Oxford HMO

Summary Plan Description

2007

Participants

Mechanics, Building Engineers, Locksmiths (Local 810)
Mechanics, Building Engineers, Locksmiths (Grandfathered)

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Introduction

The University gives you the option to choose a medical plan that works best for you and your eligible dependents. You can choose from several health plan options in your area.

Under an HMO you select a primary care physician (PCP) who will manage your care and refer you to a specialist in the network. Except in an emergency, you do not receive benefits if you receive care outside of the network.

You will need to satisfy the requirements described in this summary plan description (SPD) to receive Oxford HMO coverage.

This SPD provides a concise overview of medical coverage available for you and your eligible dependents. While this SPD contains detailed and important information about your benefit plan, every attempt has been made to communicate that information clearly and in easily understandable terms.

Benefits are determined under the terms of the plan in effect at the time you become eligible for the benefits in question. The University reserves the right to suspend, modify, or terminate these benefits at any time to the extent permitted by law. This SPD does not constitute a contract of employment or guarantee any particular benefit.

In the event of a discrepancy between this SPD and the plan document, the plan document will govern.

Eligibility

Eligible employees

You are eligible for Oxford HMO coverage on the day after you complete a waiting period of three months employment at NYU and you are:

- a full-time member of the Local 810 Mechanics, Building Engineers, and Locksmiths (Codes 107/117 810)

Eligible dependents

You can cover certain dependents under Oxford HMO coverage. You're required to provide proof of relationship of your dependents if you elect to cover them under the plan. This may include a copy of one of the following: marriage certificate, approved NYU Statement of Domestic Partnership form, birth certificate that shows the names of both the parent and the child, final adoption papers, legal

documentation substantiating placement for adoption, a court order (from a court of competent jurisdiction) showing legal guardianship, permanent or temporary custody.

Your eligible dependents are any of the following:

- your legal spouse
- your domestic partner whom you registered with the Benefits Office
- your unmarried, dependent child under age 19
- your unmarried, dependent child over age 19, up to age 25, if a full-time student at an accredited educational institution
- your unmarried, dependent child over age 19 if mentally or physically disabled

Your dependent children include:

- your natural child
- your stepchild
- your registered domestic partner's child
- your legally adopted child (or child placed with you for legal adoption)
- a child for whom you have been appointed legal guardian by a court of competent jurisdiction
- a child for whom you have been given temporary or permanent custody under an order issued by a court of competent jurisdiction

A newborn child is eligible for coverage at birth. In the case of an adoption, placement for adoption, custody or guardianship, a child becomes eligible for coverage when: the child is placed in your home, the adoption is final, the date the court awarded permanent or temporary custody or guardianship.

- In order to obtain coverage for your new child, you must enroll the child within 31 days of its birth, the date the child is placed in your home for adoption, the date the adoption is final, the date that you have been appointed legal guardian or the date you were awarded permanent or temporary custody.

In the case of temporary custody, you will be required to submit either another order which extends the period of temporary custody or an order of permanent custody in order for the child's coverage to remain in effect.

If both you and your spouse or registered domestic partner work for NYU and are eligible for a medical plan through NYU, only you or your spouse or partner can cover your child as a dependent under one plan. Both of you cannot cover your child at the same time. Also, your child has to meet the eligibility requirements.

If both you and your spouse or registered domestic partner work for NYU, you can cover your spouse or partner as a dependent under your plan, or your spouse or partner can elect separate employee coverage. You or your spouse or partner cannot be covered as both an employee and as a dependent under the plan.

Qualified Medical Child Support Order (QMCSO)

You or your dependents can obtain a description of procedures for Qualified Medical Support Order determinations at no charge from the NYU Benefits Office.

Enrollment

Enrolling in the plan

If you are a newly hired employee, you have 31 days from the day after you complete your three month waiting period to enroll in Oxford HMO coverage. Or, if you move into a benefits eligible position and have already worked more than three months at NYU, you have 31 days from the date you moved into the benefits eligible position to enroll in Oxford HMO coverage.

You cannot waive coverage for yourself. If you do not complete an enrollment form when you are first eligible for coverage, you will receive default Point-of-Service individual medical coverage for the remainder of the year. You will not be able to change coverage or enroll dependents until the next open enrollment period, unless you have a qualifying status change. See **Changes in election** section.

When coverage begins

Once enrolled, you and your eligible dependents' Oxford HMO coverage will become effective the day after you complete your three month waiting period or on the date you moved into the benefits eligible position.

If you have a qualifying status change and become eligible for coverage during the plan year, your Oxford HMO coverage will start on the date of the event.

If you are not actively at work on the date coverage is to begin, you and your eligible dependents' coverage will start on the date you begin work. If you are hospitalized on the date coverage is to begin, your coverage will start when you begin work. If your dependent is hospitalized on the date coverage is supposed to begin, the coverage for that dependent will start when your coverage takes effect.

Making changes

You may change Oxford HMO coverage during the year if you have a qualifying status change; otherwise, you may only make changes during open enrollment.

Changes in election

If you have a qualifying status change, you can change your existing NYU medical plan. A change in election due to a qualifying status change must be consistent with the qualifying status change. You must make changes to your coverage within 31 days of your qualifying status change. The following is a list of events that are considered to be a qualifying status change:

- your marital status changes (or you register or revoke a domestic partnership)
- you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, permanent or temporary custody)
- your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries)
- a court decree that orders you must provide health coverage for your dependent
- your or your dependent's work site changes
- your or your dependent's residence changes
- your dependent's Medicare/Medicaid eligibility status changes
- your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's
- coverage under your spouse's/partner's plan is significantly curtailed or ceases
- your spouse's/partner's employer adds new health plan options
- NYU adds new health plan options
- you or your spouse/partner commence or return from an FMLA leave

Changes you make within 31 days of a qualifying status change become effective on the date of the event.

Changes during open enrollment

You may change your Oxford HMO coverage once a year during open enrollment, except as provided in the **Changes in election** section.

During the open enrollment period, you may do any of the following:

- Enroll in another NYU medical plan option
- Change your coverage level

All changes in Oxford HMO coverage made during open enrollment will become effective on the first day of the new plan year.

Special enrollment rules

If you are waiving NYU medical coverage for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 31 days after other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, guardianship, permanent or temporary custody, you may be able to enroll your dependent, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption, guardianship, permanent or temporary custody.

Cost

NYU contributes 100% of the cost for your coverage and 100% of the cost for dependent coverage for this plan.
You will pay a copay for certain expenses.

Imputed income

If you elect medical coverage for your domestic partner, there are tax consequences because the Internal Revenue Service does not recognize the tax exemption of benefits extended to domestic partners. The non-tax qualified dependent's coverage cost is considered imputed income. Imputed income is the amount that is included in your taxable gross earnings as a result of covering a domestic partner. Check with the NYU Benefits Office for current imputed income values. Taxes on the imputed income amount will be withheld from the paycheck in which your benefit reductions are taken.

Deductible

The deductible is the amount of money you must pay each plan year for covered medical care before the plan begins to pay benefits. The plan has no individual or family deductibles.

Copay

The copay is the flat dollar amount you pay for certain expenses. Once you pay your copay for a service, the plan pays 100% of the remainder.

The copays under the Oxford HMO coverage apply to:

- Office visits
- PCP/specialist visits
- PCP home visits
- Routine eye exams
- Routine hearing exams
- Emergency room (waived if admitted)
- Allergy testing and treatment
- Outpatient short-term physical/occupational/speech therapies
- Chiropractic care

- Home health care

Coinsurance

Coinsurance is a percentage of expenses that a person is responsible for paying. You do not pay coinsurance for most services under the Oxford HMO plan.

Coinsurance under the Oxford HMO does apply to:

- Outpatient mental health services (per visit)

Annual out-of-pocket limit

The annual out-of-pocket limit is the maximum amount you pay for your share of covered expenses each year. You do not have an annual out-of-pocket limit under the Oxford HMO.

Benefit maximums and visit limits

The Oxford HMO plan covers a maximum number of visits per calendar year or per lifetime for the following services:

- Chiropractic care - Based on treatment plan
- Home health care - 60 visits per calendar year
- Hospice care - 210 days per lifetime
- Infertility treatments - $10,000 maximum per lifetime
- inpatient mental health - 30 days per calendar year
- outpatient mental health - 30 visits per calendar year
- Inpatient substance abuse - 30 days per calendar year (includes 7 days in-patient detoxification and 30 days inpatient rehabilitation)
- Outpatient substance abuse - 60 visits per calendar year
- Outpatient rehabilitation/short-term (physical, occupational, and speech therapies) - 60 outpatient visits per condition per lifetime
- Inpatient rehabilitation (physical, occupational, and speech therapies) - 60 consecutive days per condition per lifetime.

Once you receive benefits for the maximum number of visits or days allowed by the plan in a calendar year, you pay 100% of the cost of any remaining visits or days in the calendar year. You receive a new allowance of visits or days for each new calendar year, unless specified as a lifetime maximum.

Lifetime maximum benefit

The lifetime maximum benefit is the limit the plan will pay in each covered person's lifetime. The plan has no lifetime maximum benefit.

How the plan works

When you enroll in the Oxford HMO plan you and your covered dependents must select a Primary Care Physician (PCP) who is part of the Oxford Freedom HMO network. In general, to receive care from a specialist or other provider who is part of the Oxford network you must first obtain a referral from your PCP.

Referrals

You must have a prior written or electronic referral from your PCP to obtain services and any necessary follow-up treatment from a specialist or facility.

If it is necessary, your PCP may refer you to a non-network provider for covered services that are not available within the network. Service from non-network providers require prior approval by Oxford in addition to a special non-network referral from your PCP.

You do not need a referral to obtain care from your PCP for services for routine vision care and for routine gynecological exams.

Network specialists as Primary Care Physicians

Under certain situations, such as a life-threatening condition or disease or degenerative and disabling condition, you may request to have a network specialist as your PCP. You may make this request when you enroll in the plan or upon subsequent diagnosis. You, your PCP or a network specialist should call Oxford and ask for the Medical Management Coordinator to request this election. Information will be provided regarding the criteria for Oxford's approval, conditions that must be met, etc.

Network of doctors and hospitals

Oxford HMO's network includes general practitioners, as well as specialists and hospitals. These network providers are selected by Oxford. You get benefits only when you are treated by providers in the network. You can access a listing of these network providers at www.oxfordhealth.com and searching the directory for the Oxford Freedom HMO network. You will need to enter your user ID and password. Or call Oxford's Member Services at 1-800-444-6222.

Primary care physician

A primary care physician (PCP) is a doctor in the Oxford Freedom HMO network who you choose to manage all of your health care. Your primary care physician provides preventive and routine care like office visits, diagnoses, and treats minor, uncomplicated illnesses and injuries. Your PCP refers you to Oxford's network of specialists and hospitals, as needed. A PCP can be an internist, a family or general practitioner, or a pediatrician for children. You choose your PCP from the network of doctors.

Selecting or changing primary care physicians

Each member of your family must choose a primary care physician. You select a physician from the Oxford provider directory. You can locate the provider directory on Oxford's website at www.oxfordhealth.com or by calling Oxford at 1-800-444-6222.

You can change your primary care physician at any time.

Network of mental health and substance abuse providers

For mental health or substance abuse treatment contact Oxford's Behavioral Health Line at 1-800-201-6991 and you can speak with a Behavioral Health Coordinator. The Coordinator will provide information such as referrals to behavioral health providers or pre-certification for mental health or substance abuse services.

Network of retail and mail-order pharmacies

Prescription drug coverage under the plan includes a retail prescription drug program and a mail order prescription drug service, both of which are administered by Caremark, Inc. Log on to www.caremark.com or call 800-421-5501 to locate a Caremark retail pharmacy or obtain forms for Caremark's Mail Service pharmacy. Forms are also available online on the NYU Benefits Resource Center and www.nyu.edu/hr.

When to seek pre-certification

Network providers are responsible for obtaining any pre-certifications that are required by Oxford.

Durable Medical Equipment

Purchase or rental of durable medical equipment must be approved by Oxford in advance.

Infertility treatment

In order to see a network specialist, you must have a referral from your PCP or obstetrician/gynecologist. He or she must obtain pre-certification for all test and procedures for infertility treatment.

Maternity

All hospital admissions must be pre-certified. Your participating obstetrician is responsible for obtaining authorization from Oxford for all obstetrical care after your first visit. He or she must request

pre-certification for any tests performed outside of his or her office and for visits to other specialists. It is up to you to verify that the necessary referral has been obtained before receiving such services.

Mental Health and Substance Abuse Treatment

You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you seek treatment for mental health or substance abuse, you need to call Oxford's Behavioral Health Line at 1-800-201-6991, and you can speak with a Behavioral Health Coordinator. The Coordinator will provide information such as referrals to behavioral health providers or pre-certification for mental health or substance abuse services. All calls are confidential.

Organ Transplants

Your participating physician is responsible for obtaining authorization from Oxford. It is up to you to verify that the necessary referral has been obtained before receiving such services.

Skilled Nursing Facility

Your participating physician is responsible for obtaining authorization from Oxford. It is up to you to verify that the necessary referral has been obtained before receiving such services.

Coverage when you are away from home or your child is away at school

When you are traveling outside of the Oxford service area or if your child is away at school, Oxford covers emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. The patient's Oxford PCP should be called as soon as possible after receiving treatment.

If the provider of emergency services does not submit the claim to Oxford for you and bills you instead, you will need to submit the claim to Oxford. Be sure to keep a copy for your records. You can obtain a claim form by visiting Oxford's web site at www.oxfordhealth.com, Forms Library or contact Oxford Member Services. Send the completed claim form and itemized bill for payment with your ID number clearly marked to the address shown on your ID card.

Covered expenses

In order for a specific service to be covered under the plan it must be medically necessary for the prevention, diagnosis or treatment of your illness or condition. In general, to receive care from a specialist or other provider who is part of the Oxford network you must first obtain a referral from your PCP. See How the Plan Works.

Preventive Care

Physical exams for adults

Annual routine physical exams for adults are covered by the plan.

Physical exams for children

Annual routine physical exams for children are covered by the plan.

Pap smears

Annual routine Pap smears are covered by the plan. If your doctor recommends a non-routine Pap smear as a follow-up to a medical diagnosis, the plan covers your Pap smear the same as any other laboratory charge.

Mammograms

Routine mammograms are covered starting at age 35 as follows:

- One baseline mammogram for women age 35 through 39;

- Every two years for women age 40 through 49, or more frequently upon the recommendation of a network physician; and
- annually for women age 50 or over.

Prostate specific antigen test - PSA

Annual routine prostate specific antigen (PSA) tests are covered by the plan. If your doctor recommends a non-routine PSA test as a follow-up to a medical diagnosis, the plan covers your PSA test the same as any other laboratory expense.

Routine eye exams

Routine eye exams are covered when performed by your PCP or a network ophthalmologist as part your annual routine physical exam.

Routine hearing exams

Routine hearing exams are covered when performed by your PCP as part your annual routine physical exam.

Specialist care

Office visits to specialists are covered. A referral from a Primary Care Physician (PCP) is required to seek treatment from a specialist.

Maternity care

Prenatal visits

The plan covers prenatal visits.

Doctor’s delivery charge

The plan covers charges for delivery of the baby.

Midwives

The plan covers the services of midwives.

Maternity hospital stay

Hospital stays for maternity are covered for prenatal care; delivery of a child or children; postpartum care rendered within 24 hours after the delivery; services of an operating physician for performing an obstetrical procedure, related pre-operative and post-operative care, administration of an anesthetic; and services of any other physician for administering a general anesthetic.

Birthing centers

Birthing center expenses are covered for prenatal care; delivery of a child or children; postpartum care rendered within 24 hours after the delivery; services of an operating physician for performing an obstetrical procedure, related pre-operative and post-operative care, administration of an anesthetic; and services of any other physician for administering a general anesthetic.

Baby’s first exam

Baby’s first exam is covered during a newborn child’s initial hospital confinement. Covered expenses include hospital services for nursery care; other services and supplies given by the hospital; services of a surgeon for circumcision; and physician services.

Mental health and substance abuse treatment (in- and outpatient)

Inpatient treatment is covered for mental health conditions in a hospital or mental health facility. The plan covers expenses for substance abuse treatment in a hospital for detoxification, including medical treatment and referral services for substance abuse or addiction.

Outpatient treatment is covered for treatment of mental health conditions. The plan covers outpatient rehabilitation visits for treatment of substance abuse.

Emergency care

An emergency is defined as a serious medical condition or symptom (including severe pain) which results from an injury, sickness, or mental illness. Generally, the condition arises suddenly and requires immediate care and treatment usually within 24 hours of onset to avoid jeopardy of a covered person's life or health. If you are admitted to the hospital, you need to contact Member Services within 24 hours of admittance.

Examples of conditions that would typically be considered emergencies are chest pain, severe bleeding, appendicitis, poisoning, seizures, strokes and loss of consciousness.

Hospital emergency room

Emergency care (see above) in a hospital emergency room is covered by the plan. Coverage is the same for both in-and out-of-network care. You pay an emergency room copay which will be waived if you are admitted to stay overnight. Call Member Services within 24 hours of your admission to the hospital.

Ambulance

Ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given is covered by the plan. Or, a professional ambulance service, when used to transport you to or from a local hospital when ordered by a physician, surgeon, paramedic, or an officer of the law, is covered by the plan.

Inpatient care

Inpatient hospital services

Generally, covered hospital expenses include charges for semi-private room and board and other medically necessary services and supplies. Room and board charges include all hospital charges for services, such as general nursing care, made in connection with room occupancy as well as:

- anesthetics and oxygen,
- blood transfusion equipment and administration of blood or blood derivatives by a hospital employee,
- diagnostic lab work and x-rays,
- dressings and plaster casts,
- drugs and medicines,
- hemodialysis or peritoneal dialysis for kidney failure,
- in-hospital consultation with attending physician,
- nurses and physicians services,
- sera, biologicals, vaccines, and intravenous preparations,
- splints, trusses, braces, and crutches,
- surgical supplies,
- x-ray, radium, and radioactive isotope therapy, and chemotherapy treatment and associated administration equipment and supplies.

Not included is any charge for daily room and board in a private room over the semi-private room charge.

Surgery

The services of surgeons, assistant surgeons and anesthesiologists are covered.

Multiple surgical procedures

Multiple surgical procedures are covered by the plan. When more than one surgical procedure is performed in the same operative session a special coverage rule applies. The expense for each surgical procedure is considered individually and after the applicable deductible is applied the plan will cover 100% of the reasonable and customary (R&C) charge for the primary procedure, 50% of the R&C charge for the secondary procedure, and 50% of the R&C charge for the tertiary and any additional procedures.

Second surgical opinion

Second surgical opinions are not required by the plan to obtain benefits. If you disagree with a provider's recommended course of treatment you may request that Oxford designate another network provider to render a second opinion. If the first and second opinions disagree, Oxford will designate another network provider to render a third opinion. Oxford will pre-certify the course of treatment recommended by the majority of the network providers who reviewed your case. You must pay any copayment for a second opinion that you request. In some situations Oxford may require a second opinion. There is no cost to you when Oxford requests the second opinion.

Reconstructive surgery

Reconstructive surgery is covered under these conditions:

- when performed to correct a congenital birth defect of a dependent child which has resulted in a functional deficit; or
- is incidental to or follows surgery necessitated by injury, infection or disease of the involved part; or
- breast reconstruction (including surgery on the healthy breast to restore and achieve symmetry or
- implanted breast prosthesis following a covered mastectomy.

Hospice

Inpatient hospice care expenses are covered when provided as part of a hospice care program.

Covered services include inpatient treatment in a hospice facility, hospital, or convalescent facility that provides room and board and other services and supplies for pain control, as well as other acute and chronic symptom management, outpatient visits by nurses and social workers, counseling and emotional support, and instruction and supervision of a family member.

Physical therapy/rehabilitation

Inpatient physical therapy/rehabilitation is covered provided there is a specific treatment plan that details the nature and duration of the physical therapy and allows for ongoing review to determine the need for further physical therapy treatment. The therapist must submit progress reports at the intervals stated in the treatment plan to Oxford.

Skilled nursing facility

The plan covers services received in a licensed skilled nursing facility. Services must be provided directly by or under the general supervision of skilled nursing and rehabilitation personnel such as registered nurses, licensed practical nurses, physical therapists, etc. Admission to a skilled nursing facility must be supported by a treatment plan prepared by your network provider and approved by Oxford.

Outpatient care

Office visits

Office visits to network primary care physicians and network specialists are covered by the plan.

Outpatient hospital and alternate facility services

Outpatient hospital and alternate facility services are covered. Generally outpatient hospital and alternate facility expenses include charges for services, such as general nursing care and for medically necessary services and supplies.

Surgery

The services of surgeons, assistant surgeons and anesthesiologists are covered.

Multiple surgical procedures

Multiple surgical procedures are covered by the plan. When more than one surgical procedure is performed in the same operative session a special coverage rule applies. The expense for each surgical procedure is considered individually and after the applicable deductible is applied the plan will cover 100% of the reasonable and customary (R&C) charge for the primary procedure, 50% of the R&C charge for the secondary procedure, and 50% of the R&C charge for the tertiary and any additional procedures.

Second surgical opinion

Second surgical opinions are not required by the plan to obtain benefits. If you disagree with a provider's recommended course of treatment you may request that Oxford designate another network provider to render a second opinion. If the first and second opinions disagree, Oxford will designate another network provider to render a third opinion. Oxford will pre-certify the course of treatment recommended by the majority of the network providers who reviewed your case. You must pay any copayment for a second opinion that you request. In some situations Oxford may require a second opinion. There is no cost to you when Oxford requests the second opinion.

Hospice

Hospice care expenses are covered when provided as part of a hospice care program. Covered services include inpatient treatment and other services and supplies for pain control, as well as other acute and chronic symptom management, outpatient visits by nurses and social workers, counseling and emotional support, and instruction and supervision of a family member.

Home health care

Home health care is covered if provided through a home health care agency if a covered person is confined to his or her home and requires nursing care, therapy, or other services. The covered person's physician must prescribe a home health care plan, and the treatment received must be an alternative to care in a hospital or convalescent facility. Each visit by a nurse or therapist, or by a home health aide of up to four hours, is considered one visit. Covered home health care expenses include:

- Care by a registered nurse, licensed practical nurse, home health aide, nurse's aide, licensed clinical social worker, or therapist employed by a home health care agency;
- Home health aide services for patient care;
- Medical social services.

Specialty care

Acupuncture

Acupuncture treatment is covered when received from a licensed medical doctor. Outpatient acupuncture treatment must be medically necessary and preauthorized by Oxford. Also, see Special Oxford Programs.

Alternative care (see acupuncture and chiropractic care)

See Special Oxford Programs.

Allergy testing and treatment

Allergy testing and treatment are covered by the plan.

Chemotherapy/radiation therapy

Chemotherapy and radiation therapy are covered by the plan.

Chiropractic care

Treatment for misalignment or dislocation of the spine and strained muscles or ligaments related to the spinal disorder is covered by the plan.

Dental treatment

Generally, dental care is not covered under a medical plan. However, this plan covers oral surgery which is limited to extraction of bony, impacted teeth; treatment of bone fractures; removal of tumors and orthodontogenic cysts.

Dialysis

Dialysis is covered to treat acute or chronic kidney disease, including outpatient dialysis in your home, a hospital outpatient department or a free-standing facility. Coverage includes: lab tests related to the dialysis program; appropriate and necessary supplies if bought and billed through a hospital; rental of required equipment; and training of your family or other persons who assist in the use of the required equipment.

Durable medical equipment

Durable medical equipment is covered by the plan. Supplies include wheelchairs; crutches; hospital-type beds; equipment to provide oxygen; iron lung; other mechanical equipment to treat respiratory paralysis; orthotic devices such as arm, neck, and back braces; appliances which replace a lost body organ or part or help an impaired one to work; and monitoring devices.

Immunizations

Immunizations or vaccinations for your dependent child are covered. Adult immunizations are covered as recommended by the U.S. Department of Health and Human Services.

Infertility treatment

Basic services will be provided for a covered female if, in Oxford's opinion, she is an appropriate candidate for infertility treatment. Basic services consist of : initial evaluation, semen analysis, laboratory evaluation of ovulatory function, post-coital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction. If basic services do not result in increased fertility, Oxford may pre-certify comprehensive services which include: ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy, and laparatomy. Should the comprehensive services fail to increase fertility, Oxford may pre-certify additional advanced services. Drug therapy is covered through Caremark (see Prescription Drugs).

Occupational therapy/rehabilitation (outpatient short-term)

Occupational therapy is covered by the plan except for vocational rehabilitation and employment counseling.

Organ transplants

Organ transplants are covered by the plan.

The plan covers medically necessary hospital services for kidney, corneal, heart, heart/lung, lung, pancreas, bone marrow, liver, and multiple major organ transplant procedures as long as pre-certification is obtained and the transplant is performed in an approved facility.

Contact Oxford for details on coverage, storage, transportation costs and travel expenses.

Physical therapy/rehabilitation (outpatient short-term)

Physical therapy is covered by the plan provided there is a specific treatment plan that details the nature and duration of the physical therapy and allows for ongoing review to determine the need for further physical therapy treatment. The therapist must submit progress reports at the intervals stated in the treatment plan.

Prostheses

Prostheses after a mastectomy, artificial limbs and eyes (purchase, fitting, needed adjustments, repairs, and replacements) and other prosthetic appliances are covered by the plan when approved by the claims administrator.

Speech therapy (outpatient short-term)

Speech therapy is covered by the plan provided it is given by a licensed speech therapist to restore speech lost or impaired due to disease, injury or congenital defect.

Sterilization and reversal of sterilization

Tubal ligation and vasectomy are covered by the plan.

X-ray, laboratory, and diagnostic services

The plan covers diagnostic laboratory test and x-rays, including CAT scans, and Magnetic Resonance Imaging (MRIs).

Prescription drugs

Prescription drug coverage under the plan includes a retail prescription drug program and a mail service prescription drug service, both of which are administered by Caremark. Your prescription benefit is the same, regardless of whether your prescription is issued by an in- or out-of-network physician.

Copays that you pay for prescription drug expenses are not subject to the plan's deductible and are not counted toward your annual out-of-pocket maximum.

Your copayment will depend on the type of drug you obtain:

- generic,
- brand-name medication on Caremark's Primary Drug List, or
- brand-name medication not on Caremark's Primary Drug List.

Your copayment will be lowest when you choose a generic drug. If you obtain a brand-name medication from Caremark's Primary Drug List, your copayment will be lower than if you choose a brand-name medication that is not on the Primary Drug List. If you purchase a brand-name medication that is not on Caremark's Primary Drug List because there is no other brand on the market, you will pay the Primary Drug List copayment, which is lower.

If the cost for your generic or brand-name prescription drug is less than the copay, you pay the lower dollar amount. For example, if the cost of a generic prescription drug is $3, you pay the $3 cost for the medication - not the $5 copay for generic prescription drugs, as specified under the plan.

Caremark mail-service pharmacy

Maintenance drugs are drugs that are prescribed for certain ongoing or chronic conditions (like high blood pressure or hypothyroidism) and are generally taken for long periods of time. Use the Caremark Mail Service pharmacy for medications that you need for long-term use, usually a supply of 90-days or more, or for short term use if they are on Caremark's maintenance drug list.

Caremark retail pharmacy

Use a Caremark retail pharmacy for medications that you will take for the short-term, usually a supply of 30-days or less. The number of times you can fill a maintenance mail-service prescription at a retail pharmacy is limited to two 'fills' per calendar year. The third and each subsequent fill of your maintenance medication at a retail pharmacy is subject to a $50 copayment.

Non-Caremark pharmacy

In the event you do go to a non-participating pharmacy, you will pay the full retail price for the prescription. You will then need to submit a paper claim form, along with the original prescription receipt(s) to Caremark for reimbursement. You will be reimbursed for the discounted cost of the prescription - the cost the plan

would have paid if the prescription had been filled at a Caremark participating pharmacy - less the applicable copayment. In most cases, the discounted price will be less than the retail price, so you may end up paying more when you use a non-participating pharmacy.

Special Oxford Programs

The following programs are some, but not all, of the special programs offered by Oxford. These programs are not part of the NYU medical plan design as outlined in NYU's legal Plan Document. The continuation of these programs is not guaranteed and Oxford reserves the right to amend or discontinue any or all of these programs. For more information about these programs contact Oxford Member Services at 1-800622-4444 or log onto www.oxfordhealth.com and click on 'Tools and Resources'.

Exercise Facility Reimbursement Program

You can receive partial reimbursement for a gym membership if you join a gym that maintains equipment and programs that promote cardiovascular wellness. Covered spouses or domestic partners can also receive a partial reimbursement. To obtain reimbursement you must complete a minimum of 50 visits per six-month period to the gym.

Health Education

Oxford provides informational literature at no cost to its members. Contact Oxford Member Services to request information about Oxford programs and literature about preventive care programs, managing disease, maternity education, and quit smoking to name a few.

Health Bonus Member Discounts

As an Oxford member you can take advantage of discounts on health related services and products such as LA Weight Loss, Weight Watchers, Health Journeys magazine, Brookstone, Foot Solutions, TCBY, GVS General Vision Services, and more.

Oxford On-Call - 24 Hour Nurse Line

You can speak with an informed, registered nurse who is available 24 hours a day, 365 days a year to offer suggestion and guide you to the most appropriate source of care. Oxford On-Call nurses can: identify caller symptoms and recommend next steps, pose a series of questions; recommend a visit to an emergency room; suggest an appointment with a physician; suggest how to care for a problem at home; refer you directly to a specialist when medically appropriate; make follow-up calls; keep your PCP informed by faxing call records. You can reach Oxford On-Call by phoning 1-800-201-4911.

Restrictions and exclusions

Pre-existing condition limitation

There are no exclusions or limitations for pre-existing conditions under this plan.

Expenses not covered

General exclusions

Generally, coverage under the plan is only provided for a service or supply which is necessary for the diagnosis, care or treatment of the physical or mental condition involved. It must be widely accepted professionally in the United States as effective, appropriate, and essential based on the recognized standards of the health care specialty involved. The following listing identifies most of the care and services for which coverage is not provided. However, there may be other non-covered care or services which are not listed. If you have a question about an expense for a service that is not listed contact Oxford Member Services.

- Any service in connection with, or required by, a procedure or benefit not covered by the plan.
- Any services or supplies that are not medically necessary, as determined by Oxford.
- Biofeedback, except as specifically approved by Oxford.

• Blood, blood plasma or other blood derivatives or substitutes.
• Canceled office visits or missed appointments.
• Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
• Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
• Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
• Educational services, special education, remedial education or job training. The plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunctions, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the plan.
• Expenses that are the legal responsibility of Medicare or a third party payor.
• Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures as determined by Oxford, unless approved by Oxford in advance.
• Hair analysis.
• Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
• Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, take-home supplies, and other similar items and services.
• Recreational, educational and sleep therapy, including any related diagnostic testing.
• Services not covered by the plan, even when your PCP has issued a referral for those services.
• Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
• Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
• Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state or federal government, securing insurance coverage, travel, and school admissions or attendance, including examinations required to participate in athletics unless the services is considered to be part of an appropriate schedule of wellness services.
• Services and supplies that are not medically necessary.
• Services you are not legally obligated to pay for in the absence of this coverage.
• Services for which a required referral was not obtained
• Services provided by non-network providers, except for medical emergencies and urgent care, for those instances when you are instructed to seek treatment from a non-network provider by an Oxford Medical Management Coordinator or you PCP and Oxford has pre-certified your use of the non-network provider.

- Changes made by a non-network provider for emergency or urgent care that are in excess of the usual, reasonable, and customary charges for the covered services provided as determined by Oxford.
- Special medical reports, including those not directly related to the medical treatment of a plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Thermograms and thermography
- Treatment in a federal, state or governmental facility, including care and treatment provided in a non-participating hospital owned or operated by any federal, state or governmental entity, except to the extent required by applicable laws.
- Treatment of diseases, injuries, or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
- Expenses incurred for care or services outside of the United States (except for Canada, Mexico, and U.S. possessions) if travel out of the country was to obtain medical treatment, drugs or supplies.

Routine care exclusions

- Hearing aids
- Immunizations related to travel or work
- Vision correction services and supplies including, but not limited to: eyeglasses, contact lenses, corrective lenses, refractions, eye exercises, visual training, orthoptics, radial keratotomy, and other refractive keratoplasties.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Weight control. All services, supplies, programs, and surgical procedures for the purpose of weight control. Also not covered are special foods, diets, supplements, vitamins, and enteral feedings.

Mental health and substance abuse treatment exclusions

- Hypnotherapy, except when approved in advance by Oxford
- Religious, marital and sex counseling, including related services and treatment.
- Therapy or rehabilitation, including (but not limited to) primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide therapy.
- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to medical treatment of retarded individuals as described under "Covered expenses".

Inpatient care exclusions

- Ambulance services, when used as routine transportation to receive inpatient and outpatient services.
- Custodial care and rest cures.
- Private duty or special nursing care.

- Charges for an adopted newborn infant's initial hospital stay if the natural parent has coverage available for the infant's care.
- Transplant services required when you are the organ donor unless the recipient is also covered by Oxford. Contact Oxford Member Services for additional information.

Surgery

- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the plan covers the following reconstructive surgery to correct the results of an injury, surgery to treat congenital defects (such as a cleft lip and cleft plate) to restore normal bodily function, and surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Reversal of voluntary sterilizations, including related follow-up care
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Oxford.
- Transsexual surgery, sex change or transformation. The plan does not cover any procedure, treatment or related service designed to alter a plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

Outpatient care exclusions

- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.
- Private duty or special nursing care

Specialty care exclusions

Allergy Treatment

Specific non-standard allergy services and supplies, including (but not limited to):

- Skin titration (wrinkle method),
- Cytotoxicity testing (Bryan's Test),
- Treatment of non-specific candida sensitivity, and
- Urine autoinjections.

Dental treatment

Dental care and treatment, including (but not limited to):

- Care, filling, removal or replacement of teeth,
- Dental services related to the gums,
- Apicoectomy (dental root resection),
- Orthodontics,
- Root canal treatment,
- Soft tissue impactions,

- Alveolectomy,
- Augmentation and vestibuloplasty treatment of periodontal disease,
- Prosthetic restoration of dental implants, and
- Dental implants.
- False teeth.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):

- Treatment performed by prosthesis placed directly on the teeth,
- Surgical and non-surgical medical and dental services, and
- Diagnostic or therapeutic services related to TMJ

Durable medical equipment

- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Orthotics.

Infertility Treatment

- Injectable infertility drugs cost for an ovum donor or donor sperm, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, in-vitro service for women who have undergone tubal ligation, reversal of tubal ligations, any infertility services if the male has undergone a vasectomy, and all costs for an relating to surrogate motherhood (maternity service are covered for covered females acting as surrogate mothers).

Speech therapy

- Special education, including lessons in sign language to instruct a plan participant whose ability to speak has been lost or impaired to function without that ability.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Oxford, are equivalent in quality of care, the plan reserves the right to cover only the least costly service, as determined by Oxford, provided that Oxford approves coverage for the services or treatment in advance.

Coordination of benefits

If you or a covered dependent is covered by another medical plan, Oxford HMO coverage has a coordination of benefits feature to prevent duplication of benefit payments.

Coordination of benefits allows the plans to work together to cover eligible expenses. The plan that has the first obligation to pay is called the "primary plan;" the other plan is called the "secondary plan." Typically, a secondary plan will pay when its benefit is more generous.

A participant may be covered as a dependent under two or more plans. Certain rules govern which plan is primary and which is secondary. Those rules follow this order:

- A plan that has no coordination of benefits provision will be primary to a plan that does have a coordination of benefits provision.
- The plan of the participant whose birthday falls earlier in the calendar year is primary before the plan of the participant whose birthday falls later that year (based on month and day only).
- If both participants have the same birthday, the plan covering the person for the longest time is considered primary before the plan that covers the other person.
- If the other benefit plan doesn't have the rules described above, but instead has a rule based on the participant's gender, and if as a result the plans don't agree on the order of the benefits, the rule in the other benefit plan will determine the order of the benefits.

A participant may be covered as a dependent under two or more plans of divorced or separated parents. The following rules determine which plan is primary and which is secondary:

- If the other benefit plan doesn't have the rules described above, but instead has a rule based on the participant's gender, and if as a result the plans don't agree on the order of benefits, the rule in the other benefit plan will determine the order of benefits.
- If the parent with custody has remarried, the order of payment is the plan of the parent with custody will pay first, followed by the plan of the stepparent with custody, and followed by the plan of the parent without custody.
- If there is a court decree giving one parent financial responsibility for the medical, dental or other health expenses of the dependent child, this parent's plan will be primary to any other plan that covers the dependent child.
- If none of these rules apply, the plan that has covered the person for the longest time will be primary to all other plans.

Under coordination of benefits, if the NYU plan is the secondary payer, the NYU plan will pay the difference between the total covered charges and the amount the primary plan paid. The total payments of both plans can't be more than 100% of the covered expenses. The benefits paid by the NYU plan can't be more than the amount the plan would have paid if there was no other coverage, but together with the primary plan, most - if not all - of the covered expense may be paid.

This plan is not intended to duplicate any coverage for which covered individuals are or could be eligible, such as Medicare or any other federal or state government programs.

Filing a claim

How to file a claim

Services provided by Oxford Network Providers are billed directly to Oxford. You do not need to file a claim. If you should receive a bill from an Oxford network provider contact Oxford Member Services immediately.

You are financially responsible for the cost of any covered services received from non-network providers, unless those services were either arranged by your Oxford PCP and pre-certified by Oxford or were required to treat a medical emergency or urgent care situation. If you received such covered services from a non-network provider, you must complete a claim form, sign it, and send it to Oxford with the original, itemized bill(s). Only original bills will be considered.

Itemized bills should contain:

- Patient name
- Type of service
- Name and address of provider making the charge
- CPT-4 codes or HCPCS codes (description of services
- Date of service
- Individual charge for each service
- ICD-9 codes (diagnosis or symptoms)

Be sure to keep a copy of your claim form and bills for your own records. Claim forms are available from Oxford by calling the Member Services

All requests for reimbursement must be made within 180 days of the date covered services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 180 day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will Oxford be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request

All reimbursements to non-network providers are subject to usual, reasonable, and customary charges as determined by Oxford unless you were referred to a non-network provider by your PCP or Oxford.

You should allow up to 15 days for the processing of claims. If necessary, Oxford's Claims Department will contact you for more information regarding your claim in order to speed up the processing.

Submission of Additional Information

Payment for services may be denied due to a lack of necessary, complete, or conflicting information. You are given 45 days from the date of receipt of an Explanation of Benefits (EOB) to submit the requested additional information. If you wish to submit the additional information outside of the allotted 45 days, you must submit an appeal of the initial decision.

If a claim is denied

Oxford has a grievance resolution process designed to promptly address member problems. If you have a problem, call the Member Services toll-free number on your ID card or write to Member Services at the address on your ID card.

Or, e-mail Member Services at www.oxfordhealth.com. Please be sure to include your member ID number, Social Security number and e-mail address.

A trained professional will promptly address your inquiry. If you are dissatisfied, the next step is to file an appeal with Oxford.

Your right to appeal a denied claim

There are several methods for submitting an appeal.

- You may initiate a verbal appeal by calling Member Services at 1-800-444-6222
- You may send your appeal in writing or via fax. Any pertinent clinical information to substantiate the case should be forwarded with the appeal letter. The 1st Level of Appeal should be sent to: Clinical Appeals Department, PO Box 7078, Trumbull, CT 06611 or faxed to; Clinical Appeals Department: Fax - 1-203-459-5423. The 2nd Level of Appeals should be sent to: Grievance Review Board, 48 Monroe Turnpike, Trumbull, CT 06611 or faxed to: Grievance Review Board: Fax - 1-203-452-4610

First Level: Clinical Appeals Department (Informal Stage 1)

- Timeframe for Submission of an Appeal:
Oxford Health Plans grants you 180-calendar days from receipt of the initial adverse verbal or written notification of non-certification or Explanation of Benefit statement.
- Clinical Review:
Oxford will acknowledge the receipt of your appeal within 15 business days of receipt of the appeal request. You will be given an opportunity to submit written comments, documents, medical records, photos, peer review or other information relevant to the appeal. A Clinical Appeals reviewer who was not involved in the initial determination and is not the subordinate of any person involved in the initial determination will perform a full, clinical review of all pertinent data, including medical records, photos and peer review. A medical director who was not involved in the original determination and who does not report to the individual that made the initial determination will review your appeal.
- Decision Timeframe for 1st Level Appeals:

- Pre-Service appeal - 15 calendar days from receipt of a pre-service appeal.
- Post-Service appeal - 30 calendar days from receipt of a post-service appeal.

Full documentation of the substance of the appeal, including any aspects of clinical care involved and the actions taken, will be maintained in an appeal file.

Written appeal decisions must include the following elements, when applicable:

- The specific reasons for the appeal decision in easily understandable language
- A reference to the clinical criteria, benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as written notification that you, upon request, are allowed access to and copies free of charge of relevant documentation regarding the your appeal.
- A list of titles and qualifications of individuals participating in the appeal review.
- A description of the next level of appeal, either within the organization or to an external organization, as applicable, along with any relevant written procedures.
- The name of the person handling the appeal.

After all levels of appeals have been exhausted, you have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act (ERISA).

Second level: Grievance Review Board and/or External Appeal (Formal Stage 2)

When a first level appeal is denied, you will receive a denial from Oxford's Clinical Appeals Department, which will provide you with the option of:

- An external appeal OR
- An internal 2nd level appeal

Timeframe for Submission of an appeal to the Grievance Review Board:

You have 60 business days from the date of the receipt of the 1st level appeal determination letter to submit an Appeal to the Grievance Review Board.

Grievance Review:

The formal second level process where you, or any provider acting on behalf of you with your consent, who is dissatisfied with the results of the first level appeal, have the opportunity to pursue your appeal by submitting a written appeal. Oxford will conduct a review of the appeal that does not give deference to the denial decision. Oxford will fully investigate the substance of the appeal, including any aspects of clinical

care involved. You will be given an opportunity to submit written comments, documents, medical records, photos, peer review or other information relevant to your appeal to the Grievance Review Board.

The Grievance Review Board (GRB) is a team of Oxford employees not involved in the initial determination and who are not the subordinate of any person involved in the initial determination. They are appointed for the express purpose of reviewing and resolving member appeals. When an appeal is clinical in nature, the GRB will include a licensed physician who did not review the issue at the first level appeal. If the appeal pertains to an administrative issue, individuals of a "higher level" than those who reviewed the first level appeal will resolve the second level appeal. In addition, one of the persons appointed to review an appeal involving clinical issues is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment.

Decision Timeframe:

You will be notified of the Board's decision within:

- 15 calendar days from the receipt of a pre-service appeal
- 30 calendar days from the receipt of a post-service appeal

The resolution timeframe is calculated from the date of receipt of the request for a second level appeal.

Full documentation of the substance of the grievance and the actions taken will be maintained in a grievance file.

Written appeal decisions must include the following elements, when applicable:

- The specific reasons for the appeal decision in easily understandable language.
- A reference to the clinical criteria, benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as written notification that you, upon request, are allowed access to and copies free of charge, of relevant documentation regarding your appeal.
- A list of titles and qualifications of individuals participating in the appeal review.
- A description of the next level of appeal, either within the organization or to an external organization, as applicable, along with any relevant written procedures.
- The name of the person handling the appeal.

After all levels of appeals have been exhausted, you have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act (ERISA).

Third Level: External Appeal Level (Stage 3)

- Timeframe for Submission of an appeal to the External Appeal Agent:
  You have 45 days from the final adverse determination to appeal externally. The 45-day timeframe for requesting an external appeal begins upon the receipt of the final adverse determination letter of the first level appeal, regardless of whether or not a second level appeal is requested. By choosing to request a second level internal appeal, the time may expire for you to request an external appeal. However, if you choose to simultaneously pursue an external appeal and a second level appeal, Oxford reserves the right to waive the second level appeal process and, in lieu of a second level appeal, Oxford will be bound by the decision of the external appeal agent. In such a case, you will not be required to complete a second level appeal in order to exercise any rights under ERISA.
- External Appeal Process for medically necessary and Experimental/Investigational Treatment where you have a life threatening or disabling condition:
  A denial based upon (1) lack of medical necessity or (2) experimental and/or investigational issues for life-threatening or disabling conditions, may be eligible to be appealed through NY State's

external appeal program. You will be notified of your eligibility to pursue an external appeal in Oxford's First Level decision as described above.

• Decision timeframe: The external review agent will render a decision within 30 calendar days from the date of the request.

Right of recovery

If for some reason a benefit is paid that exceeds the benefits provided by the Oxford HMO plan or a benefit was paid that did not legally have to be paid by you or a covered family member the plan has a right to recover the excess amount from the person or agency that received it.

When coverage ends

If you leave the University

Your Oxford HMO coverage ends at the end of the month during which your employment with the University terminates. At that time, you will be eligible for COBRA continuation coverage (refer to the **COBRA** section for more information). Under some circumstances, you may be eligible to convert your coverage to an individual policy upon leaving the University. Refer to the **Conversion rights** section for more information.

Coverage when you are not working

Taking a leave of absence affects your Oxford HMO coverage. The impact depends on the type of leave that you take.

Leave of absence	How your coverage is affected
Family Leave Maternity Leave Disability Leave	Coverage continues.

If you retire

You may be eligible to continue health care benefits in retirement under an NYU retiree health care plan, if you meet the age and service requirements. For more information, please refer to www.nyu.edu/hr and refer to Policies.

If you die while employed

If you die while employed by the University, your surviving dependents may be eligible for special survivor coverage. Certain requirements must be met for them to be eligible for continued coverage. Your dependents must be covered under your plan at the time of death

For more information, please refer to www.nyu.edu/hr and refer to Policies.

If the University ends the benefit

The University has established the plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain the plan for any given length of time, and may at any time amend or terminate the plan, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be

effected by a written instrument signed by an officer of New York University, or an authorized delegate. No vested rights of any nature are provided under the plan.

When coverage ends

Your Oxford HMO coverage ends on any one of the following:

- the day before the day your coverage begins under another NYU medical plan option
- the day before the first day of any month for which you fail to make your contribution for the cost of coverage under the Plan
- the day the plan ends
- the last day of the month in which you no longer meet eligibility requirements
- the last day of the month in which your employment with NYU terminates

Your spouse's coverage ends when any one of the following occurs:

- the day before the first day of any period for which you fail to enroll your dependent for coverage under the plan
- the day your dependent's coverage under the plan ends due to a qualifying status change
- the last day of the month in which you die, unless your dependent qualifies for survivor benefits through NYU
- the day before the day on which your dependent becomes an employee of NYU and is eligible for medical coverage under one of NYU's other health plans
- the day dependent coverage under this plan ends

Your dependent child's coverage ends on any one of the following:

- the day before the first day of any period for which you fail to enroll your dependent for coverage under the plan
- the day your dependent's coverage under the plan ends due to a qualifying status change
- the last day of the month in which you die, unless your dependent qualifies for survivor benefits through NYU
- the day before the day on which your dependent becomes an employee of NYU and is eligible for medical coverage under one of NYU's other health plans
- the day dependent coverage under this plan ends

Extended Benefits

If you are totally disabled on the date your Oxford HMO coverage terminates, you may be able to continue coverage for services limited to the treatment of the sickness or injury that cause your total disability.

Extended benefits ends on the earliest of:

- The date you are no longer disabled as determined by your Oxford provider,
- The date the contractual benefit limit has been reached, or
- Twelve months from the date coverage under the Extended Benefits provision began.

Extended benefits will not be paid for:

- Any member who is not totally disabled on the date his or her insurance ends,
- Any child born as the result of a pregnancy for which benefits are being extended, and
- Beyond the extent to which Oxford would have paid benefits had coverage not ended.

Continuation of coverage under either COBRA is not available if Extended Benefits have been elected or exhausted.

Conversion coverage is not available once Extended Benefits have been elected or exhausted.

Contact Oxford Member Services for an application for Extended Benefits. Also, notify the NYU Benefits Office that you have applied for Extended Benefits.

COBRA

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, which requires continuation of medical coverage to certain eligible employees whose coverage would otherwise terminate. If this section is incomplete or in conflict with the law, the terms of the law will govern.

Continuation of coverage

You and your covered dependents may continue your current medical coverage if it ends because of one of the following:

- you voluntarily leave NYU
- the number of hours you are scheduled to work are reduced below those required for you to be eligible for benefits
- you are terminated for any reason other than gross misconduct

COBRA coverage also is available to your covered dependents if their coverage would otherwise end because of one of the following:

- your death
- your divorce, legal separation or annulment of your marriage
- Medicare entitlement
- your dependent child becomes ineligible for coverage

COBRA coverage continues for up to 18, 29 or 36 months, depending on how you or your eligible dependents become eligible. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

If you are disabled as determined by the Social Security Administration, you may elect to continue COBRA for up to 29 months and pay 102% of the cost for coverage.

Length of COBRA coverage	Reason coverage stops
18 months	Your employment ends You transfer to a position that is not eligible for medical benefits
29 months	The Social Security Administration determines that you or your dependent was permanently disabled at any time within the first 60 days of continuation coverage. You or your dependents provide notice of the Social Security Administration's determination within 60 days of receiving it.
36 months (for dependents)	You die You become entitled to Medicare Your dependent stops being eligible for coverage You divorce or legally separate

Electing COBRA

You and your covered dependents will receive election forms and more information about COBRA from EBPA, the COBRA billing administrator for New York University. In the case of a divorce, legal separation, or the ineligibility of a dependent child, you or your covered dependents must notify the NYU Benefits Office within 60 days of becoming eligible to elect COBRA.

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your University coverage ends or 60 days after the date of the notice of COBRA rights and your election is mailed to you by EBPA, whichever is later. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA.

If you elect COBRA coverage and the Social Security Administration determines that you or your covered dependent was permanently and totally disabled at any time within the first 60 days of the date of continuation coverage, you or your covered dependent must notify EBPA within 60 days of the determination. The notice must be received by EBPA within the initial 18 months of COBRA coverage so that you and your dependents can qualify for an additional 11 months of coverage.

If a 36-month event happens while a dependent is covered under COBRA, COBRA coverage may be continued for the dependent for another 18 months - up to a total of 36 months.

If you become entitled to Medicare benefits and then lose medical coverage within the next 18 months because your employment is terminated or your hours are reduced, your eligible dependents may purchase COBRA coverage for a maximum of 36 months from the date you become entitled to Medicare.

Required notices from qualified beneficiaries

To elect COBRA continuation coverage, you or your covered dependents are required to notify the NYU Benefits Office in writing within a maximum of 60 days after any of the following qualifying events:

- your divorce or legal separation
- your dependent child becomes ineligible for coverage

If you have elected continuation, you or your covered dependents are also required to notify EBPA in writing within a maximum of 60 days after any of the following:

- a second qualifying event such as divorce, legal separation, death or dependent child ceasing to be a dependent, or Medicare entitlement
- Social Security Administration determination of disability
- Social Security Administration determination of cessation of disability

The notification must include:

- name
- relationship to the employee
- a description of the qualifying event

When COBRA ends

COBRA coverage ends when one of the following events occurs:

- the COBRA period - 18, 29, or 36 months - ends
- premiums are not paid on a timely basis
- NYU stops offering any group health plan
- the person who elected COBRA becomes covered under another group medical plan and meets any **pre-existing condition** prohibitions or limitations
- the person who elected COBRA becomes entitled to **Medicare** after COBRA coverage has started

Conversion rights

If you or your eligible dependents do not elect COBRA coverage when eligible, you may convert to a different individual policy within 45 days after coverage ends. You should contact Oxford Health Plans, Inc. directly for more information.

If you elect COBRA coverage, you or your eligible dependents may arrange for conversion, if available, without providing proof of good health, after COBRA coverage ends.

Premiums for the converted policy are determined by the insurance company and are based on your level of coverage.

Administrative information

The information presented in this summary plan description is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA).

If there is any inconsistency between the SPD and the plan document, the plan document governs.

Subrogation

If you receive reimbursement from a third party for covered expenses as a result of legal action taken to recover your loss, which was due to negligence, wrongful acts, or omissions, Oxford reserves the right to repayment of benefits paid for the same covered expenses.

In addition, if you or your covered family member suffers an injury or sickness as a result of a negligent or wrongful act or omission, Oxford reserves the right to seek reimbursement (where permitted by law) from that third-party for benefits it paid for covered expenses. In such case, you are obligated to provide Oxford with any information necessary to enforce its rights under this provision.

ERISA rights

As a participant with Oxford HMO coverage, you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- examine, at the plan administrator's office and other specified locations, including work sites and union halls, if applicable, without charge, all plan documents governing the plan. These documents may include insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, after sending a written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. You may be asked to pay a fee for the copies.
- receive a written summary of the plan's annual financial report. The plan administrator is required by law to provide each participant with a copy of this summary annual report.
- 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 documents governing the plan on the rules governing your COBRA continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request COBRA continuation coverage before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties on the people responsible for the operation of the plan. The people who operate your plan, called "fiduciaries," have a duty to do so prudently and in the best 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 benefit or exercising your rights under ERISA.

If your claim for a 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.

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in 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 because of reasons beyond the administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If plan 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 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 sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your plan, contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.

Plan sponsor

New York University

c/o NYU Benefits Office

7 East 12th Street, 2nd Floor

Campus Mail Code: 8923

New York, NY 10003-4475

Phone: (212) 998-1270 (M-Th 9am-5pm, F 9am-12pm)

Email: benefits@nyu.edu

Web site: www.nyu.edu/hr

NYU Benefits Resource Center: www.home.nyu.edu

Plan name

Oxford HMO, a component of the New York University Health and Welfare Plan

Type of administration

Third Party Administration

Plan administrator

The plan administrator has the authority to control and manage the operations and administration of each plan. You can reach the administrator at:

Oxford Health Plans, Inc.

P. O. Box 7081

Bridgeport, CT 06601-7081

Phone: 1-800- 444-6222

www.oxfordhealth.com

Email: via www.oxfordhealth.com, click on 'Contact Us'

Employer Identification Number (EIN)

The EIN is 13-5562308.

Plan number

The plan number is 501.

Plan year

The plan year is January 1 to December 31.

Source of benefits funding

NYU pays the cost.

Agent for service of legal process

Office of Legal Counsel

New York University
Elmer Holmes Bobst Library
11th Floor
70 Washington Square South
New York, NY 10012

Pharmacy network

Caremark, Inc.

P.O. Box 659529
San Antonio, TX 78265-5529
Phone: (800) 421-5501
www.caremark.com
customerservice@caremark.com

Mail order prescription drug provider

Caremark Mail Order Pharmacy

P.O. Box 659529
San Antonio, TX 78265-5529
Phone: (800) 421-5501
www.caremark.com
customerservice@caremark.com

Mental health and Substance abuse network

Oxford Inc

Behavioral Health Line
(6 a.m. - 6 p.m., Mon - Fri)
Phone: 1-800-201-6991
www.oxfordhealth.com

Contacts

For COBRA

EBPA

P.O. Box 1150
Exeter, NH 03833-1150
Phone: (800) 258-7298
Or
NYU Benefits Office
7 East 12th Street, 2nd Floor
Campus Mail Code: 8923
New York, NY 10003-4475
Phone: (212) 998-1270 (M-Th 9am-5pm, F 9am-12pm)
Email: benefits@nyu.edu
Web site: www.nyu.edu/hr
NYU Benefits Resource Center: www.home.nyu.edu

For converting your coverage

Oxford, Inc. Member Services

Phone: 1-800-444-6222

To locate participating providers in the Oxford HMO Freedom network

Log on to www.oxfordhealth.com if you are enrolled in the plan.

Phone: Member Services at 1-800-444-6222
Visit the Benefits Resource Center web site and click on Provider Directories.

Getting preapproval for mental health and substance abuse

Oxford, Inc.

Behavioral Health Line
Phone: 1-800-201-6991

Issues with claims

Oxford HMO, Inc

Member Services
Phone: Member Services at 1-800-444-6222
Mail: Oxford Health Plans
P.O. Box 7081
Bridgeport, CT. 06601-7081

Mail-order program

Caremark Mail Order Pharmacy

P.O. Box 659529
San Antonio, TX 78265-5529
Phone: (800) 421-5501

Prescription drug network provider

Caremark, Inc.

P.O. Box 659529
San Antonio, TX 78265-5529
Phone: (800) 421-5501
www.caremark.com
customerservice@caremark.com

The following terms are highlighted throughout the SPD as having definitions. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of your benefit plans.

Definitions

Adverse benefit determination

Any of the following that results in the denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit:

- Based on determination of a participant's or beneficiary's eligibility to participate in a plan
- Resulting from the application of any utilization review
- Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate
- Restrictions on reimbursements for services because classified as nervous or mental

After-tax premium deductions

Contributions taken from your pay after applicable federal, state and local taxes are withheld.

Alternate facility

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

- surgical services,
- emergency health services, or
- rehabilitative, laboratory, diagnostic, or therapeutic services.

An alternate facility may also provide mental health services or substance abuse services on an outpatient or inpatient basis.

Brand-name drug

Protected by a patent issued to the original company that invented or marketed the drug.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal law that allows eligible people covered by a group health plan to temporarily extend coverage when their coverage would otherwise end, such as when they get divorced or leave employment.

Coinsurance

A percentage of expenses that you are responsible for paying.

Copay

The flat dollar amount you pay for a certain type of health care expense.

Custodial care

General assistance in performing the activities of daily living, as well as board, room and other services, generally provided on a long-term basis and that do not include a medical component.

Deductible

The amount of out-of-pocket expenses you must pay for service before the plan pays any expenses.

Disability

A condition that causes you to be unable to perform one or more regular job duties.

Discounted fees

Lower fees charged for certain services received through network providers. The plan negotiates these lower fees with providers and facilities affiliated with the claims administrator's network.

Domestic partners

Two people who:

- agree to be jointly responsible for each other's common welfare and to share financial obligations
- live together in a long-term relationship of indefinite duration
- are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside

To apply for coverage for your domestic partner, register your domestic partner with the NYU Benefits Office.

Effective date

The earliest of:

- the date coverage begins
- the first day after the plan's waiting period

Employee

A person the University hires to do a job or activities that are controlled by the University (when, where and how to do the job).

Family and Medical Leave Act (FMLA)

Job protection and limited benefits for up to 12 weeks if you are seriously ill or injured, for the birth, adoption or foster care placement of a child, to care for the child, or to care for a sick spouse, child or parent.

Full-time

Employees who are scheduled to work for the University for the full, normal work week.

Generic drug

A drug that generally contains the same ingredients and has the same effect as a brand-name drug, but is manufactured by a company other than the one that manufactures the brand-name drug.

Group health coverage

Health plans designed to provide benefits to a specific group of people, like a University, union or professional organization.

HIPAA certificate of creditable coverage

Documentation confirming your last 18 months of health coverage that can help you get coverage without a pre-existing condition exclusion.

Hospital

An institution rendering inpatient and outpatient services for the medical care of the sick or injured. It must be accredited as a hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association. A hospital may be a general, acute care or specialty institution provided that it is appropriately accredited as such, and currently licensed by the proper state authorities.

Inpatient

When you are admitted to the hospital and stay more than 24 hours.

In-network provider

A doctor, hospital, or other health care professional facility affiliated with the network.

Medical identification card

A card your health plan sends you that contains information your physician needs to process your medical expenses.

Medically Necessary

Services and supplies that are performed in a cost-efficient manner to meet the basic health care needs of you and your covered family members, as determined by the claims administrator. Treatment is considered medically necessary if care or treatment is likely to produce a significant positive outcome, result in information that could affect the course of treatment, and is no more costly (taking into account all health expenses incurred in connection with the treatment) than any alternative treatment for the disease or injury involved. In determining whether a treatment is medically necessary, the claims administrator considers the following:

- information that is provided on the covered person's health status,
- reports in peer-reviewed medical literature,
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, and treatment
- the opinion of health professionals in the general recognized health specialty involved, and
- any other relevant information brought to the claims administrator's attention

Medicare

The U.S. federal government's plan, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those over 65 or totally and permanently disabled. Benefits are provided regardless of income level. The program is government subsidized and government operated.

Notification date

When you are told about an event related to your benefits. Also, the date you notify the plan administrator of an event that may result in a change in election, such as marriage.

Open enrollment

The period of time each year designated by the University when you may generally make changes to your benefit elections, if allowed by the plan.

Out-of-network provider

A doctor, hospital, or other health care professional or facility that is not a member of the network.

Outpatient

When you visit a clinic, emergency room or health facility and receive health care without being admitted as an overnight patient.

Part-time

Employees who are scheduled to work less than the normal work week.

Physician

Any Doctor of Medicine, 'M.D', or Doctor of Osteopathy, 'D.O.", who is properly licensed and qualified by law. Any podiatrist, dentists, 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 this plan

describes a provider as physician does not mean that benefits for services from that provider are available to you under the plan.

Post-service claim

Claims that involve only the payment or reimbursement of the cost of medical care that has already been provided, and any other claims for benefits that is not a pre-service claim, for example, claims for reimbursement for already performed diagnostic tests.

Pre-certification

Authorization you may need to receive full benefits.

Pre-existing condition

A health problem you had and received treatment for before your current benefit elections took effect.

Pre-service claim

Any claim for a benefit with respect to the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Primary care physician (PCP)

A doctor you choose who is responsible for coordinating your medical care, from providing direct care to referring you to specialists and hospital care.

Primary plan

The plan that covers you first when you have coverage under more than one plan.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order that meets all of the following criteria:

- is issued by a court pursuant to a domestic relations law or community property law
- creates or recognizes the right of an alternate recipient to receive benefits under a parent's employer's group or health plan
- includes certain information relating to the participant and alternate recipient

Qualifying status change

A qualifying status change occurs when: your marital status changes (or you register or revoke a domestic partnership), you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, permanent or temporary custody of a child), your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries), a court decree that orders you must provide health coverage for your dependent, your or your dependent's work site changes, your or your dependent's residence changes, your dependent's Medicare/Medicaid eligibility status changes, your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's, coverage under your spouse's/partner's plan is significantly curtailed or ceases, your spouse's/partner's employer adds new health plan options, NYU adds new health plan options, your provider of dependent care changes, your cost for dependent care significantly increases or decreases, or you or your spouse/partner commences or returns from an FMLA leave.

The term "dependent" refers to any of the following as defined by the plan: your spouse, your domestic partner that you have registered with the NYU Benefits Office, your child, your step-child, your adopted child or child placed with you for adoption, or the child of your registered domestic partner, a child for whom you have been appointed legal guardian, a child for whom you have been awarded permanent or temporary custody.

Regular employee

An exempt or non-exempt employee who works on an ongoing basis instead of a temporary basis.

Reimburse

When you are paid back for money you spend on approved expenses.

Secondary plan

The plan that is second in responsibility under coordination of benefits when you have coverage under more than one plan.

Section 125

A of the Internal Revenue Code that allows you to pay for certain benefits with pretax dollars, and regulates enrollment and eligibility requirements for these benefits.

Service area

The geographic area established by this plan and approved by the regulatory authority, in which you must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in this plan.

Specialist

A physician who practices in a certain area of medicine like surgery, obstetrics or gynecology rather than dealing with all aspects of your health.

Spouse

Your husband or wife, married to you in a civil or ecclesiastical ceremony.

Temporary employee

Someone who is hired, usually through an agency on a per diem basis, for a short period of time. May or may not have a contract for the specific work period.

Termination date

The last day you are scheduled to work.

Total disability

An illness or injury that prevents you from continuously performing every duty pertaining to your job or from engaging in any other type of work for pay.

Urgent care claim

Claims for medical care or treatment that if processed under normal claims decisions could seriously jeopardize the claimant's life or health, jeopardize claimant's ability to regain maximum function, or subject claimant to severe pain that cannot be managed without the care or treatment that is the subject of the claim.