New York University Retiree Health Reimbursement Arrangement

Summary Plan Description

Effective, January 1, 2022
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Introduction

This Health Reimbursement Arrangement (HRA) Summary Plan Description ("SPD") describes the New York University ("University") Health Reimbursement Arrangement Plan ("HRA Plan") in which you may be able to participate as a retiree of the University. This summary is intended to meet the requirements for a Summary Plan Description (SPD) under the Employee Retirement Income Security Act (ERISA) of 1974, as amended (ERISA).

The purpose of the HRA Plan is to reimburse eligible retirees for certain medical expenses and health insurance premiums which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This Plan is also intended to be exempt from the Patient Protection and Affordable Care Act ("ACA") as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2).

Read this Summary carefully so you understand the provisions of the HRA and how you can use the HRA Plan to your advantage.

This SPD describes the current provisions of the HRA Plan which is designed to comply with applicable legal requirements. The HRA Plan is subject to federal laws, such as the Internal Revenue Code (IRC), the Employee Retirement Income Security Act (ERISA) and other federal and state laws which may affect your rights. The provisions of the HRA Plan are subject to revision at any time due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. The University may also amend or terminate the HRA Plan at any time. If the provisions of the plan described in this SPD change, you will be notified.

Note that this booklet and the incorporated documents are only a summary. If there is any difference between the information in this SPD and in the official legal plan document, the official legal plan document will govern, with one exception. If there is language in the SPD regarding a topic the official legal plan document is silent on, the language in this SPD will govern.

Note that terms used in this SPD are defined the first time they are used. Please also note that “you,” “your” and “my” when used in this SPD refer to you, the retiree.
How the HRA Works

A Health Reimbursement Arrangement (HRA) is a recordkeeping reimbursement account the University establishes on your behalf. Each year, the University credits a specific dollar amount to your HRA to help cover the cost of eligible health care expenses for you and your covered Spouse.

The purpose of the HRA is to provide a source of funds to reimburse you or your covered family member for the cost of the health care premium expenses and certain other eligible health care expenses you incur that are not otherwise reimbursable by other coverage. These expenses must be incurred while the HRA Plan remains in effect, you are eligible, qualified, and participate in the HRA.

You can use the HRA to help pay for eligible health care expenses – including premiums for health care coverage, as well as copays, deductibles, and other out-of-pocket expenses that are not covered under your medical plan.

Only the University can contribute to your HRA. The HRA is a bookkeeping account on your employer’s records only, with all reimbursements being paid from your employer’s general assets. The IRS does not permit you to contribute your own money to an HRA.

The HRA is not funded and cannot earn interest or earnings of any kind. Reimbursements under the HRA are paid from the University’s general assets. The University may at its discretion provide an increase in the annual funding amount made to the HRA.

You do not pay taxes on the HRA contributions or the amounts you are reimbursed from the HRA for eligible health care expenses.

Your Eligibility

Eligible Retiree:

An Eligible Retiree is a retired employee of the University who is eligible to participate in the HRA Plan if, at retirement:

- the retiree was hired on or after September 1, 2011 and, at retirement, is at least age fifty-five (55) with at least ten years of full-time Continuous Service and whose age plus years of continuous, full-time service equals 70 or more;
- a retiree who was hired prior to September 1, 2011, was under age fifty (50) on September 1, 2011 and, at retirement, is at least age fifty-five (55) with ten years of full-time Continuous Service and whose age plus years of full-time Continuous Service equals 70 or more;
- the retiree was hired by NYU-Poly prior to July 1, 2007 and, was under age fifty (50) on January 1, 2014 and, at retirement, is at least age fifty-five (55) with ten years of full-time Continuous Service and whose age plus years of full-time Continuous Service equals 70 or more; or
• the retiree was hired by NYU-Poly after July 1, 2007 and, at retirement, is at least age fifty-five (55) with at least ten years of full-time Continuous Service and whose age plus years of Continuous, full-time service equals 70 or more.

Participant

A Participant is an Eligible Retiree who has satisfied the preceding requirements and has commenced participating in the Plan. An eligible Spouse that has commenced participation in the Plan is also a Participant.

The following former employees are not considered Eligible Retirees:

• a retiree who is eligible for benefits under the New York University Retiree Health and Welfare Plan. This includes an Eligible Retiree who is Medicare eligible due to disability.

You are not eligible to participate in the HRA Plan unless you are classified by the University as a former employee who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former employee of the University.

Dependent Eligibility

Your eligible Dependent is your Spouse or Domestic Partner. The University makes separate Contributions for you and your Spouse or Domestic Partner, each of whom may be referred to as an HRA-eligible individual in this SPD. Wherever the term “Spouse” appears in this SPD, it includes an Eligible Retiree’s Domestic Partner.

If at retirement you are under age 65, but your Spouse is 65 or older, your Spouse will be enrolled in the HRA Plan and will receive the annual contribution for an HRA-eligible individual. You will be enrolled in the Pre-65 coverage under the New York University Retiree Health and Welfare Plan. Upon turning age 65, you will be enrolled in the HRA Plan and receive an annual contribution for an HRA-eligible individual.

Notwithstanding the preceding sentence, if your Spouse participates in another group health plan sponsored by the University, your Spouse will not be eligible to receive a contribution under the HRA.

Upon your death, your Spouse who is covered under the HRA Plan at the time of your death will be eligible to continue coverage under this Plan as a Participant. In such case, your contribution will cease and your Spouse will continue to receive an HRA contribution as an HRA-eligible individual.

When Participation Begins

An Eligible Retiree becomes a Participant in the Plan on the later of the Effective Date of the Plan as provided in the Plan Information Appendix or on the date the Eligible Retiree becomes eligible for Medicare due to age. Any retiree who at retirement is Medicare-
eligible due to disability shall only be eligible for coverage under the New York University Retiree Health & Welfare Plan.

**When Participation Ends**

Coverage under the HRA for any Participant will terminate on the last day of the month in which the earliest of the following events occurs:

- the date on which the Plan is terminated by the University;
- the date the Retiree Participant elects to terminate postretirement coverage under the Plan;
- the date on which the Retiree Participant ceases to be eligible to participate in the Plan for any reason; or
- the date the Retiree Participant dies.

Any coverage for an eligible Spouse will cease when the Participant’s coverage ceases or, if earlier, on the date the Spouse ceases to be an eligible Dependent. Notwithstanding anything in the previous sentence to the contrary, upon the death of an Eligible Retiree Participant, the Spouse of the Eligible Retiree Participant, who is covered under the HRA as an eligible Dependent at the time of the Eligible Retiree Participant's death, will be eligible to continue coverage under the Plan.

**Contributions**

Contributions for you and your Spouse will be credited to one HRA.

The University will make an annual contribution to an HRA and, if applicable, a joint HRA for the eligible retiree and their Medicare-eligible Spouse. The annual contribution per HRA-eligible individual in 2022 will be $3,291.

Contributions to your HRA will be reduced from time to time by the amount of any eligible health care expenses reimbursed under the HRA Plan. You may only receive reimbursement for eligible health care expenses up to the amount in your HRA.

After qualification, the University shall fund each contribution annually on each January 1, except in the case of an Eligible Retiree who becomes a Participant during the Plan Year, in which case the annual University contribution for the first year of such individual’s participation shall be prorated to reflect the number of months in the Plan Year during which the Eligible Retiree will be a Participant. The amount of the University’s contribution will be indexed annually based on the CPI-U.

Unused contributions remaining in your HRA are available for use in future years to reimburse you for eligible health care expenses during subsequent plan years.
Contributions are available to reimburse participants for eligible health care expenses incurred within twelve months of the date the eligible expense is incurred, but not before their initial eligibility date or during time periods of no coverage.

You may opt out of future contributions to the HRA at least annually. Remaining HRA contributions cannot be paid in cash or other form of distribution, other than through reimbursement of actual eligible health care expenses incurred while you are eligible.

**Eligible and Ineligible Expenses**

When you have an eligible health care expense that is not paid by your medical plan, you may submit a reimbursement request for reimbursement from your HRA.

**Eligible Expenses**

Eligible health care expenses include the premiums you pay for the health care coverage described below.

**Premium expenses for:** medical coverage, prescription drug coverage, dental coverage, vision coverage, Medicare Part B coverage, and Medicare Part D coverage incurred while you are eligible for the HRA Plan can be submitted for reimbursement under this Plan.

**Out of Pocket expenses for:** Medical services, prescription drugs, including over-the-counter drugs and supplies, dental services, and vision services incurred while you are eligible for the HRA Plan and that are not eligible for reimbursement through other insurance coverage can be submitted for reimbursement under this Plan.

**Ineligible Expenses**

The following expenses are not covered by the HRA Plan:

- Long Term Care Insurance premiums
- expenses incurred *prior to the date* that you became a participant in the HRA;
- expenses incurred *after the date* that you cease to be a participant in the HRA; and
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Only eligible health care expenses incurred while you are a Participant in the HRA Plan may be reimbursed from your HRA.

Health insurance premiums are incurred on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the premium is paid even if the covered individual paid the premium for the coverage prior to the first day of the plan year.
The federal government permits you to take a deduction on your income tax return for certain health care expenses, including health care premiums you pay. You should remember that you cannot be reimbursed for the same expense twice, once through the HRA and also as a tax deduction. For specific advice about your situation, you may want to consult a tax advisor. The University cannot advise you regarding tax, investment or legal considerations relating to the HRA.

You may not submit a reimbursement request for an amount that was incurred prior to the time the HRA became effective (typically the first day of the plan year or the first day your election for HRA coverage is effective, if later). In addition, you cannot submit a reimbursement request for any expenses that have been paid in-full through any other health insurance plan, Section 125 “cafeteria” plan or other similar health care expense reimbursement arrangement.

**How to Use the HRA**

You must complete a reimbursement request online, on a mobile app, mail, or fax it to the Third Party Administrator as provided in the Plan Information Appendix of this SPD, along with a copy of your insurance premium statement, an “explanation of benefits” (“EOB”) from a health insurance carrier or, if no EOB is provided, a written statement from a service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment, (d) the amount incurred and (e) name of provider. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix of this SPD. Your reimbursement request is deemed filed when the Third Party Administrator receives it.

If your reimbursement request for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination.

The Third Party Administrator shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

The Third Party Administrator may establish an automatic premium reimbursement process for the payment of certain health insurance premiums. Automatic premium reimbursements shall not be considered to be reimbursement requests for benefits and shall not be subject to the procedures described in the “Reimbursement requests and Appeals Procedures” section of this SPD. In establishing and operating any automatic premium reimbursement process, the Third Party Administrator may establish a process to remove and/or prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall also not be considered to be reimbursement requests for benefits and shall not be subject to the procedures described in the “Reimbursement requests and Appeals Procedures” section of this SPD.
Reimbursement Claims and Appeals Process

You must submit requests for reimbursement of Eligible Medical Expenses within 12 months following the date on which the expense is incurred. Any reimbursement requests submitted after that date will be denied.

Initial Claims Process

If you make a reimbursement request for eligible medical expenses under the HRA, the following timetable for reimbursement requests decisions applies:

- Notification of whether reimbursement request is denied: 30 days
- Extension due to matters beyond the control of the Plan: 15 days
- Insufficient information to process the reimbursement request: 15 days
- Notification to Participant: 15 days
- Response by Participant: 45 days
- Response to reimbursement request: 15 days

If a reimbursement request under the HRA is denied in whole or in part, the Participant will receive electronic or written notification based on the Participant’s setting. The notification will include:

- The reasons for the denial;
- Reference to the specific provisions of the HRA Plan on which the denial was based;
- A description of any additional material or information needed to further process the reimbursement request and an explanation of why such material or information is necessary;
- A description of the Plan’s internal review procedures and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the reimbursement request;
- A description of any internal rule, guideline, protocol, or similar criteria used in the decision OR statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request; and
• The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

Reimbursement Claims Appeal Process

If you disagree with a decision concerning your reimbursement request, you have a right to appeal the reimbursement request decision as described below.

You, your beneficiary, or authorized representative will have 180 days following the receipt of any notification of reimbursement request denial to appeal the decision, making a written request for reconsideration to the Third Party Administrator. Include as much information as possible to identify yourself and provide information to support your appeal. This can include but is not limited to your Explanation of Unpaid Expenses, Explanation of Payment, or Notice of Adverse Determination. To identify yourself include your name, covered participants name, employer’s name, last 4 of SSN, date of birth, ID number, phone number, and any additional information that may be relevant to your appeal.

You have the right to:

• Submit written comments, documents, records and other information relating to the reimbursement claim for benefits

• Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your reimbursement request for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your reimbursement request if it:
  ○ Was relied upon in making the benefit determination;
  ○ Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
  ○ Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; and
  ○ Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

• A review that takes into account all comments, documents, records and other information related to the reimbursement request that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination

• A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person’s subordinate
If sufficient information is available to decide the appeal, the Third Party Administrator will resolve your first level appeal within a reasonable period of time but not later than 30 business days from receipt of the first level appeal request. If more information is needed to make a decision on your appeal, the Third Party Administrator shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 business days of the appeal request, the Third Party Administrator shall conduct its review based upon the available information. The review shall be completed within a reasonable period of time but not later than 30 business days from receipt of the appeal request.

If you are not satisfied with the decision made on the first level appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (e.g. physician). To initiate a second-level appeal, you can provide all information from the first level of appeal and additional information or statements that you feel are relevant. You have the same rights with the second level appeal as you do with the first level appeal and all responses will follow the same time period.

The first and second level of appeal will not take more than 60 days combined to resolve, from the receipt of each written appeal to the notice of decision for each appeal.

Notice of an adverse benefit determination on appeals will contain all of the following information:

- The specific reasons for the denial,
- Information sufficient to identify the reimbursement request involved, including the date of the service, the health care provider and the reimbursement request amount (if applicable),
- The specific HRA Plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the plan’s standard, if any, used in denying the reimbursement request, and in the case of a final adverse determination, a discussion of the decision,
- A description of any additional material or information necessary for the reimbursement request to be completed and an explanation of why such material or information is necessary,
- A description of the Plan’s external review procedures and a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; including your right to bring a civil action in federal court following a reimbursement requests denial on review,
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge; and
• The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

However, no action at law or in equity shall be brought to recover on the plan until 90 days after proof of reimbursement request has been provided. Once you have exhausted all of your administrative appeals rights, if you decide to file a court action on your reimbursement request, the court action must be filed within 24 months following the date the cause of action arose.

If you have any questions about a denied reimbursement request, you should contact the Third Party Administrator. The Third Party Administrator’s decisions are conclusive and binding.

The reimbursement claims submission agent has other voluntary resolution options and exceptions requests for extenuating circumstances that can be access by contacting VIA benefits customer service.

You and the Plan may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

If the Third Party Administrator fails to follow the reimbursement requests appeals procedures as outlined above, you will have the right to bring a civil action in court, filing the court action within 24 months following the date the cause of action arose.

**Overpayments**

If it is later determined that you and/or your covered eligible dependent(s) received an overpayment or a payment was made in error, you (or your covered eligible dependents) will be required to refund the overpayment or erroneous reimbursement to the HRA Plan. An example of an overpayment is being reimbursed for an expense under the HRA Plan that is later determined to be ineligible or is paid for by some other health care plan.

If you do not refund the overpayment or erroneous payment, the HRA Plan reserves the right to offset future reimbursements from the HRA equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on an IRS Form 1099 as income. In addition, if the Plan Administrator determines that you have submitted a fraudulent reimbursement request, the Plan Administrator may terminate your coverage under the HRA.

**Unclaimed payments**

Any HRA payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit 18 months from the date set forth on the check or from the date the payment was otherwise approved.
If the participant or other authorized person does not contact the Third Party Administrator prior to the 18-month forfeiture time frame, the unclaimed reimbursement will be voided and the amount of the voided check will be considered to be a contribution as of such date and shall be credited to the Participant’s HRA as of such date. This means that such contribution may be used to reimburse eligible health care expenses incurred from and after the date of such contribution in accordance with the terms of the HRA Plan on such date. If the participant’s HRA has been closed as of the date such contribution would otherwise be made, the contribution will not be made, but rather will be forfeited.

If the Participant or other authorized person contacts the Third Party Administrator within six months, the Third Party Administrator may cancel and void the original check or payment and re-issue a new check or as otherwise determined by the Third Party Administrator.

If the Participant or other authorized person contacts the Third Party Administrator after six months, the Third Party Administrator will cancel and void the original check or payment and shall re-issue the payment by direct deposit, or as otherwise determined by the Third Party Administrator.

**Catastrophic Prescription Drug Coverage Reimbursement**

Catastrophic Prescription Drug Coverage Reimbursement begins after you have reached the higher of –

- The Catastrophic Coverage level as defined by Medicare for the applicable year; or
- The level set by the Plan Administrator.

Catastrophic Coverage Reimbursement can be obtained by contacting the Third Party Administrator and requesting a reimbursement request form.

Once you reach the Catastrophic Coverage Level for an applicable year, all eligible reimbursement requests for qualifying prescription drug expenses will be reimbursed without any dollar limits. Notwithstanding anything to the contrary in this SPD, reimbursement requests must be incurred during the applicable Plan Year and submitted by March 31st of the following Plan Year. All other HRA provisions set forth in this SPD continue to apply to Catastrophic Prescription Drug Expenses.

**Continuation of Coverage under COBRA**

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered Spouse, and what you need to do to protect the right to receive it.**
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your Spouse who is covered under the Plan when they would otherwise lose such coverage.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of HRA Plan coverage when you would otherwise lose such coverage because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You and your covered Spouse could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the “Paying for COBRA Continuation Coverage” section.

COBRA Qualifying Events

If you are a covered retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because the following qualifying event happens:

- The University files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are the covered Spouse of a retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because any of the following qualifying events happens:

- You become divorced or legally separated from your Spouse; or
- The University files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

Giving Notice that a COBRA Qualifying Event Has Occurred

The HRA Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the retiree’s death or the employer’s bankruptcy filing, the employer must notify the Plan administrator of the qualifying events.

For all other qualifying events (divorce or legal separation), you are responsible to notify the Plan Administrator in writing within 60 days after the later of: 1) the date of qualifying event or 2) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice in writing to:

New York University
Attn: NYU Benefits Office
105 East 17th Street, 1st Floor
Once the plan administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a “COBRA Continuation Coverage Election Notice”) to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation on behalf of their covered Spouses, but covered retirees cannot reject COBRA continuation on behalf of their covered Spouses.

If coverage under the HRA Plan is changed for retirees, the same changes will apply to individuals receiving COBRA continuation coverage.

**Duration of COBRA Continuation Coverage**

COBRA continuation coverage is a temporary continuation of HRA coverage.

When the qualifying event is divorce, COBRA continuation coverage for the retiree’s covered Spouse (but not the retiree) under the HRA Plan lasts for up to a total of 36 months from the date of the qualifying event.

When the qualifying event is the bankruptcy of the University, retiree health coverage under the HRA Plan for you and your covered Spouse may be continued for the rest of your (the retiree’s) life. After your death (including if you have already died when the bankruptcy proceeding begins), your surviving covered Spouse may continue HRA Plan coverage for an additional 36 months after your death.

The table below provides a summary of the COBRA provisions outlined in this section.

<table>
<thead>
<tr>
<th>Qualifying Events That Result in Loss of Coverage</th>
<th>Maximum Continuation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree dies</td>
<td>Retiree</td>
</tr>
<tr>
<td>Retiree and Spouse divorce or terminate domestic partnership</td>
<td>N/A</td>
</tr>
<tr>
<td>The University commences bankruptcy proceedings under Title 11 of the United States Code</td>
<td>Death</td>
</tr>
</tbody>
</table>

**Electing COBRA Continuation Coverage**

You or your covered Spouse must choose to continue coverage under the HRA Plan within 60 days after the later of the following dates:
• The date you or your covered Spouse would lose coverage under the HRA Plan as a result of the qualifying event, or

• The date the University notifies you and/or your covered Spouse (through a “COBRA Continuation Coverage Election Notice”) of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost of HRA Plan coverage.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all contributions due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the HRA Plan. Payment is considered made on the date it is sent to the HRA Plan.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The contribution due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the HRA Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any reimbursement request you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period — respectively — for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any qualified beneficiary will end when the first of the following occurs:
• The applicable 36-month COBRA continuation coverage period ends;
• Any required premium is not paid on time;
• After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an retiree or otherwise) under another group health Plan (not offered by the University);
• After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (that is, enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA continuation coverage if bankruptcy is the qualifying event; or
• The date the University ceases to provide any group health plan for its employees and retirees.

COBRA continuation coverage may also be terminated for any reason the HRA Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

**Continuing Your Health Reimbursement Account under COBRA**

If you elect to continue your HRA under COBRA, the HRA will provide for continuation of the maximum reimbursement available at the time of the qualifying event reduced by any reimbursement requests reimbursed during the period of coverage.

If you continue your HRA under COBRA, any amounts that would otherwise have been contributed by the University into the HRA will continue.

**Alternatives to COBRA.**

As explained above, when you lose your coverage under the HRA Plan by reason of a COBRA qualifying event, you temporarily can elect to continue that coverage under the applicable health plan at your own expense at group rates (known as COBRA coverage). You also may have special enrollment rights to enroll under another group health plan (such as your Spouse’s employer plan). Because the HRA Plan only provides benefits to Eligible Retirees age 65 or older, you will likely not have viable purchasing options for individual health insurance policies through the Health Insurance Marketplace (“Public Marketplace”) or through other commercial insurance issuers outside of the Public Marketplace.

You should carefully and timely review all of your coverage options before making a final decision. If you decide to purchase other health coverage (e.g. through your Spouse or other commercial insurance) and do not elect COBRA within the 60-day election period, you will no longer have the right to elect COBRA coverage under the health plans.

If you decide to elect COBRA coverage, you also should be aware that you are restricted in when you can enroll in an individual health insurance policy. For example, if you enroll
in COBRA medical coverage under the plan, but decide mid-year that you want to drop that coverage because it is not affordable to you, most insurance carriers will not permit you to enroll in an individual health insurance policy until the next open enrollment period. This restriction applies even though COBRA is no longer affordable to you (e.g. when your financial situation changes or a COBRA subsidy, if any, from the University or another source ends).

More information regarding COBRA coverage is included above and in the COBRA Notices available from the plan administrator. Additional information regarding Public Marketplace coverage is available by visiting www.healthcare.gov and also in the health plans' COBRA Notices.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Additional Information

Keep Your Plan Informed of Address and Contact Changes

In order to protect your rights, as well as the rights of your Spouse, you should keep the Service Center informed of any changes in the addresses of your Spouse. You should also keep a copy for your records of any notices you send to the Service Center.

Plan Accounting

Via benefits will periodically furnish you with a statement of your HRA balance and reimbursements so you can track your account balance during the year. This will also help you budget for expense reimbursement needs in future plan years. You may also submit a written request to the plan administrator to receive a copy of your account information at any time.

Your Rights

As a participant in the HRA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:
Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator’s office and at other specified locations such as work sites, all documents governing the plan, including insurance contracts, and a copy of 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, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue group health coverage for yourself or your Spouse if there is loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this Summary Plan Description (this booklet and the carrier-prepared materials listed in the section “For More Information”) and the documents governing the component plans for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your reimbursement request for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
If you have a reimbursement request for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court but only after you have exhausted the Plan’s reimbursement requests and appeals procedure as described in this SPD or the reimbursement request and appeals sections in the materials prepared by your Plan carrier. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. Any action at law or in equity must begin within three years after the denial of any appeal from an initial adverse benefit determination, regardless of any state or federal statutes establishing procedures relating to limitations of actions.

If it should happen that 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 a federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your reimbursement request is frivolous.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HRA Plan is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The University is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices can be obtained by contacting the NYU Privacy Officer at:

New York University
Attn: Office of AVP, Global Benefits
105 East 17th Street, 1st Floor
New York, NY 10003

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Please confirm that the addresses here and immediately above are correct and that the Privacy Officer is the right contact for the NPP.
Administration at 1-866-EBSA (1-866-444-3272), logging on to www.dol.gov or contacting the EBSA field office nearest you.

**Plan Information Appendix**

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<th>Details About Plan Administration</th>
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| **Plan Sponsor/Plan Administrator** | Name: New York University  
Address: 105 East 17th Street, 1st Floor, New York, NY 10003  
Phone Number: 212-992-5465 |
| **COBRA Administrator** | Name: EBPA  
Address: 37 Industrial Drive, Suite E, Exeter, NH 03833-4585  
Phone Number: (888)232-3203 |
| **Employer Identification Number** | 13-5562308 |
| **Official Plan Name and Number** | New York University Retiree Health Reimbursement Arrangement Plan  
Plan Number 525 |
| **Plan Year** | January 1 through December 31 |
| **Type of Plan** | Welfare benefit plan providing health care reimbursements under ERISA. |
| **Agent for Service of Legal Process** | Name: NYU Office of General Counsel  
Address: 70 Washington Square South, 12th Floor, New York, NY 10012  
Phone Number: (212)998-2240  
Legal process can also be served on the plan administrator |
| **Third Party Administrator** | Via Benefits  
10975 South Sterling View Drive  
South Jordan, UT 84905  
(866) 322-2824  
My.ViaBenefits.com/funds |
Reimbursement Requests Submission Information

Name: Via Benefits
Mobile App: Search for Via Benefits
Accounts where you download apps URL VIAbenefits.com
Online: my.viabenefits.com/funds
Mail: P.O. Box 981156, El Paso, TX 79998-1156
Fax: (866) 886-0878

Plan Funding

The University contributes to the participants’ HRAs as described in this SPD. The HRAs are notional accounts and reimbursements of eligible health care expenses are made from the University’s general assets.

Plan Administrator’s Discretionary Authority to Interpret the Plan

The administration of the HRA Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretionary authority to determine all matters relating to the HRA Plan, including eligibility, coverage and benefits, to the extent permitted under the applicable collective bargaining agreement.

The Plan Administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of the HRA Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

Requirement to File an Appeal Before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it begins within three years of the Plan’s final decision on the reimbursement request or other request for benefits. If the Plan decides an appeal is untimely, the Plan’s latest decision on the merits of the underlying reimbursement request or benefit request is the final decision date. You must exhaust the Plan’s internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.
Plan Document

This SPD is intended to help you understand the main features of the HRA Plan. It should not be considered a substitute for the official legal HRA Plan document that governs the operation of the HRA Plan. That document sets forth the provisions concerning the HRA Plan and is subject to amendment. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the official legal HRA Plan document, the text of the official legal HRA Plan document will determine how questions will be resolved, with one exception. If this SPD contains provisions regarding an issue on which the official legal HRA plan document is silent, this SPD will determine how that issue will be resolved. To request a copy of the plan document, contact the Plan Administrator at (212)992-5465.

The University’s Right to Amend or Terminate the Plan

It is the University’s intent that the HRA Plan will continue indefinitely. However, the University reserves the right to amend, modify, suspend or terminate the HRA Plan, in whole or in part, by action of the University. Any such action would be taken in writing and maintained with the records of the HRA Plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the HRA Plan to the extent permitted by law and to the extent permitted under the applicable collective bargaining agreement.

The University’s rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third-party administrators, etc., at any time, and the right to revise the amount of University contributions. Participants will be notified of any material modification to the HRA Plan.

If the HRA Plan is terminated, there will not be any plan assets that would need to be distributed.

Limitation on Assignment

Your rights under the HRA Plan cannot be assigned, sold or transferred to your creditors or anyone else. However, you may assign any benefit payments you may be entitled to the health care provider who provided the covered services.

Your Employment

This SPD, provides detailed summary of the University’s HRA Plan and how it works. This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the HRA Plan or any of its component plans should not be interpreted as an implied or express contract or guarantee of employment. The University’s employment decisions are made without regard to benefits to which you are entitled upon employment.