



Benefit Summary
ASO Choice Plan
NYU Langone Care Plan

UnitedHealthcare Service LLC and New York University want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **Member Services telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

There is No Coverage for services received outside of NYU Langone Health Providers or In-Network UHC Choice Providers.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS		
<i>Types of Coverage</i>	<i>NYU Langone Health Providers-Tier 1 Benefits</i>	<i>UHC Choice Network Providers-Tier 2 Benefits</i>
Annual Deductible & Copays		
Individual Deductible	\$200 per year	\$2,600 per year
Family Deductible	\$400 per year	\$5,200 per year
PCP Copay	\$0 Copay	\$30 Copay
Specialist Copay	\$0 Copay	\$40 Copay
Medical Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$1,000 per year	\$8,000 per year
Family Out-of-Pocket Maximum	\$2,500 per year	\$15,000 per year
Benefit Plan Coinsurance – The Amount the Plan Pays		
	95% after Deductible has been met	50% after Deductible has been met
Lifetime Maximum Benefit		
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.	No Lifetime Maximum Benefit	No Lifetime Maximum Benefit
Information on Benefit Limits		

The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description.

BENEFITS		
<i>Types of Coverage</i>	<i>NYU Langone Health Providers-Tier 1 Benefits</i>	<i>UHC Choice Network Providers-Tier 2 Benefits</i>
Ambulance Services – Emergency and Non-Emergency		
	95% after Deductible has been met	95% after Deductible has been met
Dental Services – Accident Only		
	100% with a \$0 Copayment per visit	100% with a \$40 Copayment per visit
Durable Medical Equipment (DME)		
	95% after Deductible has been met	95% after Deductible has been met
Emergency Health Services - Outpatient		
	100% after you pay a \$150 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	
Home Health Care		
200 visits per calendar year. Combined with Private Duty Nursing Outpatient	95% after Deductible has been met	95% after Deductible has been met
Hospice Care		
	95% after Deductible has been met	95% after Deductible has been met
Hospital – Inpatient Stay		
	95% after Deductible has been met (for emergent) 95% after Deductible has been met (for non-emergent)	95% after Deductible has been met (for emergent) 50% after Deductible has been met (for non-emergent)
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	95% after Deductible has been met	50% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	95% after Deductible has been met	50% after Deductible has been met
Mental Health / Substance Use Disorder		

	95% after Deductible has been met for Inpatient Confinements and Outpatient Services Office Visits – 100% with a \$0 Copayment per visit	95% after Deductible has been met for Inpatient Confinements and Outpatient Services Office Visits – 100% with a \$0 Copayment per visit
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	95% after Deductible has been met	95% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	95% after Deductible has been met	50% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	Coverage based on Tier and Physician Status. 100% with a \$0 Copayment per visit	100% with a \$30 Copayment per visit
Specialist Physician Office Visit	Coverage based on Tier and Physician Status. 100% with a \$0 Copayment per visit	100% with a \$40 Copayment per visit
Pregnancy – Maternity Services		
	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 Benefit Summary.	
Preventive Care Services		
Covered Health Services include but are not limited to: Primary Physician Office Visit Specialist Physician Office Visit Lab, X-Ray or other preventive tests	100% with a \$0 Copayment per visit 100% with a \$0 Copayment per visit 100% with a \$0 Copayment per visit	100% with a \$0 Copayment per visit 100% with a \$0 Copayment per visit 100% with a \$0 Copayment per visit
Reconstructive Procedures		
	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 Benefit Summary.	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		

Benefits are limited as follows: 60 visits of physical therapy 60 visits of occupational therapy 60 visits of speech therapy 60 visits of manipulation unlimited visits of pulmonary rehabilitation unlimited visits of cardiac rehabilitation 60 visits of post-cochlear implant aural therapy	100% with \$0 Copayment per visit. Visit limits apply.	100% with a \$40 Copayment per visit
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	95% after Deductible has been met	50% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 365 days per Confinement	95% after Deductible has been met	95% after Deductible has been met
Surgery – Outpatient		
Facility	95% after Deductible has been met	50% after Deductible has been met
Transplantation Services		
	95% after Deductible has been met for Inpatient Stay	50% after Deductible has been met
Urgent Care Center Services		
	100% with a \$0 Copayment per visit	100% with a \$40 Copayment per visit
Vision Examinations		
Benefits are limited as follows: 1 exam per year	100% with a \$0 Copayment per visit	100% after \$40 Specialist Copay, no Deductible

MEDICAL EXCLUSIONS

It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

OTHER COVERED SERVICES

Infertility treatment through Progyny.