

2007

New York University Point-of-Service Plan

Summary Plan Description

Participants

Non-Union Service Staff

This page is blank.

Table of Contents:

Introduction	3
Eligibility.....	3
Enrollment	5
Cost	6
How the plan works	9
Covered expenses	12
Restrictions and exclusions	18
Coordination of benefits.....	22
Filing a claim	23
When coverage ends.....	27
Administrative information	30
Contacts	35
Definitions	38

Introduction

The university gives you the option to choose a medical plan that works best for you and your eligible dependents. You can choose either the Point-of-Service plan or a health maintenance organization (HMO) - one or more may be available in your area.

This Point of Service (POS) plan gives you the freedom to seek care from any UnitedHealthcare Network provider or facility without a referral. With this plan, you will receive the highest level of benefits when you seek care from a UHC Network provider or facility. In addition, you do not have to worry about any claim forms for in-network care. You may also choose to seek care outside the UHC Network, without a referral. However you should know that care received from a non-UHC network physician, facility or other health care professional means you must satisfy a deductible and higher out-of-network expense. If you choose to seek care outside the UHC Network, your plan only pays a portion of those charges and it is your responsibility to pay the remainder. Reasonable and customary is the typical charge for a specific procedure in a specific geographic region. This amount you are required to pay above R&C, which could be significant, does not apply to the out-of-pocket maximum.

You will need to satisfy the requirements described in this summary plan description (SPD) to receive POS 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 POS 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 Non-Union Service Staff

Eligible dependents

You can cover certain dependents under POS 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 POS 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 POS coverage. If you do not complete an enrollment form when you first become eligible for coverage, you will receive default individual medical coverage in the NYU Point-of-Service plan.

When coverage begins

Once enrolled, you and your eligible dependents' POS 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 POS 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.

Types of coverage

When you enroll in one of the NYU medical plan options, you may choose from the following:

- Employee only;
- Employee plus spouse or registered domestic partner;
- Employee plus child (or children); or
- Employee plus spouse or registered domestic partner, plus child (or children).

Making changes

You may change POS 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 POS 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 POS 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

You and NYU share the cost of your healthcare. Your cost includes a monthly contribution from your paycheck, depending on your coverage level, as well as any deductible, copays and coinsurance amounts that may be required by the plan.

Monthly contributions

You and NYU share the cost of coverage. If you cover yourself only or yourself, NYU pays the full cost of coverage. If you cover yourself plus your spouse or domestic partner, yourself plus one child, or yourself plus your spouse or domestic partner plus one or more children under the POS plan, you pay a small part of the cost of coverage.

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. A deductible does not apply to in-network expenses. However, you must satisfy an annual deductible for out-of-network expenses.

Please Note: Expenses for in-network care - for example, copays and coinsurance - do not apply toward the out-of-network deductible.

Individual deductible

The individual deductible applies to out-of-network care for each covered person. Once you meet the individual deductible, the plan begins paying benefits. The out-of-network deductible is \$400.

Family deductible

To meet the family deductible, one family member must meet the individual deductible, and the expenses of other family members can be combined to meet the balance of the family deductible. The out-of-network family deductible is \$1,000.

Copay

The copay is the flat dollar amount you pay for certain expenses. The plan has a lower copay for services received from a physician who is part of the NYU Medical Center's University Physician's Network who is a member of UnitedHealthcare's (UHC) Choice Plus Network than for services by non-NYU physicians who are part of UHC's Choice Plus Network. Once you pay your copay for a service, the plan pays 100% of the remainder. The copay does not get credited toward meeting your annual deductible or out-of-pocket limit. The copays under the POS coverage apply to:

- emergency room visits (waived if admitted)
- in-network allergy testing and treatment
- in-network annual OB/GYN exams
- in-network chiropractic care
- in-network office visits
- in-network outpatient mental health and substance abuse care
- in-network outpatient short-term physical/occupational/speech therapies
- in-network PCP/Specialist visits
- in-network routine eye exams
- in-network routine hearing exams
- in-network routine physical exams
- in-network well child care and immunizations

Coinsurance

Coinsurance is a percentage of expenses that a person is responsible for paying after meeting the deductible. If you use a network provider, POS coverage pays 90% of covered expenses (unless a copay applies). If you do not use a network provider, the plan pays 80% of R&C charges after you meet the deductible, and you pay the remaining amount. Once you reach the annual out-of-pocket limit, the plan pays 100% of covered expenses for the remainder of the calendar year.

Penalties

Pre-certification is required for certain services. For in-network services your physician or facility is required to obtain pre-certification. For out-of-network services you are required to obtain the pre-certification in order to receive the full benefit amount. If you do not obtain the required pre-certification a \$400 penalty will apply to certain services. Refer to the **pre-certification** section for more information.

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. POS coverage has different individual and family out-of-pocket limits for in- and out-of-network coverage. Once you reach the individual or family out-of-pocket limit, the plan pays 100% of in-network covered costs and 100% of R&C out-of-network covered costs, for the rest of the calendar year. Refer to the **Reasonable and customary amounts** section for more information.

Expenses that count toward your annual out-of-pocket limit include:

- coinsurance
- deductibles

These expenses do not apply to the out-of-pocket limit:

- charges that exceed individual benefit maximums
- plan penalties
- charges when copays apply
- prescription drug benefits

Individual out-of-pocket limit

The individual out-of-pocket limit applies to each covered person. The in-network out-of-pocket limit is \$2,000 per year. The out-of-network out-of-pocket limit is \$6,000 per year.

The out-of-pocket limits for in-network and out-of-network care cross-apply. For example, assume you've paid \$4,000 in out-of-network covered expenses - this amount would apply to the out-of-network annual out-of-pocket limit of \$12,000. However, since the out-of-pocket limits cross-apply, the \$1,000 would also apply to the in-network annual out-of-pocket limit of \$1,000. That means you've met the in-network out-of-pocket limit and the plan will pay 100% for any additional in-network covered expenses you have during the calendar year.

Family out-of-pocket limit

To meet the family out-of-pocket limit, one family member must satisfy the individual out-of-pocket limit, and the expenses of other family members can be combined to satisfy the balance of the family out-of-pocket limit. The family out-of-pocket limit is \$4,000 for in-network expenses and \$12,000 for out-of-network expenses.

Annual benefit maximums and visit limits

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

- acupuncture - 14 sessions per calendar year for out-of-network services
- chiropractic care - 38 visits per calendar year (combined for in-network and out-of-network services)
- home health care - 200 visits per calendar year (combined for in-network and out-of-network services)
- hospice care - 210 days per lifetime (combined for in-network and out-of-network services)
- inpatient mental health and substance abuse - 60 days per calendar year (in-network) or 30 days per calendar year (out-of-network) with a lifetime maximum of 730 days (combined for in-network and out-of-network services)
- outpatient mental health and substance abuse - 30 visits per calendar year (combined for in-network and out-of-network services)
- speech therapy - 35 outpatient sessions per calendar year (out-of-network care).

Once you receive benefits for the maximum number of visits allowed by the plan in a calendar year, you pay 100% of the costs of any remaining visits in the calendar year. Visits beyond the calendar year maximum do not go against the plan's deductible or out-of-pocket maximum. You receive a new allowance of visits for each new calendar year.

Lifetime maximum benefit

The lifetime maximum benefit is the limit the plan will pay in each covered person's lifetime. POS coverage has no lifetime maximum for in-network benefits, but there is a lifetime maximum of \$1,000,000 for out-of-network benefits.

How the plan works

In-Network

Network of doctors and hospitals

You get the higher level of benefits when you receive care from network providers namely:

- There is no deductible to meet.
- You have lower out-of-pocket costs.
- You pay a copay each time you visit your Primary Care Physician (PCP) or any other UHC specialist. You pay \$5 each time you visit an NYU Medical Center doctor who is part of the Medical Center's University Physicians Network (UPN) and is a member of the UnitedHealthcare network. You pay \$10 each time you visit any other UnitedHealthcare network doctor.
- In-network providers charge discounted fees for services negotiated with UHC.
- The plan pays a greater percentage of coinsurance for covered expense than it does for expenses incurred out-of-network.
- Pre-certifications are handled by your network provider.
- There are no claim forms to file.
- The lifetime maximum for in-network care received under the plan is unlimited.

Locating providers in UnitedHealthcare's 'Choice Plus' network

Online

Before you are enrolled in the plan:

You can find participating providers by searching UnitedHealthcare's online provider directory at www.uhc.com and click on the 'Find a Physician' link at the top of the page and click on 'Search the General Physician Directory' in the middle of the page. The search criteria will require that you select a health plan so scroll down to 'UnitedHealthcare Choice Plus' which includes general practitioners, as well as specialists and hospitals.

After you are enrolled in the plan:

You can locate network providers and access your personalized health care and benefits information online at www.myuhc.com. Follow the prompts through the short registration process. Once you log in click on the Physicians and Facilities tab at the top of the page and then click on 'Find a Provider'.

At any time, you can also visit the NYU Benefits Resource Center web site and click on Provider Directories.

Telephone

You can call UnitedHealthcare's Member Services Department at 866-633-2474 to locate a network provider.

Primary care physician

A primary care physician provides preventive and routine care such as office visits and diagnoses, and refers you to specialists and hospitals as needed. A primary care physician can be an internist, a family or general practitioner, or a pediatrician for children.

The POS plan is an open access plan and you are not required to designate a primary care physician (PCP). You can use the services of any network provider or facility without a referral from a PCP. However, there can be advantages to using the services of a network PCP such as:

- The network PCP knows your family and medical history, lifestyle and habits; treats you as a whole person; diagnoses and treats minor, uncomplicated illnesses and injuries.

- If you wish, the network PCP coordinates your care and acts as an expert guide to the medical system.
- You will have a lower copay when you see your network PCP than if you see a network specialist.

Each family member may choose a different physician to be his or her network PCP

Selecting or changing primary care physicians

If you and your covered dependents want to locate a primary care physician, you can visit UnitedHealthcare's web site at www.uhc.com or www.myuhc.com or call UHC's Member Services Department. NYU's Point-of-Service plan uses the 'Choice Plus' Network. There is no need to contact UHC when you first select or change a PCP. However, it is a good idea to contact the PCP and confirm they are accepting new patients.

Network of mental health and substance abuse providers

To find a network mental health or substance abuse provider, you first have to contact, United Behavioral Health, the mental health and substance abuse network under UnitedHealthcare. Before seeking treatment, obtain pre-certification by calling UnitedHealthcare at 866-633-2474 and follow the prompt to United Behavioral Health. You will speak to a master's level clinician who will assess your needs and refer you to a local provider who has experience dealing with situations such as yours. Note: All calls to United Behavioral Health are confidential.

If you are using out-of-network mental health or substance abuse providers, you do not have to call United Behavioral Health prior to treatment.

Network of retail and mail-order pharmacies

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

Out-of-network

If you choose to receive out-of-network care, you may go to any doctor you choose. For out-of-network care:

- You must meet the annual deductible before the plan starts paying benefits.
- You pay a percentage of the reasonable and customary (R&C) cost for care after the deductible is met.
- You pay the provider's charges usually at the time of service and then submit a claim form in order to be reimbursed.
- The plan pays a lower percentage for covered out-of-network expenses than it does for expenses incurred in-network.
- You must arrange pre-certification for non-emergency hospital stays and certain outpatient procedures by calling UnitedHealthcare at 866-633-2474. If you do not call to pre-certify, the plan will not cover the first \$400 of reasonable and customary expenses you incur. Please note: These non-covered amounts will not apply toward your deductible or out-of-pocket maximum.
- For emergency hospital admissions, you or someone on your behalf must call UnitedHealthcare at 866-633-2474 within 24 hours in order to receive the in-network level of benefits for an emergency admission.

Out-of-network lifetime maximum

The maximum dollar amount the New York University Point-of-Service Plan will pay for out-of-network care during your lifetime and that of each covered family member is \$1,000,000 per covered person.

Out-of-network pregnancy care

You need to call for pre-certification before the end of your first trimester (12 weeks) of pregnancy so UnitedHealthcare can identify whether you will need any special care while hospitalized, for example, if you have a high-risk pregnancy. A registered graduate nurse (RN) will certify your admission and any special care, if needed. If you are hospitalized before your expected delivery date, you or a family member needs to call UnitedHealthcare within 24 hours after delivery at 866-633-2474.

Reasonable and customary vs. discounted fees

Discounted fees are lower fees charged for in-network services, which UnitedHealthcare negotiates with providers affiliated with its Choice Plus network.

Reasonable and customary (R&C) charges apply to certain services received out-of-network and are based on the typical charge made by most providers for similar services or supplies in that particular geographic area. If the charge for services or supplies is more than the R&C limit set by the claims administrator, you will have to pay your provider the amount of charges above the R&C limit, in addition to applicable deductible and coinsurance amounts. Any amounts above R&C do not apply to the plan's out-of-pocket maximum.

When to seek pre-certification

In general, network providers are responsible for notifying UnitedHealthcare before they provide certain services to you. However, you are responsible for notifying UHC for pre-certification of out-of-network care for the following conditions:

- Dental services - accident only
- Durable medical equipment over \$1,000 - purchase or rental of any single item of durable medical equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item)
- Emergency health services if you are admitted to a non-network hospital
- Home health care
- Hospice care
- Hospital in-patient stay
- Maternity: In-patient stay of a mother and/or the newborn that will be more than:
 - 48 hours for the mother and newborn child following a normal vaginal delivery or
 - 96 hours for the mother and newborn child following a cesarean section delivery.
- Reconstructive procedures
- Skilled nursing facility - elective admissions to a skilled nursing facility or inpatient rehabilitation facility
- Transplant services - notify UHC as soon as the possibility of a transplant arises (and before the time a pre-transplant evaluation is performed at a transplant center)

Extension of your hospitalization or ongoing medical treatment

To request an extension of your ongoing treatment or your inpatient hospitalization beyond the length of time that was initially approved, you or someone on your behalf should contact UnitedHealthcare at 866-633-2474.

If your request for an extension of treatment or hospitalization involves urgent care, the plan will make a benefit determination within 72 hours after receipt of your request. For non-urgent treatment which requires pre-certification, UnitedHealthcare will notify you within 15 days after the receipt of your claim.

Coverage when you are away from home

Coverage when you are traveling

When you are traveling or temporarily away from home, you can continue to receive care through the network. If you have access to the internet you can log on to www.myuhc.com and search for a health care provider in your temporary location or you can call member services at 866-633-2474.

If you receive care from an out-of-network provider you will be covered at the out-of-network benefit level for non-emergency care. Emergency coverage is always available as long as you contact the claims administrator within 24 hours after receiving treatment.

Coverage when your child is away at college

If there is not a network provider within 25 miles of your child's location, contact the claims administrator who will work with you to coordinate care at the in-network level.

Coverage outside of the United States

Outside of the United States, the plan will pay at the out-of-network benefit level.

Covered expenses

In order for a specific service to be covered under this plan it must be medically necessary for the prevention, diagnosis or treatment of your illness or condition. Certain services must be pre-certified. In-network participating providers are responsible for obtaining pre-certification. Out-of-network you are responsible for obtaining pre-certification.

Preventive Care

Physical exams for adults

Annual routine physical exams for adults are covered by the plan for services provided in-network. Out-of-network routine physical exams are not covered by the plan.

Physical exams for children

Annual routine physical exams for children are covered by the plan for services provided in-network. Out-of-network routine physical exams, immunizations and vaccinations are not covered by the plan.

Pap smears

Annual routine Pap smears are covered by the plan when obtained in-network. The plan does not cover routine Pap smears if you go out-of-network. 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

Annual routine mammograms are covered when obtained in-network. Out-of-network you are covered for one mammogram per year and you pay the standard coinsurance percentage.

Prostate specific antigen test - PSA

Annual routine prostate specific antigen (PSA) tests are covered by the plan when obtained in-network. The plan does not cover routine prostate specific antigen (PSA) tests if you go out-of-network. 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. Out-of-network routine exams are not covered by the plan.

Routine hearing exams

Routine hearing exams are covered when performed by your PCP as part your annual routine physical exam. Out-of-network routine exams are not covered by the plan.

Specialist care

Office visits to specialists are covered. A referral from a PCP is not 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.

Outpatient treatment is covered.

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 plan's allowance for a semi-private room.

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 during the same operative session, special payment rules apply. The expense for each surgical procedure is considered individually and the plan will pay for each covered procedure as follows: 100% for the primary surgical procedure, 50% for the secondary surgical procedure, and 50% for each additional surgical procedure.

Second surgical opinion

Second surgical opinions are not required by the plan to obtain benefits. The plan covers second surgical opinions.

Reconstructive surgery

The plan covers reconstructive surgery when the purpose is to improve the function of a part of the body that is malformed as a result of a severe birth defect, including harelip, webbed fingers or toes, or a malformation as a direct result of disease or surgery.

Hospice

Inpatient and outpatient 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;
- Bereavement counseling for family members by a licensed clinical social worker (or a licensed pastoral counselor, except when administered to a member of his or her congregation).
- Charges made by a hospice care agency for: part-time or intermittent nursing care by a registered nurse or licensed practical nurse, for up to eight hours in any one day; medical social services under the direction of a physician; psychological and dietary counseling; consultation or case management services by a physician; physical and occupational therapy; part-time or intermittent home health care aide services for up to eight hours in any one day, consisting mainly of caring for the person; and medical supplies, drugs, and medicines prescribed by a physician.

Physical therapy/rehabilitation

Physical therapy 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 UnitedHealthcare.

Skilled nursing facility

The plan covers services received in a convalescent facility.

Outpatient care

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 during the same operative session, a special payment rule applies. The expense for each surgical procedure is considered individually for each covered procedure as follows: 100% for the primary surgical procedure, 50% for the secondary surgical procedure, and 50% for each additional surgical procedure.

Second surgical opinion

Second surgical opinions are not required by the plan to obtain benefits. The plan covers second surgical opinions.

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 when received from a licensed medical doctor is covered.

Alternative care (see acupuncture and chiropractic care)

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

Some treatment of mouth, jaws, and teeth is covered and pre-certification is required. Covered expenses for treatment received out-of-network from a physician or dentist for teeth, mouth, jaws, jaw joints, or supporting tissue (bones, muscles, and nerves) include surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:
 - Teeth partly or completely impacted in the bone of the jaw;
 - Teeth that will not erupt through the gum;
 - Other teeth that cannot be removed with cutting into the bone;
 - The roots of a tooth without removing the entire tooth;
- Cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases is covered. However, this does not include those of or related to the teeth.

Covered services also include: dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition sound and natural teeth which have been damaged, lost, or removed, or other body tissues of the mouth which have been fractured or cut due to injury, under the following conditions:

- Any affected teeth must be either free from decay or in good repair and firmly attached to the jaw bone at the time of the injury.

- The treatment must be done in the calendar year of the accident or the next one.
- Crowns, dentures, bridgework, or in-mouth appliances are installed due to such injury, covered medical expenses include only charges for:
 - The first denture or fixed bridgework to replace lost teeth;
 - The first crown needed to repair each damaged tooth; and
 - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

In-network services are not covered. Out-of-network you pay the standard coinsurance amount after you satisfy the annual deductible; a penalty applies if you do not obtain pre-certification.

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

If long-term use is planned and the equipment either cannot be rented or is likely to cost less if purchased, then covered expenses include the purchase, repair, and replacement of durable medical and surgical equipment, as well as accessories needed for its operation, as determined by the claims administrator. Durable medical equipment includes 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

The plan covers immunizations or vaccinations for your child in-network when obtained from a network provider. The plan does not cover immunizations or vaccinations out-of-network.

Infertility treatment

Coverage for infertility treatment is limited to the diagnosis and treatment of the underlying condition and includes surgery and drug therapy. Drug therapy is covered through Caremark (see Prescription Drugs).

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 UnitedHealthcare 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 surgery, radiation therapy, or other treatment which affects the vocal

chords; cerebral thrombosis (cerebral vascular accident); brain damage due to accidental injury or organic brain lesion (aphasia).

Speech therapy is covered by the plan for children under age three whose speech is impaired due to infantile autism; developmental delay or cerebral palsy; hearing impairment; or major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.

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.

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. Specifically, coverage is not provided for the following:

- Expenses incurred before you or your dependents become covered under the plan.
- Expenses incurred after your or your dependents coverage ends under the plan.
- Expenses that a covered person has no legal responsibility to pay.
- Services and supplies that are not medically necessary, as determined by the claims administrator. This applies even if the services and supplies are prescribed, recommended, or approved by your health care provider.
- Services or supplies that are not prescribed, recommended, and approved by your health care provider.
- Services or supplies that are, as determined by the claims administrator, experimental or still under clinical investigation by health professionals.
- Exams or treatments ordered by a court in connection with legal proceedings, unless these exams or treatments otherwise qualify as covered expenses.
- Services and supplies that any school system is required to provide under any law.
- Expenses covered by the Workers' Compensation Act or similar federal or state legislation.
- To the extent allowed by law of the jurisdiction where the group contract is delivered, charges for services and supplies that are provided by, paid for, or for which benefits of any person in the armed forces of a government, or under any law of a government. This does not include a plan established by a government for its own employees or their dependents, or Medicaid.
- Services or supplies received as a result of declared or undeclared war or international armed conflict.
- Expenses for items provided for your personal convenience or comfort.
- Services given by volunteers or persons who do not normally charge for services.
- Telephone consultations.
- Services performed by a provider who is your family member by birth or marriage, including your spouse (or registered domestic partner), brother, sister, child, parent or grandparent. This includes any service the provider may perform on himself or herself.
- Ecological or environmental medicine, diagnosis, and/or treatment.
- Herbal, holistic, or homeopathic care, including drugs.
- Nutritional counseling, surgical correction, or other treatment, unless for diabetes.
- Sensitivity training, educational training therapy, or treatment for an educational requirement.

- Education, special education, or job training, whether or not given in a facility that also provides medical or mental health treatment.
- Services of a resident or intern.

Preventive care exclusions

The following services are not covered by the plan if performed by an out-of-network provider:

- routine physical exams;
- immunizations and vaccinations;
- routine eye exams;
- routine hearing exams; and
- routine dental exams;
- treatment of tobacco dependency;
- weight reduction or control (unless there is a diagnosis of morbid obesity);
- special foods, food supplements, liquid diets, diet plans, or any related products; and
- membership costs for health clubs, weight loss clinics, and similar programs.
- sensitivity training, educational training therapy, or treatment for an educational requirement.
- education, special education, or job training, whether or not given in a facility that also provides medical or mental health treatment.
- therapy, supplies, or counseling for sexual dysfunction or inadequacies.
- treatment of gender identity disorders.
- marriage, family, child, career, social adjustment, pastoral, or financial counseling.

Inpatient care exclusions

Inpatient services including: any charge for daily room and board in a private room over the amount the plan covers for semi-private room charges; private duty nursing; custodial care; confinement in a special area of a hospital which provides non-acute care, including, but not limited to, the type of care given by an adult or child day care center; a halfway house; a treatment center; or a vocational rehabilitation center; and any other area of a hospital which provides services on an inpatient basis for non-acute care of sick, injured or pregnant persons.

Surgery

- Plastic surgery, reconstructive surgery (in some cases), cosmetic surgery or other services and supplies which alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:
 - Improve the function of a part of the body that is not a tooth or structure that supports the teeth, or is malformed as a result of severe birth defect, including harelip or webbed fingers or toes, or as a direct result of disease or surgery performed to treat a disease or injury;
 - Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year;
 - Abdominoplastys, except for reconstructive surgery;
 - Breast reduction surgery;
 - Chelation surgery, except to treat heavy metal poisoning;
 - Liposuction; and
 - Sex change operations or treatment of gender identity disorders.

Hospice

Hospice related charges that are not covered include:

- funeral arrangements;
- homemaker or caretaker services (services not solely related to the care of the covered person); and
- pastoral, financial or legal counseling (including estate planning or the drafting of a will).

Physical therapy/rehabilitation

The plan does not cover supplies associated with inpatient physical therapy.

Skilled nursing facility

The plan does not cover skilled nursing facility charges that include expenses related to:

- drug addiction;
- chronic brain syndrome;
- alcoholism;
- senility;
- mental retardation; or
- any other mental disorder

Outpatient care exclusions

Home health care

The plan does not cover the following home health care expenses:

- funeral arrangements;
- pastoral, financial, or legal counseling (including estate planning or the drafting of a will);
- services of a person who lives with you or is a member of your or your spouse's family;
- services of a social worker;
- services and supplies that are not part of a home health care plan; and
- transportation expenses.

Specialty care exclusions

Dental treatment

The following expenses for mouth, teeth and jaw are not covered by the plan:

- to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures, or bridgework for non-surgical periodontal treatment;
- in-mouth scaling, planning, or scraping;
- myofunctional therapy - muscle training therapy or training to correct or control harmful habits;
- in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services except as provided for injury, whether or not the purpose of such services or supplies is to relieve pain;
- root canal therapy or dental cleaning;
- routine tooth removal (not needing cutting of bone), except as provided for accidental injury to sound and natural teeth;
- treatments of temporomandibular joint syndrome;

- care of, or treatment to, the teeth, gums, or supporting structures, to improve the ability to chew or speak, such as, but not limited to periodontal treatment; endodontic services; extractions; and implants.

Dialysis

Expenses for the operation of a dialysis machine, including the purchase of:

- blood;
- electricity;
- water;
- installation of electrical power;
- water supply or waste disposal system; and
- services of a person to assist in the use of the dialysis machine.

Infertility treatment

Procedures that facilitate a pregnancy but do not treat the cause of infertility, including, but not limited to artificial insemination, in-vitro fertilization, or embryo zygote, gamete, or ovum transfer procedures.

Prostheses

- Orthopedic shoes or other foot support devices; and
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair due to an accidental injury), hair transplants, hair weaving, or any drug, if the drug is used in connection with baldness - e.g., Rogaine®.

Speech therapy (outpatient short-term)

Speech therapy to refine a person's existing speech or to educate an individual whose speech has not yet developed. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as a result of a disease or injury.

Coordination of benefits

If you or a covered dependent is covered by another medical plan, New York University Point-of-Service Plan 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.

Filing a claim

How to file a claim

For in-network services, you do not need to submit a claim form and payment will be sent directly to your provider. For out-of-network services, you must follow the instructions below and send the required documentation to UnitedHealthcare.

These items must be submitted when filing a claim:

- Your name and social security number
- NYU's name and the NYU Point-of-Service Plan's contract number, which you'll find on the front of your NYU Point-of-Service Plan ID Card
- Patient's name and diagnosis
- Specific services or supplies provided
- Date the expenses were incurred
- Amount already paid to the provider, if any
- Your medical bills

Be sure to file a separate claim for each member of your family. Make copies of all itemized bills for your records.

You have 12 months from the date of service to file a claim.

You can get a claim form from this web site, www.nyu.edu/hr and click on Forms or from UnitedHealthcare at www.myuhc.com.

Notification and explanation of benefits

You will receive a detailed statement called an explanation of benefits, (EOB) after you file a claim. The EOB will explain the amounts that have been paid and what amounts have not been paid. The EOB will explain the reasons why a claim has not been paid. You will receive the EOB in the mail or you can log on to www.myuhc.com to see your EOBs.

For urgent care claims and pre-service claims, the plan administrator, UnitedHealthcare, will notify you of its benefit determination within the following time frames:

- 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification)
- 15 calendar days after receipt of a pre-service claim

For post-service claims (claims that are submitted for payment after receiving medical care), the plan administrator will notify you of an adverse benefit determination within 30 calendar days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For urgent care claims, if you fail to provide the plan administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the plan administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The plan administrator's receipt of the requested information
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For pre-and post-service claims, a 15-day extension may be allowed to make a determination, provided that the plan administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the plan administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is needed

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the plan's timeframe for making a benefit determination is stopped from the date the plan administrator sent you an extension notification until the date you respond to the request for additional information.

If you do not follow claims procedures

If you or your authorized representative fails to follow the plan's procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This only applies to a failure that:

- is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters.
- is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

If a claim is denied or reduced

If your claim for benefits is denied or reduced, you will be notified in writing of the reason for the denial. The notice will include:

Maximum timeframes for the plan to notify you of a denied claim:

- as soon as possible taking into account medical circumstances that require action but no later than:
- 72 hours for urgent care claims
- 15 days for pre-service claims
- 30 days for post service claims

Appealing a denied claim

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact UnitedHealthcare's member services department before requesting a formal appeal. If UnitedHealthcare's member services department cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination you may appeal it as described below, without first informally contacting UnitedHealthcare's member services department. If you first informally contact UnitedHealthcare's member services department and later wish to request a formal appeal in writing, you should contact UnitedHealthcare's member services department and request an appeal. If you request a formal appeal, a UnitedHealthcare's member services department representative will provide you with the appropriate address of UnitedHealthcare.

If you are appealing an urgent care claim denial, please refer to the **Urgent Claim Appeals that Require Immediate Action** section below and contact UnitedHealthcare's member services department immediately. UnitedHealthcare's member services department telephone number is shown on your ID card. UnitedHealthcare's member services department representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact UnitedHealthcare in writing to formally request an appeal. Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to UnitedHealthcare within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. UnitedHealthcare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information.

Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determination

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims, the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action."

If you are not satisfied with the first level appeal decision of UnitedHealthcare, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted to UnitedHealthcare in writing within 60 days from receipt of the first level appeal decision.

For pre-service and post-service claim appeals, we have delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the Plan. UnitedHealthcare's decisions are conclusive and binding.

Please note that UnitedHealthcare's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call UnitedHealthcare as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 72 hours following receipt by UnitedHealthcare of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the plan. UnitedHealthcare's decisions are conclusive and binding.

Voluntary External Review Program

If a final determination to deny benefits is made, you may choose to participate in our voluntary external review program. This program only applies if the decision is based on either of the following:

- clinical reasons.
- the exclusion for experimental, investigational or unproven services.

The external review program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits.

Contact UnitedHealthcare at the telephone number shown on your ID card for more information on the voluntary external review program.

Right of recovery

If for some reason a benefit is paid that exceeds the benefits provided by the POS 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 POS coverage ends at the end of the month following the date in which you terminate from the University. 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 New York University Point-of-Service Plan coverage. The impact depends on the type of leave that you take.

Leave of absence

Family Leave
Maternity Leave
Disability Leave

How your coverage is affected

Coverage continues; you must continue to pay your share of the cost of coverage during your leave.

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 POS 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

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

18 months

29 months

36 months (for dependents)

Reason coverage stops

Your employment ends
You transfer to a position that is not eligible for medical benefits

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.

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 UnitedHealthcare 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.

Assignment of benefits

When you file a claim, you can assign benefit payments to the provider of the service.

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, UnitedHealthcare 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, UnitedHealthcare 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 UnitedHealthcare with any information necessary to enforce its rights under this provision.

ERISA rights

As a participant with POS 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

New York University Point-of-Service Plan, 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:

UnitedHealthcare
P.O. Box 740 800
Atlanta, GA 30374-0800

Phone: (866) 633-2474
www.unitedhealthcare.com

Employer Identification Number (EIN)

The EIN is 13-5562308.

Plan number

The plan number is 175396.

Plan year

The plan year is January 1 to December 31.

Source of benefits funding

You and NYU pay 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

Claims administrator

UnitedHealthcare
P.O. Box 740 800
Atlanta, GA 30374-0800
Phone: (866) 633-2474
www.unitedhealthcare.com

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

United Behavioral Health, the mental health and substance abuse designee of UnitedHealthcare.

Phone: (866) 633-2474

Contacts

For appealing a claim

UnitedHealthcare
P.O. Box 740 800
Atlanta, GA 30374-0800
Phone: (866) 633-2474

For claim forms

This website, UnitedHealthcare at www.myuhc.com, NYU at www.nyu.edu/hr 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)

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

UnitedHealthcare
P.O. Box 740 800
Atlanta, GA 30374-0800
Phone: (866) 633-2474

To locate participating providers in the UnitedHealthcare Choice network

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

Log on to www.uhc.com if you are not currently enrolled in the plan,
Call (866) 633-2474
Visit the Benefits Resource Center web site and click on Provider Directories

For sending a completed claim

UnitedHealthcare
P.O. Box 740 800
Atlanta, GA 30374-0800
Phone: (866) 633-2474

Getting preapproval for mental health and substance abuse

United Behavioral Health, the mental health and substance abuse designee of UnitedHealthcare
Phone: (866) 633-2474

Getting preapproval for non-emergency services

UnitedHealthcare
P.O. Box 740 800
Atlanta, GA 30374-0800
Phone: (866) 633-2474

Issues with claims

UnitedHealthcare
P.O. Box 740 800
Atlanta, GA 30374-0800
Phone: (866) 633-2474
www.unitedhealthcare.com

Mail-order program

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

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 after you meet your deductible.

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.

Family deductible

The family deductible is an amount of money that you must pay out-of-pocket before your insurance will cover expenses. The deductible can be satisfied by the combined expenses of all covered family members. For example, a program with a \$100 deductible may limit its application to a maximum of three deductibles (\$300) for the family, regardless of the number of family members. Once the family deductible is met, no other covered member needs to satisfy the full individual deductible. An aggregate family deductible may be met by one or more family members.

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.

Individual deductible

The amount of covered expenses each covered individual is responsible for paying each year before the plan starts paying certain benefits.

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.

Out-of-pocket maximum

The maximum amount you have to pay toward the cost of your medical care in the course of one year. There are some exceptions to the out-of-pocket maximum.

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.

Reasonable and customary charges

Reasonable and customary (R&C) charges are set by the claims administrator, and apply to covered services. R&C charges are based on the typical charge made by most providers for similar services or supplies in your geographic area. If the charge for services or supplies is more than the R&C limit set by the claims administrator, you pay the portion above the R&C limit for any service covered by the plan for which R&C applies in determining the benefit you receive.

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 section 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.