is Secondary**

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

• The Plan determines the amount it would have paid based on the allowable expense
• The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved

You will be responsible for any Copay, Coinsurance, or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.
Determining the Allowable Expense If This Plan is Secondary

**What is an allowable expense?**

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

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

When a Covered Person Qualifies for Medicare

**Determining Which Plan is Primary**

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don’t elect it. There are however, Medicare-eligible individuals for who 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 active 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 give service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

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

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

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

**If this Plan is Secondary to Medicare**

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

- The Plan determines the amount it would have paid had it been the only plan involved
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved
The maximum combined payment you may receive from all plans cannot exceed 100% of the applicable allowable expense.

**Medicare Crossover Program**

The Plan offers a Medicare Crossover program for Medicare Part 1 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. You 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 go on to file claims for these expenses.

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

**Right to Receive and Release Needed Information**

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

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

**Overpayment and Underpayment of Benefits**

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

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

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

**Refund of Overpayments**

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

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

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.
If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes 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 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 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 the 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, judgement, 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 the 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 worker’s 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), worker’s 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 part 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
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, judgements, 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, 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 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, judgement, 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 have the right to recover Benefits it has paid on you or your Dependent’s behalf that were:

- Made in error
- Due to a mistake in fact
- Advanced during the time period of meeting the calendar year Deductible
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year

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

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

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

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

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.
SECTION 12 – WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end
- 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, YMCA Employee Benefits 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 your YMCA ends, unless you are eligible for Retired Employee coverage
- 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 YMCA Employee Benefits to end your coverage, or the date requested in the notice, if later
- The last day of the month you retire under the Plan, unless specific coverage is available for retired 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 YMCA Employee Benefits to end your coverage, or the date requested in the notice, if later
- The last day of the month your Dependents no longer qualify as Dependents under this Plan
- The last day of a period for which contributions for the cost of coverage have been made for which the Employee’s YMCA ceases to be an included YMCA

Note: YMCA Employee Benefits has the right to demand that you pay back Benefits YMCA Employee Benefits paid to you, or paid in your name, during the time you were incorrectly covered under the Plan, to the extent permitted under applicable law.

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 YMCA Employee Benefits find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact YMCA Employee Benefits has the right to demand that you pay back all Benefits YMCA Employee Benefits 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 YMCA Employee Benefits proof of the child’s incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age
- You provide proof, upon YMCA Employee Benefits’ request, that the child continues to meet these conditions

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

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

Continuing Coverage through COBRA

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

Continuation Coverage under Federal Law (COBRA)

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

In order to be eligible for a 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:

- An Employee
- An Employee’s enrolled Dependent, including with respect to the Employee’s children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law
- An Employee’s former Spouse
## Qualifying Events for Continuation Coverage under COBRA

<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 and 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>YMCA Employee Benefits files for bankruptcy under Title 11, United States Code²</td>
<td>36 months</td>
</tr>
</tbody>
</table>

¹ Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after (a) the determination of the disability, (b) the date of the qualifying event, (c) the date the Qualified Beneficiary would lose coverage under 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.

² This is a qualifying event for any Retired Employee 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.

³ From the date of the Retired Employee’s death if the Retired Employee dies during the continuation coverage.
How Your Medicare Eligibility Affects Dependent COBRA Coverage

If any Qualified Beneficiary first becomes entitled to Medicare after electing COBRA coverage, the COBRA coverage will be terminated early (i.e., before the end of the maximum coverage period shown in the table above). However, this will not affect the COBRA rights of other Qualified Beneficiaries in the family who are not entitled to Medicare.

If you become entitled to Medicare while you are employed, and your Plan coverage later ends with 18 months after you became entitled to Medicare because your employment terminates, or your work hours are reduced, your Spouse and Dependents who are Qualified Beneficiaries will be entitled to COBRA coverage for 36 months. You remain eligible for the 18 months of COBRA coverage, as described above.

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 Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

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

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

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

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

Notification Requirements

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

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

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage. For example, if your coverage terminated because your work hours are reduced or your employment terminates, and there is a second qualifying event that would have entitled your Dependents to 36 months of COBRA coverage (death of the Employee, divorce or legal separation, or a child ceasing to be a Dependent under the Plan), the COBRA period is extended to 36 months for your Spouse and Dependent children if you notify the Plan Administrator within 60 days of the second qualifying event.
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 Human Resources 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 16, 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.

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

An Employee 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 Employee and the Employee’s Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms “Uniformed Services” or “Military Services” 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, Employees 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 an Employee’s behalf. If an Employee’s Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24-month period beginning on the date of the Employee’s absence from work
- The day after the date on which the Employee fails to apply for, or return to, a position of employment

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee’s health coverage and that of the Employee’s eligible Dependents will be reinstated under the Plan. No exclusions...
or waiting period may be imposed on an Employee or the Employee’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 YMCA Employee Benefits
- Relationships with providers
- Interpretation of Benefits
- Information and records
- Incentives to providers and you
- The future of the Plan
- How to access the official Plan documents

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgement, 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 procedure 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 YMCA Employee Benefits

In order to make choices about your health care coverage and treatment, YMCA Employee Benefits 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 receive (the Plan pays for Covered Health Services, which are more than fully described in this SPD)
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

YMCA Employee Benefits 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. YMCA Employee Benefits and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. YMCA Employee Benefits and UnitedHealthcare will use de-identified data for commercial purposes, including research.
Relationships with Providers

The relationships between YMCA Employee Benefits, UnitedHealthcare, and Network providers are solely contractual relationships between independent contractors. Network providers are not YMCA Employee Benefits agents or employees, nor are they agents or employee’s of UnitedHealthcare. YMCA Employee Benefits and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employee’s agents or employees of Network providers.

YMCA Employee Benefits and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, YMCA Employee Benefits and UnitedHealthcare arrange for health care providers to participate in a Network and pay 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 YMCA Employee Benefits employees nor are they employees of UnitedHealthcare. YMCA Employee Benefits and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. YMCA Employee Benefits and UnitedHealthcare are not liable 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 administrator or provision of benefits under this Plan.

YMCA Employee Benefits is solely responsible for:

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

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

Your provider is solely responsible for the quality of the services provided to you.

Interpretation of Benefits

The Claims Administrator has the sole and exclusive discretion to:

- Interpret Benefit under the Plan
- Interpret the other terms, conditions, limitations, and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments
- Make factual determinations related to the Plan and its Benefits

The Plan Administrator has delegated the discretionary authority to interpret Plan provisions relating to the payment of benefits to the Claims Administrator (UnitedHealthcare) for both initial claims processing and for ERISA appeals requested in writing by Plan participants and beneficiaries. The discretionary authority delegated to the Claims Administrator includes the authority to interpret the provisions of the Plan for purposes of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission. Benefits will be paid under the Plan only if the Plan Administrator, or its delegate, determines in its discretion that the applicant is entitled to them.
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 United Healthcare’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 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.

Information and Records

YMCA Employee Benefits 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. YMCA Employee Benefits and UnitedHealthcare may request additional information from you to decide your claim for Benefits. YMCA Employee Benefits and UnitedHealthcare will keep this information confidential. YMCA Employee Benefits 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 YMCA Employee Benefits and UnitedHealthcare with all information or copies of records relating to the services provided to you. YMCA Employee Benefits and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Person, including enrolled Dependents whether or not they have signed the Employee’s enrollment form. YMCA Employee Benefits and UnitedHealthcare agree that such information and records will be considered confidential.

YMCA Employee Benefits 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 YMCA Employee Benefits is required to do by law or regulation. During and after the term of the Plan, YMCA Employee Benefits 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 YMCA Employee Benefits 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, YMCA Employee Benefits 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.
Use and Disclosure of Your Health Information

The Health Insurance Portability and Accountability Act of 1996 and its applicable regulations (HIPAA) is a federal law that, in part, requires health plans like the Plan to protect the privacy and security of your confidential health information. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your individually identifiable health information without your authorization, except for purposes of treatment, payment, health care operations, program administration, or as required or permitted by law. In addition, YMCA Employee Benefits 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.

UnitedHealthcare will use de-identifiable data for commercial purposes, including research. A description of the Plan’s uses and disclosures of your individually identifiable health information and your rights and protections under the HIPAA privacy rules is set forth in the Notice of Privacy Practices, which has been furnished to you. You can receive another copy of the Plan’s Notice of Privacy Practices by contacting the Plan Administrator.

Incentives to Providers

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

Examples of financial incentives for Network providers are:
- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness

A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person’s health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by a financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but YMCA Employee Benefits 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 the back of your ID card if you have any questions.

Rebates and Other Payments

YMCA Employee Benefits and UnitedHealthcare may receive rebates from 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. YMCA Employee Benefits and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers’ Compensation Not Affected

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

Uncashed Checks or Unclaimed Benefits

Any Benefits payments or reimbursements made by check must be deposited within one year after it is issued. If any check for Benefits payable under the Plan is not deposited within one year of the date of issue, the Plan will have no liability for the Benefits or the bank fees associated with a stale dated check returned, the amount of the check will be deemed a forfeiture and no funds will escheat to any state.
No Guarantee of Employment

Your participation in the Plan does not constitute an employment contract and does not expand your employment rights with the Company, any Employer, or any subsidiary or affiliate. Nothing in this Summary Plan Description says or implies that participation in the Plan is a guarantee of continued employment, nor is it a guarantee that contribution and benefit levels will give any employee the right to be retained in the service of the Company or any Employer, or for any Employer to discharge any employee at any time.

No Assignment of Benefits

The Plan will not prevent a Provider from receiving payment for eligible charges for Covered Health Services if there is a valid assignment of Benefits that meets the Plan’s requirements. The Claims Administrator has the discretionary authority to determine, in accordance with the terms of the Plan, whether an assignment of Benefits to a Provider is valid. You may not commit Benefits payable to you to pay your personal debts or other obligations that are not otherwise covered under a valid assignment of Plan Benefits. You may not sell any right or interest you or a covered Dependent may have in any Benefit under this Plan.

Future of the Plan

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

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

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

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by an 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.
Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

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

**Alternate Facility** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:
- Surgical services
- Emergency Health Services
- Rehabilitative, laboratory, diagnostic or therapeutic services

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

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

**Annual Deductible (or Deductible)** - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

**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)

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

**Bariatric Resource Services (BRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by YMCA Employee Benefits. The BRS program provides:
- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options
- Access to specialized Network facilities and Physicians for obesity surgery services

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

**BMI** - see Body Mass Index (BMI).

**Body Mass Index (BMI)** - a calculation used in obesity risk assessment which uses a person’s weight and height to approximate body fat.
Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by YMCA Employee Benefits. The CRS program provides:

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

CHD - see Congenital Heart Disease (CHD)

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) 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, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works and Section 15, Outpatient Prescription Drugs.

Company - YMCA Employee Benefits

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

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

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

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 and Section 15, Outpatient Prescription Drugs.

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

- The applicable Copayment.
- The Eligible Expense

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

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

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

- Medically Necessary
- Described as a Covered Health Service in this SPD under Section 5, Plan Highlights and 6, Additional Coverage Details and Section 15, Outpatient Prescription Drugs
- 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 or Section 15, Outpatient Prescription Drugs
**Covered Person** - either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

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

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

**Deductible** - see Annual Deductible.

**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 an Employee. No one can be a Dependent of more than one Employee.

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

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

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

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

**Domestic Partner** - a person of the same or opposite sex with whom the Employee has established a Domestic Partnership.

**Domestic Partnership** - a relationship between an Employee and one other person of the same or opposite sex.

For further information on what constitutes a Domestic Partnership with respect to your Employer, please see your Human Resource representative.

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

**Durable Medical Equipment (DME)** - medical equipment that is all of the following:
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms
- Is not disposable
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms
- Can withstand repeated use
- Is not implantable within the body
- Is appropriate for use, and is primarily used, within the home
Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, How the Plan Works.

Eligible Expenses are determined solely in accordance with UnitedHealthcare’s reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

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 Emergency, both of the following:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))

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

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 – The Company and each corporate Young Men’s Christian Association which has been recognized for membership in the National Council of Young Men’s Christian Associations of the United States of America, each recognized unit of YMCA work, and each auxiliary or related organization, as described in the Constitution of the National Council of Young Men’s Christian Associations of the United States of America, that has adopted the Plan for the benefit of its employees.

EOB - see Explanation of Benefits (EOB).


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

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

Fertility Solutions - a program administered by UnitedHealthcare or its affiliates made available to you by YMCA Employee Benefits. The Fertility Solutions program provides:

• Specialized clinical consulting services to Employees and enrolled Dependents to educate on infertility treatment options
• Access to specialized Network facilities and Physicians for infertility services

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

Diagnostic criteria for adults and adolescents:

• A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  • A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  • A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  • A strong desire for the primary and/or secondary sex characteristics of the other gender.
  • A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  • A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  • A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  • The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Diagnostic criteria for children:

• A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  • A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
o In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

o A strong preference for cross-gender roles in make-believe play or fantasy play.

o A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.

o A strong preference for playmates of the other gender.

o In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.

o A strong dislike of ones' sexual anatomy.

o A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

o The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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

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

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

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

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

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

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

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

- Fewer than seven days each week
- 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 YMCA Employee Benefits. 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
- Guidance for the patient on the prescribed plan of care

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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

Medically Necessary - health care services 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, 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, 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) 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.UnitedHealthcareOnThe.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 - Covered Health Services for the diagnosis and treatment of Mental Illnesses listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Mental Health/Substance-Related and Addictive Disorders Services Administrator - the organization or individual designated by YMCA Employee Benefits who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by YMCA Employee Benefits. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time. 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 Benefits** - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, Plan Highlights to determine whether or not your Benefit plan offers Network Benefits and Section 3, How the Plan Works, for details about how Network Benefits apply.

**Non-Network Benefits** - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, Plan Highlights to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, How the Plan Works, for details about how Non-Network Benefits apply.

**Open Enrollment** - the period of time, determined by your employer, during which eligible Employees may enroll themselves and their Dependents under the Plan.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 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.

**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.

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

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

**Plan** - The YMCA Employee Benefits.

**Plan Administrator** – the Management Committee of YMCA Employee Benefits of the National Council of Young Men’s Christian Associations of the United States of America.


**Pregnancy** - includes all of the following:

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

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

**Private Duty Nursing** - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- No skilled services are identified
- Skilled nursing resources are available in the facility
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.
**Reconstructive Procedure** - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

**Residential Treatment** – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

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

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

**Retired Employee** - an Employee who retires under his or her Employer’s personnel policy, at or after the attainment of age 55 and completion of ten (10) years of full-time YMCA service, while covered under the Plan.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Shared Savings Program** - a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

**Skilled Care** - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient
- A Physician orders them
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair
- They require clinical training in order to be delivered safely and effectively
- They are not Custodial Care, as defined in this section

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

**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.

**Spouse** - an individual to whom you are legally married, or a Domestic Partner as defined in this section.
**Substance-Related and Addictive Disorders Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Transitional Living** - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Unproven Services** - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com](http://www.myuhc.com).

**Please note:** If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare’s discretion. Other apparently similar promising but unproven services may not qualify.

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

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

What this section includes:
- Benefits available for Prescription Drug Products
- How to utilize the retail and mail order service for obtaining Prescription Drug Products
- Any Benefit limitations and exclusions that exist for Prescription Drug Products
- Definitions of terms used through this section related to the Prescription Drug Product Plan

Payment Terms and Features

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan’s Prescription Drug Product Coverage. It includes Copay amounts that apply when you have a prescription filled at a Network Pharmacy. For detailed descriptions of your Benefits, refer to Retail and Mail Order in this section.

Note: The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, Additional Coverage Details.

- Certain coupons or offers from pharmaceutical manufacturers will not be included in calculating any Out-of-Pocket Maximum stated in your SPD. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

If a Brand-Name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-Name Prescription Drug Product, the tier placement of the Brand-Name Prescription Drug Product may change. Therefore, your Copayment and/or Coinsurance may change, and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-Name Prescription Drug Product.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare or its designee to determine if the Prescription Drug Product, in accordance with UnitedHealthcare’s approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, Glossary

The Plan may also require you to obtain prior authorization from UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare’s approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from UnitedHealthcare.

If you do not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, Claims Procedures.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge, and any Deductible that applies.
To determine if a Prescription Drug Product requires prior authorization, either visit [www.myuhc.com](http://www.myuhc.com) or call the number on your ID card. The prescription Drug Products requiring prior authorization are subject to UnitedHealthcare’s periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service, or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization participation or activation requirements associated with such programs through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card.

## Schedule of Benefits

<table>
<thead>
<tr>
<th>Covered Health Service 1,2</th>
<th>Network</th>
<th>Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail</strong> – up to a 31-day supply(^2)</td>
<td>Before you meet the Annual Deductible, you will pay 100% of the Prescription Drug Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier-1, Tier-2, and Tier-3</td>
<td>After you meet the Annual Deductible, the Plan will pay 100% of the Prescription Drug Charge</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies – Insulin syringes and needles</td>
<td>Before you meet the Annual Deductible, you will pay 0% of the Prescription Drug Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>After you meet the Annual Deductible, the Plan will pay 100% of the Prescription Drug Charge</td>
<td></td>
</tr>
<tr>
<td><strong>Mail-Order</strong> – up to a 90-day supply(^3)</td>
<td>Before you meet the Annual Deductible, you will pay 100% of the Prescription Drug Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier-1, Tier-2, and Tier-3</td>
<td>After you meet the Annual Deductible, the Plan will pay 100% of the Prescription Drug Charge</td>
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<td></td>
<td>After you meet the Annual Deductible, the Plan will pay 100% of the Prescription Drug Charge</td>
<td></td>
</tr>
</tbody>
</table>

1 You, your Physician, or your pharmacist must obtain prior authorization from UnitedHealthcare to receive full Benefits for certain Prescription Drug Products. Otherwise, you may pay more out-of-pocket. See Prior Authorization Requirements in this section for details.

2 You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications

3 If mail order Prescription is 31-day supply or less, the retail copay applies

**Note:** The Coordination of Benefits provision described in Section 10, Coordination of Benefits (COB) applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.
Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don’t show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, Claims Procedures, under the heading, If Your Provider Does Not File Your Claim. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:
Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2, and tier-3 Prescription Drug Products. All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times calendar year, based on the Prescription Drug List Management Committee’s periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit www.myuhc.com or call UnitedHealthcare at the number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service – see the table shown at the beginning of this section for further details. Here’s how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide the are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:

- The applicable Copayment and/or Coinsurance
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product
- The Prescription Drug Charge for that Prescription Drug Product

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copay
- The Prescription Drug Charge for the particular Prescription Drug
Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto www.myuhc.com.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Copay.

The Plan pays Benefits for certain covered Prescription Drug Products:

- As written by a Physician
- Up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer’s packaging size or based on supply limits
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copay for each cycle supplied.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Network Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the number on your ID card.

The plan pays mail order Benefits for certain covered Prescription Drug Products:

- As written by a Physician
- Up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer’s packaging size or based on supply limits

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for an Prescription Order or Refill if you use the mail order service. If mail order Prescription Order is a 31-day supply or less, the retail copay applies. To obtain the greatest savings, be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Pan include those for Preventive Care Medications as defined under Glossary – Prescription Drug Products. You may determine whether a drug is a Prevent Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the number on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.
If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the Non-Network Benefit from that Prescription Drug Product.

**Specialty Prescription Drug Products**

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Products from a Designated Pharmacy, no Benefits will be paid, and you will be responsible for paying all charges.

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

**Want to lower your out-of-pocket Prescription Drug costs?**

Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

**Assigning Prescription Drug Products to the PDL**

UnitedHealthcare’s Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare’s behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits, or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product’s acquisition cost, including, but not limited to, available rebates and assessments on the cost-effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost-effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

**Prescription Drug List (PDL)**

The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.
Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, Claims Procedures.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits as stated in the table under the heading Prescription Drug Product Coverage Highlights. For a single Copayment and/or Coinurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification. Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

Prescription Drug Products that are Chemically Equivalent

If two drugs are Chemically Equivalent (they contain the same active ingredient) and you choose not to substitute a lower tiered drug for the higher tiered drug, you will pay the difference between the higher tiered drug and the lower tiered drug, in addition to the higher tiered drug’s Copay. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is chemically the same available at a lower tier. An Ancillary Charge does not apply to any Out-of-Pocket Maximum.

Special Programs

YMCA Employee Benefits and 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 the back of your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described in this section or Pharmaceutical Products for which Benefits are described in this SPD under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements by visiting www.myuhc.com or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and YMCA Employee Benefits may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates on to you, nor are they taken into account in determining your Copays.

UnitedHealthcare and a number of its affiliated entities conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants, and research. Amounts received from pharmaceutical manufacturers pursuant to
such arrangements are not related to this Outpatient Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

**Coupons, Incentives, and Other Communications**

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for you medical condition.

**Exclusions – What the Prescription Drug Plan Will Not Cover**

Exclusions from coverage listed in Section 8, Exclusions and Limitations also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com](http://www.myuhc.com) through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

Medications that are:

- For any condition, Injury, Sickness, or mental illness arising out of, or in the course of employment for which benefits are available under any workers’ compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received
- Any Prescription Drug Product for which payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law
- Pharmaceutical products for which Benefits are provided in the medical (not in Section 15, Outpatient Prescription Drugs) portion of the Plan
- This exclusion does not apply to Depo Provera and other injectable drugs used for contraception
- Available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Compounded drugs that contain certain bulk chemicals (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3). Compounded drugs that are available as a similar commercially available Prescription Drug Product.
- Dispensed by a non-Network Pharmacy
- Dispensed outside of the United States, except in an Emergency
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered)
- Certain Prescription Drug Products for smoking cessation
- Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition)
- The amount dispensed (days’ supply or quantity limit) which exceeds the supply limit
- The amount dispensed (days’ supply or quantity limit) which is less than the minimum supply limit
- Certain Prescription Drug Products that have not been prescribed by a specialist physician
- Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee
- Prescribed, dispensed, or intended for use during an Inpatient Stay
• Prescribed for appetite suppression, and other weight loss products
• Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that UnitedHealthcare and YMCA Employee Benefits determines do not meet the definition of a Covered Health Service
• Prescription Drug Products that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product
• Prescription Drug Products that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product
• Typically administered by a qualified provider or licensed health professional in an outpatient setting (This exclusion does not apply to Dep Provera and other injectable drugs used for contraception)
• Unit does packaging of Prescription Drug Products
• Used for conditions and/or dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and YMCA Employee Benefits have agreed to cover Experimental or Investigational or Unproven treatment, as defined in Section 14, Glossary
• Prescription Drug Product as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken, or destroyed
• General vitamins, except for the following which require a prescription:
  o Prenatal vitamins
  o Vitamins with fluoride
  o Single entity vitamins
• Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury
• A Prescription Drug Product that contains marijuana, including medical marijuana
• Dental products, including but not limited to prescription fluoride topicals
• Medications used for cosmetic purposes
• A prescription Drug Product with an approved biosimilar an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar“ is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision
• Health services and supplies that do not meet the definition of a Covered Health Service as defined in this Section 15, Outpatient Prescription Drugs, under Glossary – Outpatient Prescription Drugs. Covered Health Services are those health services including services, supplies, or Prescription Drug Products, which UnitedHealthcare determines to be all of the following:
  • Medically Necessary as defined in this Section 15, Outpatient Prescription Drugs, under Glossary – Outpatient Prescription Drugs
  • Described as a Covered Health Service in this SPD under the Schedule of Benefits – Prescription Drug Coverage Highlights in this Section 15, Outpatient Prescription Drugs
  • Not otherwise excluded in this SPD

How to Apply for an Exception

If an excluded drug is prescribed for a specific medical condition, you may qualify for an exception. To request an exception, submit a letter to UnitedHealthcare from your Physician stating the medical condition that requires the non-covered drug and the length of project use. The maximum time for which a letter can justify an exception is 12 months. If your exception is approved, you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable Copay or Coinsurance amount.

If your request for an exception is denied, see Claim Denials and Appeals in Section 9, Claims Procedures, for information regarding the appeals process.
You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 30423
Salt Lake City, UT 84130-0432

Glossary - Outpatient Prescription Drugs

In addition to the definitions in Section 14, Glossary, the following definitions apply in this Section 15, Outpatient Prescription Drugs.

Ancillary Charge - a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Brand-Name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

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

- Medically Necessary
- Described as a Covered Health Service under the Schedule of Benefits in this Section 15, Outpatient Prescription Drugs
- Provided to a Covered Person who meets the Plan’s eligibility requirements, as described in this SPD under Eligibility in Section 2, Introduction

Not otherwise excluded in this Section 15, Outpatient Prescription Drugs or under Section 8, Exclusions and Limitations of this SPD.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35.

- Have failed to achieve Pregnancy following twelve cycles (under age 35) or six cycles (age 35 or over) of donor insemination. In addition, in order to be eligible for Benefits, the Covered Person must also:
  - Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

Infertility Maximum Plan Benefit - the maximum amount the Plan will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Plan. Refer to the Benefit Information table for details about how the Infertility Maximum Plan Benefit applies.

Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our periodic review and modification and varies by Therapeutic Class.
**Maximum Allowable Cost (MAC) List** - a list of Generic Prescription Drug Products that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare’s periodic review and modification.

**Medically Necessary** – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, 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, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms
- Not mainly for your convenience or that of your doctor or other health care provider
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms

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

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

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

**Network Pharmacy** - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products
- Been designated by UnitedHealthcare as a Network Pharmacy

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare’s PDL Management Committee
- December 31st of the following calendar year

**Out-of-Network Reimbursement Rate** – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

**PDL** - see Prescription Drug List (PDL).

**PDL Management Committee** - see Prescription Drug List (PDL) Management Committee.

**Prescription Drug Charge** - the rate UnitedHealthcare has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

**Prescription Drug List (PDL)** - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to UnitedHealthcare’s periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the number on your ID card or by logging onto [www.myuhc.com](http://www.myuhc.com).
**Prescription Drug List (PDL) Management Committee** - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

**Prescription Drug Product** - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers)
- Insulin
- The following diabetic supplies:
  - Standard insulin syringes with needles
  - Blood-testing strips - glucose
  - Urine-testing strips - glucose
  - Ketone-testing strips and tablets
  - Lancets and lancet devices
- Glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.

**Prescription Order or Refill** - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Preventive Care Medications** - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible) as required by applicable law under any of the following:

- 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*
- 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*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare at the number on your ID card.

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card.

**Therapeutically Equivalent** - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.
SECTION 16 – 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

National Council of Young Men’s Christian Associations of the United States of America is the Plan Sponsor and named fiduciary of YMCA Employee Benefits. The Management Committee of YMCA Employee Benefits of the National Council of Young Men’s Christian Associations of the United States of America is the Plan Administrator of YMCA Employee Benefits. The Plan Sponsor and Plan Administrator have the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Management Committee of YMCA Employee Benefits of the National Council of Young Men’s Christian Associations of the United States of America
101 North Wacker Drive
Chicago, IL 60606
(800) 872-9622

Claims Administrator

UnitedHealthcare is the Plan’s Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan’s coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor’s Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor’s Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

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:

General Counsel
National Council of Young Men’s Christian Associations of the United States of America
101 North Wacker Drive
Chicago, IL 60606
(800) 872-9622-phone
(312) 977-1025 -fax

Legal process may also be served on the Plan Administrator or on the Trustee of the National YMCA Employee Benefit Trust.

Trustee

Benefits are funded through the National YMCA Employee Benefits Trust. You may contact the Plan Trustee at:

U.S. Bank – Institutional Trust & Custody
190 S. Lasalle
Chicago, IL 60603
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.

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<thead>
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<th>YMCA Employee Benefits</th>
</tr>
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<td>Self-Insured</td>
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<td>Source of Plan Contribution:</td>
<td>Employee and Employer</td>
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<tr>
<td>Source of Benefits:</td>
<td>Benefits under the Plan are self-insured and payable from the National YMCA Employee Benefit Trust. The Plan’s contributions are shared by the Employers and Covered Persons. The Employee/Retired Employee contribution is subject to change each year, depending upon claims experience and Plan expenses, or for any other reason at the discretion of the Company</td>
</tr>
</tbody>
</table>

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits
- Examine, without charge, at the Plan Administrator’s office and at other specified worksites, all plan documents - including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, Claims Procedures, for details. Plan Benefits will only be paid if the Claims Administrator determines, in its discretion, that you are entitled to them. The Claims Administrator’s decisions are conclusive and binding on all persons. You may not bring any legal action to recover under the Plan until you have exhausted the Plan’s claims and appeals procedures described in this SPD. After exhaustion of the Plan’s review procedures, any further legal action taken against the Plan or its fiduciaries, other than a breach of fiduciary duty claim, must be filed in a court of law no later than
the earliest of (a) 90 days after the final denial of the claim, (b) within 3 years after the date that the medical treatment at
issue in the legal action was provided by a physician or other medical provider, or (c) the statutory deadline for filing a
claim or lawsuit with respect to the Plan benefits at issue in the judicial proceeding as determined by applying the most
analogous statute of limitations for the state of Illinois or you lose any rights to bring such an action against YMCA
Employee Benefits or the Claims Administrator.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan
documents or the latest summary annual report from the Plan, and do not receive them within 30 days, you may file suit in
a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay 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 any judicial or administrative proceeding is undertaken, the evidence presented will be strictly limited to the evidence
timely presented to the Plan Administrator or designated Claims Administrator. Benefits will be paid under the Plan only if
the Plan Administrator, or its delegate, determines in its discretion that the applicant is entitled to them. No action at law or
in equity shall be brought to recover benefits under this Plan until the appeal rights herein provided have been exercised
and the Plan benefits requested in such appeal have been denied in whole or in part.

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
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 the Management Committee of YMCA Employee Benefits of the National Council
of Young Men’s Christian Associations of the United States of America, the Plan Administrator. UnitedHealthcare is the
Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and
YMCA Employee Benefits are not responsible for any decision you or your Dependents make to receive treatment,
services, or supplies, whether provided by a Network or a non-Network Provider. UnitedHealthcare and YMCA Employee
Benefits are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network
providers.
ATTACHMENT I – HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act (PPACA)

Patient Protection Notices

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

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

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

Women’s Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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

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

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc. on behalf of itself and its affiliate 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 who primary language is not English, such as: Qualified Interpreters
- Information written in other languages

If you need these services, please call the toll-free 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 with 60 calendar days of the date that you became aware of the discriminatory action and contain the name and address of the person filing it along with the problem and 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>United HealthCare Services, Inc. Civil Right 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 841230</td>
</tr>
</tbody>
</table>

The toll-free member phone number listed on your health plan ID card, TTY 711

UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Department 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, 1-800-537-7697 (TDD)

Mail: U.S. Department 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 and 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 and press 0. TTY 711, Monday through Friday, 8 AM to 8 PM.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translated Taglines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albanian</td>
<td>Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.</td>
</tr>
</tbody>
</table>
| Amharic          | ከአቱ በማህበር ከበታች ማወቅ መድረስ መስቀል ያሆ እንደ ከተጠበቀው ከአው የሚቀጥል ሰት ሲለ ፈስገን ያለው ሰት የተሰሩ ሲቀን 0 ዓ የሚቀጥል የተረጋ ሳ የተጠበቀው ያሆ የሚቀጥል የተረጋ ሳ ያለው ሰት የተሰሩ ሲቀን 0 ዓ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥል ያሆ የሚቀጥﻟ
<table>
<thead>
<tr>
<th>Language</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Choctaw</td>
<td>Chim anumpa ya, apela micha nana aiimma yvt nan aivikey ky hgu ish isha hinla kvt chim aiivhpesa. Tosholi ygy asiilha chji hokmrt chji akhukmgka holisso kallo iskitini ygy tvli alanumpuli holhtena ya ibai achvffa yvt peh pila ky hgu ish l paya cha 0 ombetipa. TTY 711</td>
</tr>
<tr>
<td>Cushite-Oromo</td>
<td>Kaffaltii male afaan keessaninii odeeefannooofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufus sarara bilbilaa kan bilisaas waraqaa eenyummaa karooa fayyaay keerratti tarreeseame bilbiluun, 0 tuqi. TTY 711</td>
</tr>
<tr>
<td>Dutch</td>
<td>U heeft het recht om hulp en informatie in uw taal zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart tref, druk op 0. TTY 711</td>
</tr>
<tr>
<td>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>French Creole-Haitian</td>
<td>Ou gen dwa pou jwenn ed ak enfòmason yon lang natinfatal ou gratis. Pou monde yon entèprèt, rele nimewo gratis mann lan ki endike sou kat ID plan sante ou, peze 0. TTY 711</td>
</tr>
<tr>
<td>Creole</td>
<td>Ou gen dwa pou jwenn ed ak enfòmason yon lang natinfatal ou gratis. Pou monde yon entèprèt, rele nimewo gratis mann lan ki endike sou kat ID plan sante ou, peze 0. TTY 711</td>
</tr>
<tr>
<td>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>Greek</td>
<td>Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711</td>
</tr>
<tr>
<td>Gujarati</td>
<td>तमने बिना मुख्ये मद्द अने तमारी भाषामा माध्यमी मेयूवालां अधिकार छ। दुभािषए बाट विनंती करवा, तमारी हेल्थ प्लान ID कार्ड पर्नी सूचीमा अपेश टोल-फ्री मेम्बर क्रेन नंबर हाइ देब करो, 0 दिबांसो। TTY 711</td>
</tr>
<tr>
<td>Hawaiian</td>
<td>He pono ke kókua ‘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‘ilo ‘oe me kekahai kanaka unuhi, e kāhea i ka helu kelepona kākī ‘ole ma kou kāleka olakino, a e kāomi i ka helu 0. TTY 711</td>
</tr>
<tr>
<td>Hindi</td>
<td>आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभािषए के लिए अनुरोध करने के लिए, अपने हेल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर क्रेन करें, 0 दिबांसो। TTY 711</td>
</tr>
<tr>
<td>Hmong</td>
<td>Koj muaj cau teu kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711</td>
</tr>
<tr>
<td>Ibo</td>
<td>Inwere ikike inweta enyemaka nakwa jmuta asusu g n’efu n’akwughig fowo. Maka ikpoturun onye nsughari okwu, kpoq akara ekwenti nke di nákwujwko njirimara g ni nke emere maka ahuje ji, pia 0. TTY 711</td>
</tr>
<tr>
<td>Ilocano</td>
<td>Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti myasa nga agipatarus, tumawag iti tol-free nga numero ti telepono nga para kadagithi kameng nga nakalista ayana ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711</td>
</tr>
<tr>
<td>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>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>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>Language</td>
<td>Translated Taglines</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Karen</td>
<td></td>
</tr>
<tr>
<td>Korean</td>
<td>귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 펜던 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711</td>
</tr>
<tr>
<td>Kru- Bassa</td>
<td>Ni gwe kunde l bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711</td>
</tr>
<tr>
<td>Kurdish-Sorani</td>
<td>ماهەی‌ی‌ ناوودت‌ه‌ی‌ کە بی‌پی‌رەیامبر. بارەمەی‌ی‌ و زانیاری پێوپێست به زمانتی‌ی‌ خۆت و وەرگریت. بو داکردنی و وەرگریتی‌ی‌ زارەکی، پاوپەندی‌ی‌ بکە پەی زامارە تکانیتی‌ی‌ نووەرەوا لە‌کانو نای‌‌دی کارتی‌ی‌ ی پێن‌سی‌ی‌ لاین‌‌تاکوتوستی‌ی‌ خۆت و پایا‌شند دەگەر. 0. TTY 711</td>
</tr>
<tr>
<td>Laotian</td>
<td>щанмөнщаъ їдэг исламскам моноядовскам фармактаматам їбъа та тамракам ївъа їба це їбъа їбъа їдэг исламскам моноядовскам фармактаматам їбъа це їбъа. Тат је јо је јо је јо јо јо јо јо јо јо јо јо. ТММ 711</td>
</tr>
<tr>
<td>Marathi</td>
<td>आप्ऩाल्या आप्ऩाल्या भाषेत्ता विनामूळ यद्य आणि माहिती मिळूनाचा अधिकार आहे. दुसऱ्याकाळ विविधत करण्यासाठी आप्ऩाल्या आरोग्य योजना कल्याणमत्रवाटी सुलभ्य केलेल्या संदर्भांत मध्ये जीवन मंदिर करण्यासाठी दावा 0. TTY 711</td>
</tr>
<tr>
<td>Marshallese</td>
<td>Eor am maron an bok jipan im mejele ilo kajin eo am ilo ejelok wusin. Nan kajitok an juon ri-ukok, kurjok nomba eo enoj an jeje ilo kaat in ID in karok in ajmour eo am, jiped 0. TTY 711</td>
</tr>
<tr>
<td>Micronesian-Pohnpeian</td>
<td>Komw ahneki manaman unsek komwi en alehli sawah os mengihtik ni pein omwi tungao lokia ni soh isep. Pwek peki sawaw en sou kawweh, ekere depwohn nempe ong towehkan me soh isep me ntingihdi ni pein omwi daoropwe me pid koasoundi en kehl, padik 0. TTY 711</td>
</tr>
<tr>
<td>Navajo</td>
<td>T'áá jiik’e doo bách ‘alínígóó bee baa hane’ii gi t’aá ni taaad bee niká’e’eyego bee na’hooit’i. ‘Ata’ halne’i la yinikeedoq, ninaaltsoos níff’is7 ’ats’77s bee baa’ahay! bee n44hizin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodfilinhi dóo 0 bi’ ‘adidičilh. TTY 711</td>
</tr>
<tr>
<td>Nepali</td>
<td>तपाईले आफ्नो भाषामा नियुक्त सहयोग र जानकारी प्राप्त गर्न सक्दैन अधिकार तथा तपाईँसँग अनुसार आफ्नो स्वास्थ्य योजना परिवार काउँदा सुरक्षीकृत टोल-फ्री सदस्य फोन नंबरमा सम्पर्क गर्नुहोस्।, 0 धिनुहोस्। TTY 711</td>
</tr>
<tr>
<td>Nilotic-Dinka</td>
<td>Yin nong lông bë yu kuñey ne we réçic de thông du åbûc ke cîn wê mu tâuē ke pîny. Aćan bâ ran yê kok ger thôk thiéèc, ke yin cîl nàmbîa yene yup abac du ran tông ye kok wâar thök to né ID kat duôn de pâñakim yic, thàny 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 Dutch</td>
<td>Du hoschn die Recht fer Hilf unn Information in deine Schprooch gierc, fie nix. Wann du en Iwwersetsen hawwe willsch, kannsch 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 دادیم که کمک و اطماع به زبان خود را به طور رایگان دریافت نمایید. برای درخواست متوجه شفاهی با خود تماس حاصل نموده و 0 را فشار دهید. بهداشتی برنامه شناسایی کارتر در شده قید رایگان شماره تلفن TTY 711</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਉੱਚੜੇ ਵੇਲ ਅਪ੍ਰੀਟੀ ਡੁਸਟਰ ਸਾਲਕੀਂ ਆਇੰਤ ਕੋਲਵਾਈ ਭੁੱਲਣ ਪੁਲਿੱਟ ਬਲਚ ਪਾਵਾਂਹਲ ਅਧਿਕਾਰ ਹਨ। ਉੱਚੜੇ ਬਲਚ ਵੇਲ ਆਪ੍ਰੀਟੀ ਡੁਸਟਰ ਸਾਲਕੀਂ ਆਇੰਤ ਕੋਲਵਾਈ ਭੁੱਲਣ ਪੁਲਿੱਟ ਬਲਚ ਪਾਵਾਂਹਲ ਅਧਿਕਾਰ ਹਨ। TTY 711</td>
</tr>
<tr>
<td>Language</td>
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</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Polish</td>
<td>Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoni 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 имеете 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>
<tr>
<td>Samoan- Fa’asamo</td>
<td>E iai lou āiā tatau e maua atu ai se fesoasoani ma fa’amatalaga i lau gagna e aunoa ma se totogi. Ina ia fa’atalosagaina se tagata fa’aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau pelei i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711</td>
</tr>
<tr>
<td>Serbo-Croation</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>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 encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711</td>
</tr>
<tr>
<td>Sudanic-Fulfulde</td>
<td>Ɗum hakke maada mballedaa kadin kebaa habaru nder wolde maada naa maa a yobii. To a yidi pirtoowo, noddu limngal mo telefoni caahu limtaa ɗo nder kaatiwol ID maa ngol njamu, nyo”u 0. TTY 711</td>
</tr>
<tr>
<td>Swahili</td>
<td>Una haki ya kupata msada na taarifa kwa lugha yako yali bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711</td>
</tr>
<tr>
<td>Syriac-Assyrian</td>
<td>ܐܼܿܚܬܘܿܢ ܐܝܼܬܠܵܘܟ݂ܘܿܢ ܚܼܿܩܘܼܬܵܐ ܕܩܼܿܒܠܝܼܬܘܿܢ ܗܼܿܝܼܿܪܬܵܐ ܘܡܼܿܘܕܥܵܢܘܼܬܵܐ ܒܠܸܫܵܢܵܘܟ݂ܽܘܿܢ ܡܼܿܓܵܢܵܐܝܼܬ ܠܡܼܿܚܟܘܿܝܹܐ ܥܼܿܡ ܚܼܿܐ ܡܬܼܿܪܓܡܵܢܵܐ ܩܪܝܘܼܢ ܥܼܿܠܝܼܿܢܵܐ ܬܹܠܝܼܦܘܿܢ ܕܐܝܼܠܹܗ ܟܬܼܝܼܒܼܵܐ ܐܸܠܸܕ ܦܸܬܩܵܐ ܕܚܘܼܠܡܵܢܵܐ ܘܡܚܝܼ 0. TTY 711</td>
</tr>
<tr>
<td>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>Telugu</td>
<td>ఎంప ఖంప పంతకం ని మరియమి మాత్రమి స్థాపనం చెందడం సాధ్యం ఉంది. ఆసహిత్యం ప్రయాణం రాళ్ళం, మీ జీవితం సాధనాలు మీ సాధనాలు ప్రయాణం ఉండే రీతిలో స్థాపనం ఉంది, 0 భాస్తి. TTY 711</td>
</tr>
<tr>
<td>Thai</td>
<td>คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในการษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอสัมภาษณ์ โปรดโทรศัพท์ถึงหมายเลขที่อยู่บนบัตรประจําตัวสําหรับแผนสุขภาพของคุณแล้วกด 0 สำหรับผู้ที่มีความประสงค์ทางการ国民经济 โปรดโทรถึงหมายเลข 711</td>
</tr>
<tr>
<td>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’a e memipa ‘a ee oku lisi ‘i ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’i ‘a e 0. TTY 711</td>
</tr>
<tr>
<td>Trukese (Chuukese)</td>
<td>Mi wor omw pwung om kopwe nounou ika amasou noun ekewee aninis ika toropwen aninis nge epwe awewetiwn non kapasen fonoum, ese kamo. Ika ka mwochen tungoren aninisin chiakk, kori ewe member nampa, ese pwan kamo, mi pachanong won an noun health plan katen ID, iwe tiki “0”. Ren TTY, kori 711.</td>
</tr>
<tr>
<td>Language</td>
<td>Translated Taglines</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Turkish</td>
<td>Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartının üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. 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, заз телефонуйте на безкоштовний номер телефону учасника, вказаного на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711</td>
</tr>
<tr>
<td>Urdu</td>
<td>آپ کو اپنی زبان میں مفت مڈ اور معلومات حاصل کریں کا حق ہیں۔ کسی ترجمان سے بات کریں کے لئے، تölفر ممبر فون نمبر پر کال کریں جو آپ کے بیلہ باندہ انی ذی کارہ پر درج ہے۔ 0 دنیوں۔</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Quý vị có quyền được giúp đỡ và cập 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 hỏi viện được nếu trên thẻ ID thường trình báo имени tỷ của quý vị, bấm số 0. TTY 711</td>
</tr>
<tr>
<td>Yiddish</td>
<td>אזון פוטני דר רעסן זא באקואמען טילן שואאף שפראך אאיזיר שפראך פארא פאראט. פאראלב我がדבען קאראט, דרייטק 0. TTY711 IDE פאראלעמענער טעלפאן קאראט, אאיזיר שפראך פאראט טאאלאסشرع.</td>
</tr>
<tr>
<td>Yoruba</td>
<td>O ní ẹto lati ri iranwo ẹtị ifitnílẹọ gbà ní ẹdè rẹ láísanwó. Láti bá ógbufo ọkan sọrọ, pè sòrí nombà ẹrọ ibáníṣọrọ láísanwó ọdọbọ ti a tò sòrí kádi idánimo ti ètò ilera rẹ, tẹ ‘0’. TTY 711</td>
</tr>
</tbody>
</table>