New York University

Prescription Drug Plan

Active Employees

Summary Plan Description

January 2019

NYU Prescription Drug Plan

New York University (the "University") recognizes the importance of good health and offers you the option to elect coverage under the New York University Prescription Drug Plan (the "Plan"), which is a component of the New York University Health and Welfare Plan (the "Welfare Plan"). The following is your Summary Plan Description ("SPD"), as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). It has been prepared to help you gain a better understanding of the terms and conditions of the Plan. It summarizes the Plan's current rules on eligibility and other administrative procedures. In the event of any conflict between any other document and this SPD, this SPD will govern.

A person's rights to Plan benefits, if any, will be determined under the Plan provisions in effect when the related claim is incurred. If there are any legal rules that require changes not yet written into this SPD, this SPD will be interpreted by the Plan Administrator as including those legal rules. Please note that the University reserves the right to end, suspend or amend the Plan at any time.

As used in this summary, the term "University" includes certain of its affiliates that have joined the Plan with the approval of the University.

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Benefits at a Glance

The Prescription Drug Plan allows you to purchase prescription drugs through local network pharmacies or a mail delivery program. If you enroll in the NYU medical plan options (the "Medical Plan"), you will be automatically enrolled in the Prescription Drug Plan administered by CVS/Caremark ("CVS").

If you do not want medical and prescription drug coverage, you may choose to waive Medical Plan coverage. If you enroll in the Medical Plan, you may also enroll your eligible dependents. See the applicable Medical Plan SPD for details on your medical benefits, eligibility and enrollment. This document only describes the prescription drug benefits administered by CVS Caremark.

CVS Caremark is the "Claims Administrator" for your prescription drug benefits under the Plan. For any prescription drug questions, please contact CVS Caremark Customer Service at 1-800-421-5501 or in writing at:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

This prescription drug program provides access to prescription drugs and certain over-the-counter medications and supplies through network pharmacies and mail order service. If you enroll in the Medical Plan, you are automatically covered for prescription drug coverage under the Plan as described below. Once enrolled, you will receive a separate CVS Caremark prescription drug card. You will need to use this card (and not your medical card) to receive benefits under this program.

Eligibility

Coverage for You

You are generally eligible to participate in the Plan if you are a regular employee who is employed in a classification of employees designated by the University as benefits eligible or if you are a collectively bargained employee whose bargaining agreement provides for participation in the Plan.

You are not eligible to participate in the Plan if:

- You are classified by the University as an employee of a temporary agency or leasing organization that contracts with the University to provide staff to fulfill staffing needs of specific duration.
- You are covered by a collective bargaining agreement that does not provide for participation in the Plan, if participation in the Plan was the subject of good faith bargaining.
- You are hired by the University pursuant to an employment agreement or personal services agreement if the agreement provides that you are not eligible to participate in the Plan.
- You enter into an agreement with the University that designates you as an independent contractor or otherwise contemplates or implies that you will function as an independent contractor.
- You are classified by the University as an independent contractor, consultant or on another contractual basis, and you are not treated by the University as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding.
- Your employment is terminated and you fail to elect COBRA.
- If at any time, your employee classification is changed by the University, any governmental agency, judiciary or other entity, including if you are held or found to be a "common law employee," you will not be eligible to participate in the Plan for any period during which you were not treated as an employee by the University and your eligibility for benefits will be determined prospectively from the date of such change.

Coverage for Your Eligible Dependents

You may enroll your eligible dependents for Plan coverage at the same time you enroll yourself. Your eligible dependents include:

- Your spouse. For purposes of the Plan, your spouse is your legal partner in marriage and to whom you are not legally separated or divorced.
- Your dependent children, which include children up to the end of the month in which your child turns age 26.
- Your unmarried mentally or physically disabled children who have been classified as disabled and are incapable of self-support because of their disability (you must provide proof of incapacity

within 30 days after your child reaches age 26, if applicable) provided that they become disabled while covered under the Plan.

- Your Domestic Partner and his or her eligible dependent children (see "*Coverage for Your Domestic Partner and Eligible Dependents*" below).

Your children include your biological children, children in your legal custody pursuant to placement for adoption, legally adopted children, children in your legal custody pursuant to a legal guardianship and stepchildren who live with you and depend on you for primary financial support as determined under criteria established by the Plan Administrator. The term children also includes any child(ren) covered by a "Qualified Medical Child Support Order" ("QMCSO") issued by a court. (See "*Changing Your Coverage Election*").

Coverage for Your Domestic Partner and Eligible Dependents

The University allows you to enroll your eligible Domestic Partner and his or her eligible dependent children at the same time as you enroll yourself.

An eligible Domestic Partner is an individual of the same or opposite sex, with whom you share a bona fide "Domestic Partnership" and who meets the requirements established by the University for participation in the Plan.

Declaring a Domestic Partnership

To declare a Domestic Partnership, please contact the NYU PeopleLink team at askpeoplelink@nyu.edu. You and your Domestic Partner will need to sign an Affidavit of Domestic Partnership before a representative from the PeopleLink team and submit form to the PeopleLink team.

Tax Implications

Submitting an Affidavit of Domestic Partnership may create new legal rights and tax liabilities.

For example, the Internal Revenue Code currently treats Domestic Partners differently than spouses in several ways. This includes, but is not limited to:

- Treating as imputed income the difference between the "fair market value" of your Domestic Partner's prescription drug coverage under the Plan (and/or his or her eligible dependent children), and the amount you pay for such coverage.
- Requiring that premium contributions (included as part of the medical premium) paid for your Domestic Partner's prescription drug coverage under the Plan (and/or his or her dependent children) be paid on an after-tax basis.

This means that the cost of providing prescription drug coverage to your Domestic Partner and/or his or her eligible dependent children, less the premium for such coverage paid by you, will be reported as income on your W-2 form, unless your Domestic Partner (and/or his or her dependent

children) qualifies as your dependent under Internal Revenue Code Section 152, as modified for health coverage purposes.

Note: For a full description of the University's Domestic Partner Policy, contact the PeopleLink team.

Enrollment

When enrolling in a Medical Plan option, participants automatically receive prescription drug coverage under the Plan. Any election change under the Medical Plan option impacts the prescription drug election. Enrolling in the Medical Plan is optional. You may not enroll in Plan coverage for prescription drugs unless you enroll in a Medical Plan option. When you first become eligible:

- You will be able to enroll yourself and your eligible dependents.
- You may also choose to waive medical and prescription drug coverage.
- You must enroll in the Medical Plan in order to enroll your eligible dependents.

Whether you choose to enroll in the Medical Plan or to waive Medical Plan coverage, you must make your elections:

- Using the method of enrollment communicated by the Benefits Office. The Benefits Office will communicate the enrollment process and enrollment dates prior to the Annual Enrollment period.
- Within 31 days of the date you become eligible to participate in the Medical Plan. If you do not enroll within the required 31 days, you will be automatically enrolled in the University's default enrollment benefits as indicated in the Benefits Overview Guide and will not be able to enroll until the next Annual Enrollment period for coverage beginning the next January 1st unless you have a qualified change in status during the Plan year.
- It is fraudulent to enroll any non-eligible dependent or other person not eligible for coverage or fail to notify the University of a change in eligibility for a covered dependent. This fraudulent activity may result in the retroactive termination of your coverage as well as termination of employment, criminal or civil penalties can result from such acts.

When Coverage Begins

If you meet the eligibility requirements, your coverage begins on the effective date of your Medical Plan coverage. If you enroll during Annual Enrollment for subsequent Plan years, your participation will begin on the next January 1st. If you enroll due to a qualified change in status, coverage will be retroactive to the date of the status change, provided your election is submitted within the 31-day eligibility period.

If Your Employee Classification Changes

If, at any time, your employee classification changes, your eligibility for benefits will be determined prospectively from the date of the change. You will be required to meet the service requirements, if any, before your coverage becomes effective.

When Coverage Ends

Your coverage under the Medical Plan and the Plan will stop on the last day of the month in which:

- You terminate employment or otherwise no longer meet the eligibility requirements, and you fail to elect COBRA.
- The Plan is terminated by the University.
- You neglect to pay required contributions in a timely manner.

Coverage for your eligible dependents will stop as follows:

- When your coverage ends as noted above.
- On the date of the event for:
  - Your spouse, upon divorce, legal separation or annulment.
  - Your Domestic Partner, if you no longer meet the requirements of a Domestic Partnership.
  - The last day of the month in which a dependent child turns age 26.

Under certain circumstances you may continue medical/prescription drug coverage for yourself and/or your eligible dependents pursuant to COBRA provided you notify the PeopleLink Team within 60 days of your dependent no longer being eligible for coverage.

Changing Your Coverage Election

During the Annual Enrollment Period

Each year, the University conducts an Annual Enrollment period so that you can make changes to your benefit elections. Any changes made during the Annual Enrollment period will take effect on the next January 1st. If you choose not to make any changes during the Annual Enrollment period, your prescription drug coverage will continue in the next calendar year (if applicable). The only time you may make mid-year changes to your benefit elections is when you experience a qualified change in your status.

During the Year (Due to a Change in Status)

The benefit elections you make when you enroll in the Medical Plan, which includes prescription drug benefits under the Plan, will be in effect for the entire Plan year (or portion of the Plan year that remains, if you are a newly enrolled employee) unless you have a qualified change in status.

You will not be able to change your elections unless you file a request for change on the Benefits Resource Center within 31 days of any of the following events:

- Marriage, divorce, annulment or legal separation.
- Birth, adoption or placement for adoption of a child or the addition of foster children.
- Death of a spouse or eligible dependent child.
- A change in employment status for you or your spouse/domestic partner that affects health care coverage (such as changing from full-time to part-time employment or your spouse/domestic partner or dependent commencing or terminating employment).
- A change in benefit status for you, your spouse/domestic partner (such as your spouse/domestic partner losing coverage elsewhere or enrolling you as a dependent under his/her health care coverage).
- COBRA coverage under another health plan is exhausted.
- A dependent child satisfies or ceases to satisfy Plan requirements for unmarried dependents (such as age limitations or graduation from college).
- A change in place of residence or work for you, your spouse or your eligible dependent children which affects your access to coverage.
- Entitlement to or loss of Medicare or Medicaid benefits.
- Any other permitted charge within the meaning of Section 125 of the Code and regulations, rulings and releases thereunder that the Plan Administrator chooses to apply on a uniform, consistent and nondiscriminatory basis.
- You may make an election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's or dependent's employer, so long as: (a) his or her employer's Plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage that is different from the period of coverage under his or her employer's plan.

If you have a qualified change in status, it is your responsibility to make an election within 31 days of the qualified change in status. Otherwise, you may not be able to enroll your new eligible dependents or make other appropriate changes until the next Annual Enrollment period for coverage beginning the next January 1st. Your change in coverage (if applicable) will be effective retroactively to the date of the status change provided your election is submitted within the 31-day eligibility period.

Keep in mind that the mid-year election change events described in this Section apply to your Medical Plan election. If you change your Medical Plan election mid-year as described in this Section, your Plan election will automatically be changed consistently.

Changes must be Consistent

If you wish to change your election based on a qualified change in status, the change must be consistent with the change in status. The Plan Administrator (in its sole discretion) will determine

whether a requested change is on account of and corresponds with a change in status. As a general rule, a desired election change will be found to be consistent with a change in status event if the event affects coverage eligibility. For example, if you gain a dependent (marriage, birth or adoption of a child), you may add your new family member to your existing prescription drug coverage. In addition, you must also satisfy the following specific requirements in order to alter your election based on that change in status:

Loss of Dependent Eligibility

For health benefits, including prescription drug coverage, a special rule governs which types of election changes are consistent with the change in status.

For a change in status involving your divorce, annulment or legal separation from your spouse, the death of your spouse or your dependent children or your dependent child ceasing to satisfy the eligibility requirements for coverage, your election to cancel prescription drug benefits for any individual other than your spouse involved in the divorce, annulment or legal separation, your deceased spouse or dependent child or your dependent child that ceased to satisfy the eligibility requirements, would fail to correspond with that change in status. Hence, you may only cancel coverage for the affected spouse or dependent.

Gain of Coverage Eligibility Under Another Employer's Plan

For a change in status in which you, your spouse/domestic partner or your dependent children gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your spouse's/domestic partner's or your dependent children's employment status that affect your access to coverage, your election to cease or decrease coverage for that individual under the Plan would correspond with that change in status only if coverage for that individual becomes effective or is increased under the other employer's plan and you make such changes within 31 days of the event.

During the Year (Due to a Change in Cost)

If the Plan Administrator notifies you that the cost of your coverage under the Plan significantly increases during the plan year or there is a loss of coverage mid-year, you may choose either to make an increase in your contributions, enroll in a different Plan option or revoke your election if there is no other Plan option that provides similar coverage. You may also revoke your election if there is a significant curtailment that amounts to a loss of coverage and there is no other Plan option that provides similar coverage.

However, if there is a significant curtailment that does not amount to a loss of coverage (e.g., an increase in deductibles or co-payments), you may not drop your coverage but only switch to a different Plan option. If the cost of coverage under the Plan significantly decreases, all eligible employees, even those who previously did not participate in the Plan, may elect coverage under the

Plan. For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

During the Year (Due to a Change in Coverage)

If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Plan option that provides similar coverage.

If, during the Plan year, the Plan adds or eliminates a coverage option, you may elect the newly-added option or elect another Plan option (when a Plan option has been eliminated), and may do so on a pre-tax basis by making a corresponding election change under another Plan option which provides similar coverage.

You may make an election change when there is a significant improvement in coverage provided under an existing benefit option.

You may make an election change that is on account of and corresponds with a change made under the Plan of your spouse's, former spouse's or dependent child's employer, so long as: (a) his or her employer's Plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage that is different from the period of coverage under his or her employer's Plan.

During the Year (Due to Judgment, Decree or Order)

If a judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), resulting from a divorce, separation, annulment or custody change requires your dependent child to be covered under a health plan (i.e., medical, dental and/or vision), you may change your election. If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke or reduce your coverage provided that you notify the PeopleLink Team within 31 days of the notice.

During the Year (Due to Special Enrollment Rights Under HIPAA)

You may change your coverage under the Plan during the year if one of the following events occur, as long as your election change is consistent with these special enrollment rights and you make your changes within 31 days of the date of the event occurs.

- If you waive participation in the under the Plan when you first become eligible because you and/or your eligible dependents have coverage in another medical/prescription drug plan, you may enroll in the Plan at a future date if that other coverage is lost. In this case, you may enroll in the Plan as long as you do so on or before the 31st day after such coverage ends. You will be asked to provide documentation indicating that you and/or your dependent's coverage has terminated. This documentation must also be submitted within 31 days of the termination of your other coverage.

- If you have a new eligible dependent child as a result of a marriage, birth, adoption or placement of adoption, you may enroll any new dependents during the year, within 31 days of the event. You will be asked to provide documentation as proof of the event, such as a marriage certificate, birth certificate or adoption paperwork. The date of the event (e.g., date of birth or marriage date) is day one.
    - Acquiring a new dependent also grants special enrollment rights to you, your spouse/domestic partner, or both, even if you previously declined coverage. However, special enrollment rights are not available to other dependents who previously declined coverage or for dependents who are newly acquired for reasons other than marriage, birth, adoption or placement for adoption. If your documentation is approved, you will be able to select from all the benefits options on the same terms as they were made available to you at initial enrollment.
    - To qualify for this special enrollment require, the following requirements must be satisfied:
        - You must either be participating in the Prescription Drug Plan or eligible to enroll in it; and
        - Your dependent, as determined by the Plan's terms, must have become your dependent through marriage, birth, adoption or placement of adoption. This special enrollment right does not apply to any other qualifying life event.

During the Year (Due to Family and Medical Leave Act)

If you are absent from work in accordance with the Family and Medical Leave Act ("FMLA"), you may continue coverage in the Plan while on FMLA leave. If your leave is unpaid you may also elect to cancel your coverage and reinstate it upon return from FMLA leave. You should contact the PeopleLink Team to advise the University if you are requesting a leave of absence under the FMLA.

Cost of Coverage

Your cost for medical/prescription drug coverage under the Plan depends on your employment classification and the coverage level you select under the Medical Plan. Employee contributions will be communicated at the time of enrollment and any changes in the cost will be communicated to you before you are required to make your benefit elections.

Most Employee contributions are deducted on a pre-tax basis, unless a portion of is attributable to your Domestic Partner (and his or her eligible dependent children) that do not qualify as your dependents under Internal Revenue Code Section 152, as modified for health coverage purposes, as described in the section called "Declaring a Domestic Partnership" And "Tax Implications" above. Adjunct Faculty and Employees on an unpaid leave of absence are billed on a post-tax basis.

Pre-tax Contributions Can Save You Money

If you are an employee who has Plan contributions deducted on a pre-tax basis, your Plan contributions will be taken in equal installments from your paychecks and, except the portion attributable to your Domestic Partner (and his or her dependent children) that do not qualify as your dependents under Internal Revenue Code Section 152, as modified for health coverage purposes, will be deducted before federal, state and Social Security (FICA) taxes are deducted. In some cases, local taxes may apply as well. By paying on a pre-tax basis, you are paying less in taxes, which may help offset your cost of coverage.

The amount of your taxable compensation from the University will be reduced by the amount you contribute towards your benefits under the Plan. This reduction in taxable compensation will affect your Social Security taxes. If you earn less than the Social Security taxable wage base and contribute towards your benefits under the Plan, your Social Security taxes will be reduced. Since Social Security benefits are determined, in part, by the taxes you pay over your career, you should be aware that any future Social Security benefits you receive may be slightly reduced if you purchase benefits under the Plan. In most cases, the effect is minimal since Social Security benefits reflect your compensation over your entire career.

How to Use the Plan

You should get your prescriptions filled through a participating CVS Caremark pharmacy. Your prescription benefits can be accessed at more than 60,000 retail pharmacies nationwide. For a complete list of participating pharmacies, including addresses, and driving directions, please visit www.caremark.com or call the Customer Service Department at the phone number listed on your ID card (1-800-421-5501) for assistance locating a pharmacy near you.

For your longer-term prescriptions, CVS Caremark also offers a mail order option through CVS Caremark mail service. Instructions for filling your prescription through the mail order pharmacy are below.

To receive the highest level of benefits at the lowest cost to you, you should fill your prescriptions through a participating CVS Caremark pharmacy. However, the prescription drug program also provides benefits for certain prescriptions filled at a non-participating pharmacy. In the event that you are traveling outside of the United States or are unable to fill your prescription at a participating CVS Caremark pharmacy, you will generally have to pay for the prescription upfront and then submit a manual request to CVS Caremark for reimbursement. The reimbursement claim form can be found on www.caremark.com.

You may register on www.caremark.com to access your prescription information, start prescription drug mail service and download claims forms. You will need your member ID number on your CVS Caremark member ID card to register online.

Your cost share is dependent on how you fill your prescription and what type of prescription drug is prescribed. In almost all cases, generic prescriptions are your lowest net cost option and should be purchased whenever possible.

Following is a brief summary of your prescription benefits. If you are in the High Deductible Health Plan ("HDHP") option, your plan is based on a combined deductible and maximum out-of-pocket of medical and prescription claims. The deductible is the total "out- of- pocket" spending required by you before prescription benefits are paid. Until this deductible amount is met, you will pay 100 percent for your prescriptions. The deductible will be waived for medications on the CVS Caremark Preventive Therapy Drug List [http://www.caremark.com/portal/asset/preventive_dl.pdf]. Coinsurance will apply. If you are in the POS or HMO plans, you will pay a flat copay for your prescription drugs which will vary depending on whether you purchase generic, preferred brand or non-preferred brand medication. Under all of the Medical Plan options, if you fill a prescription at a non-participating pharmacy you will pay the difference between the retail price of the medication and the negotiated discounted price of the medication, in addition to your coinsurance or copayment. In the chart below, find the name of the Medical Plan option in which you are enrolled for a description of your prescription drug coverage.

	CVS Caremark Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	**Maintenance Choice** **CVS Caremark Mail Service Pharmacy or CVS/pharmacy** For long-term medications (Up to 90-day supply)
Where	The CVS Caremark Retail Network includes more than 64,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and CVS/pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative Toll-free at 1-800-421-5501.	You have the convenience of getting your long-term medications at one of our 7,100 CVS/pharmacy locations for your mail service copay. Or simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice.
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**UHC HDHP: 10% for a generic prescription** (after deductible) **UHC POS VALUE or UHC POS ADVANTAGE**: $10 **UHC POS PLAN (union), Aetna HMO and Oxford HMO:**: $5	**UHC HDHP: 10% for a generic prescription** (after deductible) **UHC POS VALUE or UHC POS ADVANTAGE :**$5 up to 90 days/$10 up to 180 days **UHC POS PLAN (union), Aetna HMO and Oxford HMO :**$10 up to 90 days/$20 up to 180 days
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**UHC HDHP: 10% for a preferred brand-name prescription** (after deductible) **UHC POS VALUE or UHC POS ADVANTAGE ::** $35 **UHC POS PLAN (union), Aetna HMO and Oxford HMO::** $20	**UHC HDHP: 10% for a preferred brand-name prescription** (after deductible) **UHC POS VALUE or UHC POS ADVANTAGE** :$75 up to 90 days/$150 up to 180 days **UHC POS PLAN (union), Aetna HMO and Oxford HMO::** $50 up to 90 days/$100 up to 180 days
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**10% for a non-preferred brand-name prescription** (after deductible) **UHC POS VALUE or UHC POS ADVANTAGE :**$55 **UHC POS PLAN (union), Aetna HMO and Oxford HMO** : $55	**10% for a non-preferred brand-name prescription** (after deductible) **UHC POS VALUE or UHC POS ADVANTAGE** $90 up to 90 days/$180 up to 180 days **UHC POS PLAN (union), Aetna HMO and Oxford HMO :** $75 up to 90 days/$150 up to 180 days
Refill Limit	One initial fill plus one refill for long-term	None
Copay After Limit	Up to $75 for each prescription	None
Annual Deductible	UHC HDHP: $1,600 per individual / $3,200 per family (your medical and prescription costs will count toward one combined deductible)	

Maximum Out-of-Pocket	UHC HDHP: $3,000 per individual / $6,000 per family (for HDHP, Maximum Out-of-Pocket limit includes medical and prescription drug cost-sharing combined); UHC POS VALUE, UHC POS ADVANTAGE, UHC POS, Aetna HMO, and Oxford HMO options: $2,500 per individual/$5,000 per family. For the UHC POS VALUE, UHC POS ADVANTAGE, UHC POS, Aetna HMO, and Oxford HMO options, this Maximum Out-of-Pocket limit applies only to your prescription drug benefits; see your Medical Plan SPD for the separate Maximum Out-of-Pocket limit for medical benefits)
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card available.
Customer Care	Visit www.caremark.com or call toll-free at 1-800-421-5501.

ABOUT THE CVS CAREMARK RETAIL NETWORK

Can I receive additional Prescription Cards?

Yes, for additional Prescription Cards, please call a Customer Care representative toll-free at 1-800-421-5501.

May I fill my medication at a non-participating pharmacy?

There are more than 68,000 participating pharmacies in the CVS Caremark retail network. When you choose to go to a non-participating pharmacy, you will pay the full prescription price. If you use a non-participating pharmacy, you should submit a paper claim form along with the original prescription receipt(s) to CVS Caremark for reimbursement of covered expenses. You will be reimbursed for the discounted cost of the prescription - the cost the plan would have paid had you gone to a network pharmacy - less the applicable copay. In most cases, the discounted price will be less than the retail price. You can download and print a claim form when you log in to www.caremark.com.

How do I change my prescription from a non-participating retail pharmacy to a CVS Caremark participating retail pharmacy?

Go to a CVS Caremark participating retail pharmacy and tell the pharmacist where your prescription is currently on file. The pharmacist will contact the pharmacy and make the transfer for you. To find a CVS Caremark participating retail pharmacy, click on "Find a Pharmacy" at www.caremark.com.

When should I use a retail pharmacy instead of the CVS Caremark Mail Service Pharmacy?

You should use the retail pharmacy for your immediate and short-term medication needs. Use mail service or a retail CVS/pharmacy for your long-term maintenance medication needs. Find a participating pharmacy at www.caremark.com.

FAQs ABOUT THE HIGH DEDUCTIBLE HEALTH PLAN

If I am enrolled in a High Deductible Health Plan (HDHP) plan, how do I find out the cost of my medication?

During Annual Enrollment you can log onto www.caremark.com/nyu. After Annual Enrollment, you can log onto www.caremark.com, register, and search your drug for up to date cost information.

How can I find out how much money has accumulated towards my deductible and out of pocket maximum?

CVS Customer Care representatives are available to help you. They can be reached by calling 1-800-421-5501.

I understand that some preventive drugs will skip the deductible phase and the co-insurance will apply. Where can I find this list?

Visit http://www.caremark.com/portal/asset/preventive_dl.pdf or call Customer Care at 1-800-421-5501.

ABOUT THE CVS CAREMARK MAIL SERVICE PHARMACY

Why should I use the CVS Caremark Mail Service Pharmacy for my prescriptions?

The CVS Caremark Mail Service Pharmacy is a convenient and cost-effective way for you to order up to a 90-day supply of maintenance or long-term medication. You can have your long-term medication delivered to your home, office or a location of your choice with free standard shipping. By using mail service, you minimize trips to the pharmacy while saving money on your prescriptions.

How long does it take for my prescriptions to arrive by mail?

Please allow 7-10 days for delivery from the time the order is placed.

How do I check the status of my order?

You can check your refill order status at www.caremark.com or by calling toll-free at 1-800-421-5501.

How should I ask my doctor or other prescriber to write my prescription in order to receive the maximum benefit from the CVS Caremark Mail Service Pharmacy?

Remind your doctor or other prescriber to write a "90-day supply plus refills," when clinically appropriate, for maintenance medications that are purchased through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy. CVS Caremark must fill your prescription for the exact quantity of medication that your doctor or healthcare provider prescribes, up to your plan design limit. When you need to take your maintenance medication right away, ask your doctor or other prescriber for two prescriptions:

- The **first** for up to a 30-day supply
- The **second** for up to a 90-day supply, with refills when clinically appropriate

Have the short-term supply filled immediately at a CVS Caremark participating retail pharmacy and send the 90-day supply prescription to the CVS Caremark Mail Service Pharmacy.

Long-term medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol.

Choose one of four easy ways to start using the Maintenance Choice program:

- Bring your prescription to a CVS/pharmacy location
- Fill out and send in a mail service order form
- Visit www.caremark.com/faststart
- Call FastStart toll-free at 1-800-875-0867

ABOUT THE CVS CAREMARK DRUG LIST

What is a drug list?

It is a list of preferred prescription medications that have been chosen because of their clinical effectiveness and safety. This list is typically updated every three months. The drug list promotes the use of preferred brand-name medications and generic medications whenever possible. Generic medications are therapeutically equivalent to brand-name medications and must be approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness. Generally, generic medications cost less than brand-name medications. You can get a drug list by either visiting www.caremark.com or by calling Customer Care toll-free at 1-800-421-5501.

How do I change to a generic or preferred drug?

To save money, have your doctor or other prescriber choose a generic or preferred brand-name medication from the CVS Caremark Drug List, if appropriate. You may want to take the list with you when you visit your doctor or other prescriber.

What's Covered

For the prescription drug plan, the plan of coverages offered by CVS Caremark will control the determination of which drugs, medicines, supplies, and charges will be covered under your plan. After you pay the required copays and any ancillary cost differences associated with the generics preferred policy, the plan will cover many drug expenses. In addition, certain prescription drugs are available through the CVS step therapy program or may require prior authorization, as described below.

Step Therapy Program

The CVS pharmacy plan for Faculty, Administrators, Professional Researchers and Adjunct Faculty includes a step therapy program for drugs used to treat medical conditions such as arthritis and high blood pressure. When many different drugs are available for treating a condition, a step therapy program is helpful in finding the most appropriate, cost-effective drug treatment.

The first step in a step therapy program is usually a simple, inexpensive treatment that is known to be safe and effective for most people. This treatment is known as first-line therapy and is the preferred therapy for most people. If you have tried first-line therapy without success, the next step is to try second-line therapy. Second-line drugs are heavily advertised and promoted, are generally no more effective than first-line therapy, but are usually a more costly treatment. First-line drugs are often generic and have a lower cost than that for second-line drugs, which are brand-name products.

The penalty for not following step therapy on a targeted drug is the member paying 100%. The member and provider can go through a prior authorization process to prove medical necessity to remain on the drug. If approved, the member will pay the appropriate copay/coinsurance.

Prior Authorization Drugs

In some cases, prior authorization is required by CVS Caremark to determine whether the following drugs will be approved for coverage:

- some Specialty Medications, including growth hormones;
- lost, stolen or broken medication;
- early refills for vacation supply; and
- all compound medications over $300.

In most cases, authorization can be started by phone. Your pharmacist or physician should call the toll free number on the back of your CVS Caremark ID card. CVS Caremark will fax a Prior Authorization to your physician to obtain the needed information. Once the Prior Authorization is faxed back to CVS Caremark, a pharmacist will review and approve or decline the request based on clinical criteria.

The drugs requiring prior authorization are subject to change at the discretion of CVS. A regularly updated listing of drugs requiring prior authorization is available at www.caremark.com.

To learn more about drugs requiring prior authorization, contact Customer Care at 1-800-421-5501.

Quantity Level Limits

Under the prescription drug plan, certain drugs have preset coverage limitations (quantity limits). For these prescription drugs, CVS Caremark will apply quantity level limits based on national standards and current literature, which may be amended from time to time. Quantity limits will be established and applied according to CVS Caremark's standards and limitations.

Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and benefit plan design.

Quantity limits encourage safe, effective, and economic use of drugs and ensure that members receive quality care.

If your prescription exceeds the quantity limits, your pharmacist can ask your doctor to decide whether an exception should be requested. If your doctor is not available, your pharmacist can fill the prescription up to the quantity limit. If your doctor does not agree with the quantity limit, he or she can contact CVS Caremark's Prior Authorization department at 800-626-3046 to request an exception; however, this does not guarantee approval.

Specialty Medications

You will need to use CVS Specialty to get Specialty Medications. **Specialty Medications filled through other pharmacies will not be covered by the Plan.**

Generally, Specialty Medications:

- are used in the management of specific chronic or genetic conditions, such as cancer, Hepatitis C, HIV, Crohn's Disease, or osteoporosis;
- are often injectable or infused medicines, but may also include oral medicines;

- require additional education and close monitoring of your clinical response in collaboration with your doctor;
- may require patient-specific dosing, medical devices to administer the medicine, and/or special handling and delivery; and
- require extensive patient education for safe and cost-effective use.

A list of Specialty Medications is available at www.CVSspecialty.com or by calling CVS Caremark at **1-800-237-2767**.

Through CVS Specialty, you will receive personalized specialty pharmacy services like:

- access to pharmacists and nurses who specialize in your condition;
- on-call pharmacist 24 hours a day, seven days a week;
- coordination of care with you and your doctor;
- ability to drop off and pick up (most) specialty prescriptions at a CVS pharmacy retail location (where available and to the extent allowed by law);
- convenient delivery to the location of your choice, including your home or doctor's office (to the extent allowed by law); and
- online support through CVSspecialty.com, including access to condition specific information and the Specialty Medicines list.

If you require a Specialty Medication, ask your doctor to send your specialty prescription order to CVS Specialty. Your doctor can:

- Fax in your specialty prescription(s) at **1-800-323-2445**
- e-Prescribe your specialty prescription(s) to CVS Specialty
- Call your specialty prescription(s) in at **1-800-237-2767**

Lifestyle Prescriptions

Prescriptions to treat sexual dysfunction for males 18 years of age or over are covered by the prescription drug program. However, benefits are limited to 13 pills per 30 days obtained through a retail pharmacy, and 36 pills per 90 days if obtained through the CVS Caremark mail order pharmacy.

Formulary Overview

The CVS Caremark formulary is a list of FDA approved prescription drugs that is created, reviewed and continually updated by participating physicians and pharmacists. It is a good idea to periodically review the status of your medications. The list contains generic and preferred brand name drugs. If your drug is not on the list it will be filled at the "non-preferred brand name drug" co-pay or coinsurance amount. You can view the complete formulary online at www.caremark.com, or you may request a copy by calling CVS Caremark at the number located on your CVS Caremark ID card (1-800-421-5501).

Generic Drugs

Each prescription and each refill will be filled with a generic prescription drug if there is a generic equivalent available. In the Faculty, Administrators, Professional Researchers and Adjunct Faculty plans, if the physician specifies that the medication must be a preferred or non-preferred brand name drug and has indicated "dispense as written" on the prescription, you will be required to pay the difference between the cost of the brand drug and the generic drug and also be charged the applicable generic co-pay. The majority of generic prescription drugs are available at the lowest generic co-pay. However, some generics are more expensive and are priced comparable to the brand name drug. In those situations, you may be charged the brand name drug co-pay or coinsurance amount.

Participating Retail Pharmacies

Upon enrollment, you will receive a CVS Caremark card. You must present the ID card at the participating CVS Caremark pharmacy in order for the pharmacy to apply the correct co-pay or coinsurance amount. If you do not provide your ID card, the pharmacy may charge you the full cost of the prescription drug, which is higher than your co-payment or coinsurance amount. Visit the CVS Caremark web site at www.caremark.com to locate a participating pharmacy in your area. You may also call the number on the back of your card (1-800-421-5501.) for participating pharmacy information.

Non-Participating Retail Pharmacies

The prescription drug program will reimburse you for covered prescriptions filled at non-participating pharmacies. If you use a non-participating pharmacy, you must pay the full cost of the prescription and submit a claim to CVS Caremark for reimbursement. However, the amount you will receive from the program will be limited to the benefit you would have received if you had filled your prescription at a participating CVS Caremark pharmacy. Your reimbursement will be calculated based on the pharmacy's submitted price less your applicable co-pay for your prescription.

Mail Order

If you have a longer-term prescription or are taking any maintenance medications, you can save money by using the CVS Caremark mail order pharmacy. To fill your prescription through the mail order pharmacy, have your physician write you a 90 day prescription. Mail your physician's prescription and a CVS Caremark registration form which is available on www.caremark.com to the address indicated on your registration form. You may also enroll online and have your physician fax your prescription to the mail service fax number. You can enroll for the mail order pharmacy at www.caremark.com/mailservice and sign in or register to request a new prescription. To save time and effort on your part, your physician may also indicate up to three fills. You will be charged for each refill. The mail order customer service toll-free number is 800-875-0867.

Maintenance Choice – Available at CVS Retail Pharmacies

Maintenance Choice offers you another way to save money on certain long-term medicines. You can fill a 90 day prescription or 3 month supply at any CVS retail pharmacy. To find a CVS retail pharmacy near you, register on www.caremark.com and visit Find a Pharmacy under the Order Prescriptions section.

Diabetic Supplies

Through mail order: You may qualify for a blood glucose meter at no cost to you. For more details or to see if you qualify for this offer, please contact the CVS Caremark Diabetic Meter Team toll-free at 1-800-588-4456. When you call, please have your CVS Caremark member ID number and your doctor's name and phone number available. Lancets and test strips are also available via mail order.

Preventive Care Medications

Preventive care medications and supplies, as defined under the federal Patient Protection and Affordable Care Act, are covered at no cost to you if you use a participating CVS Caremark pharmacy. This includes certain over-the-counter preventive care drugs and supplies if you have a prescription from your doctor. For example, aspirin may be covered as a preventive care expense (with a prescription) if your physician determines that the potential benefit due to a reduction in myocardial infarctions or in ischemic strokes outweighs the potential harm. Effective January 1, 2013, generic and certain brand name oral contraceptives obtained through a participating CVS Caremark pharmacy are covered as preventive care at no cost to you. Certain smoking cessation drugs are also covered as preventive care.

Contact CVS Caremark (1-800-421-5501) or login to www.caremark.com for information on benefits available for preventive care medications and supplies.

Prescription Drug Program Expenses Not Covered

The prescription drug program does not provide benefits for any of the following excluded expenses. This list is not inclusive and does not list all of the exclusions.

- any devices or appliances such as orthotics and other non-medical substances (except for diabetic supplies, as described above);
- any vaccine administered for the prevention of infectious disease (NOTE: Preventive care vaccines administered in a physician's office *are* covered as a medical benefit under the Plan);
- antineoplastic agents except in oral or self-injectable dosage form;
- any medication administered and entirely consumed in connection with care rendered in the home or physician office ;
- any charges for administration of covered drugs;
- any covered drug in excess of the quantity specified by the prescribing physician, or any refill dispensed after one year from the physician's order;
- any drug requiring a prescription by state law, but not federal law;
- medication furnished on an inpatient or outpatient basis that is covered as a medical benefit under the Plan or that is covered any other plan providing group coverage for prescription drugs or insulin through a coordination of benefit provisions, such as major medical, home health care benefits, or outpatient benefits;
- excess retail cost charged by a CVS Caremark participating pharmacy in the event it was not informed of your CVS Caremark coverage;
- over the counter products are not covered unless specifically included;
- pregnancy termination drugs (however, certain emergency contraceptive drugs are covered if you use a participating CVS Caremark pharmacy);
- medical supplies, such as those purchased from a durable medical supplier (except for diabetic supplies, as described above);
- diagnostic biologicals;
- blood products;

- immunizations (NOTE: Preventive care immunizations *are* covered under the Medical Plan);
- nutritional supplements (NOTE: Pre-natal vitamins are covered with a prescription from a physician);
- homeopathic products, whether or not requiring a prescription;
- cosmetic products;
- any prescriptions that are needed as the result of a work-related illness or injury;

However, some of the above items and services may be covered as a medical benefit under the Plan. For questions regarding your prescription drug coverage, contact CVS Caremark at the phone number listed on the back of your card (1-800-421-5501) or by visiting their web site at www.caremark.com.

Experimental/Investigative Service Exclusions

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness or other health condition which CVS Caremark, as the Claims Administrator of the Plan's prescription drug program, determines in its sole discretion to be experimental/investigative is not covered under the prescription drug program.

Drugs that are not approved by the Federal Drug Administration (FDA) are not covered by the prescription drug program. In addition, if your prescribed drug is not approved by the FDA for your specific diagnosis, even if the drug is approved for another diagnosis, it will not be covered under the prescription drug program.

Tobacco Cessation Products

Tobacco cessation products prescribed by your physician are covered under your prescription drug plan, as described below.

For all plans, all FDA-approved tobacco cessation products, brand, generic and over-the-counter (with a prescription from your doctor) will be $0 copay for members over age 18 for a maximum quantity of 180 days of therapy over a 365 day period. If the tobacco cessation products exceed the 180 days of therapy within a 365 day period, then normal copays/coinsurance will apply dependent on the plan you are enrolled in.

Compounded Medications

Most compounded medications will require a prior authorization. If your doctor believes a compounded medication is necessary he or she can contact CVS Caremark's Prior Authorization department at 800-626-3046.

COBRA Continuation of Coverage

The following section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, as well as other coverage alternatives that may be available to you through the Health Insurance Marketplace. 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 your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

Your COBRA election for Medical Plan coverage includes COBRA for prescription drugs under the Plan. You may not separately elect COBRA only for prescription drugs.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, your Domestic Partner and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both).
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both).
- Parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event.

There may be other coverage options for you and your family. You may choose to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child due to aging out of the plan), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice by contacting the PeopleLink team. If you do not notify the PeopleLink team within 31 days, your spouse or dependent child will not be eligible for COBRA coverage.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse and parents may elect COBRA continuation coverage on behalf of their children. Upon election of COBRA coverage,

covered employees and/or qualified beneficiaries may elect either of the options offered under the Plan, if applicable, regardless of the original election.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide the written documentation of disability from the Social Security Administration to the Plan Administrator within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the Qualifying Event or the date your benefits terminated as an active employee or dependent; and prior to the end of the 18 month COBRA continuation period. You will be required to pay up to 150% of the group rate during the 11-month extension. If you need to request an extension of your COBRA benefits due to disability, please contact your COBRA Plan Administrator.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated, or if the

dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Cancellation of COBRA Coverage

Once COBRA coverage is cancelled, it will not be reinstated. COBRA coverage will be cancelled in less than 18 months (or, if applicable, 36 months) if the following situation occurs:

- Payments for the COBRA coverage are not paid on a timely basis by you, your spouse or your child. To be timely, a payment must be paid within 30 days of its due date (or 45 days of the due date for the initial payment).

- After you (or your spouse or children) have elected COBRA coverage under this Plan, you (or they) become covered under another group health plan. However, you (or they) may continue COBRA coverage if the other group health plan limits coverage for pre-existing medical conditions that you (or they) may have. There are limitations on plans' imposing preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act.

- After you (or your spouse or children) have elected COBRA coverage under this Plan, you (or your spouse or children) become enrolled in Medicare.

- The Plan terminates for all University employees.

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 web site at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's web site.) For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of eligible family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

This section explains how to file a claim and how the Plan pays benefits and provides information about what to do if your claim for benefits is denied.

Please note that you will not be entitled to challenge a claim decision made by the Claims Administrator in federal or state court or in any other administrative proceeding unless and until the claims procedures described below have been complied with and exhausted. In addition, all such appeals must be brought within the timeframe mentioned below. No lawsuit shall be brought against the Plan, the University or the Plan Administrator after 90 days from the receipt of the final decision on a claim appeal.

Filing a Claim

If you wish to make a claim for prescription drug benefits in accordance with your rights under ERISA, you must do so in writing by filing a formal claim for benefits, as described below. Prescription drug benefits under the Plan will only be paid if CVS Caremark determines, in its discretion, that the claimant is entitled to them.

In general, if you obtain your prescription drugs from a participating CVS Caremark pharmacy, the pharmacy will charge you for your medicine based on the terms of your Plan coverage. If you are enrolled in the HDHP Medical Plan option, you will be charged the full cost of the medication unless you have satisfied the annual combined medical/prescription drug deductible. If you have satisfied the deductible, you will have to pay only the coinsurance amount. If you are charged more than your correct copay or coinsurance amount, contact CVS Caremark at the phone number listed on the back of your card (1-800-421-5501) for assistance. If the participating CVS Caremark pharmacy informs you that the Plan will not cover your prescription, you may file a formal claim for benefits.

If you obtain your prescription drugs from a non-participating pharmacy, you must pay for the medications in full and submit a claim to CVS Caremark for reimbursement. To file a claim for prescription drug benefits, mail your completed claim form (available at www.caremark.com) with your receipt to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Failure to provide all the information requested on the claim form may delay any reimbursement that may be due you. All prescription drug claims must be submitted to CVS Caremark within 12 months after the date you filled your prescription. Otherwise, the Plan will not pay any benefits for your medications.

Claims and Appeals Procedure

Either you or your authorized representative may file claims for prescription drug benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. You must follow CVS Caremark's procedures to appoint an authorized representative. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your authorized representative. An assignment of payment to your Physician, hospital, or other health care provider does not constitute a designation of an authorized representative for this purpose and does not authorize your provider to bring a legal action for Plan benefits on your behalf.

If your prescription drug claim is denied, you will receive a written denial notice from CVS Caremark. If you believe that your claim was denied in error, your doctor may file an appeal with CVS Caremark. Your denial letter will provide you with a form and instructions on how to file your request for appeal. You have 180 days from the date of the denial notice in which to file your appeal.

The member's appeal should include the following information:

- Name of the person for whom the appeal is being filed;
- CVS Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

Requests for non-Specialty Medications appeals should be mailed to CVS Caremark at:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Specialty Medications appeals should be mailed to CVS Caremark at:

CVS Caremark Specialty Appeals Department
800 Biermann Court
Mount Prospect, IL 60056

For an urgent care claim, you may expedite your appeal by calling CVS Caremark Exceptions at 1-855-240-0536 or sending your appeal by fax to 1-866-443-1172 for non-Specialty Medications or 1-855-230-5548 for Specialty Medications.

CVS Caremark's Internal Review

The review of a member's Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of the Employee Retirement Income Security Act (ERISA). Members will be accorded all rights granted to them under ERISA.

Review of Adverse Benefit Determinations

CVS Caremark will determine the first-level appeal of Adverse Benefit Determinations. Such appeals will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested. If the member's first-level appeal is denied, the member may appeal CVS Caremark's decision and request an additional second-level Medical Necessity review. The review of whether the requested drug or benefit is Medically Necessary will be conducted by an Independent Review Organization (IRO) on behalf of CVS Caremark. Appeals that do not involve a question of whether a drug or benefit is Medically Necessary are not eligible for a second-level review.

Timing of Review

Pre-Authorization Review

CVS Caremark will make a decision on a Pre Authorization request for a Plan benefit within 15 days after it receives the request.

Pre-Service Claim Determinations

CVS Caremark will make a decision involving a Pre-Service Claim within 15 days after it receives the Claim.

Post-Service Claim Determinations

CVS Caremark will make a decision involving a Post-Service Claim within 30 days after it receives the Claim.

Urgent Care Claim Determinations

If a request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours.

Pre-Authorization and Pre-Service Claim Appeal

CVS Caremark will make a decision on a first level appeal of an Adverse Benefit Determination involving a Pre-authorization or a Pre-Service Claim within 15 days after it receives the member's appeal. If CVS Caremark renders an Adverse Benefit Determination on an appeal involving Medical Necessity, the member may request a second-level appeal of that decision by providing the information described in the Appeals of Adverse Benefit Determinations section above. A decision on the member's

second-level appeal of the Adverse Benefit Determination involving Medical Necessity will be made by Caremark's IRO within 15 days after the second-level appeal is received.

If the member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first- and second-level appeals, combined).

Post-Service Claim Appeal

CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives such appeal.

If you fail to request an appeal within any of the required time-frames, it shall be conclusively determined for all purposes that the denial of the Claim is correct.

Scope of Review

During its review of an Adverse Benefit Determination, CVS Caremark shall:

- Take into account all comments, documents, records and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members;
- Provide the member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the member's Claim for benefits;
- Provide a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If a member appeals an Adverse Benefit Determination involving Medical Necessity and requests an additional second level Medical Necessity appeal by Caremark's IRO, the IRO shall:

- Consult with an appropriate health care professional who was not consulted in connection with the initial Adverse Benefit Determination (and is not a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination

Following the review of a member's Claim or appeal, CVS Caremark will notify the member of any Adverse Benefit Determination in writing, explaining how the Claim or appeal was processed and giving notice of the member's appeal rights. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Sufficient information for the member to identify the Claim involved (including, if applicable, the date of service, the health care provider, the Claim amount, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- Reference to the pertinent Plan provisions on which the Adverse Benefit Determination was based;
- A statement that the member is entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request;
- If the Adverse Benefit Determination is based on Medical Necessity or an experimental treatment or similar exclusion or limit, the member will be provided with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- If the Adverse Benefit Determination is based on a medical judgment or a rescission of coverage, an explanation of the member's right to request an external review of the Claim, including the applicable time frames, and the member's right to obtain information about such procedures;
- A statement of the procedures available for further review of the member's Claim and the time limits applicable to such procedures, and a statement that the member has the right to bring a civil action under Section 502(a) of ERISA;
- Contact information for a health insurance customer assistance program or ombudsman; and
- With respect to a notice on appeal, the following statement "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local Department of Labor Office and your state insurance regulatory agency."

Authority as Claims Fiduciary

CVS Caremark shall serve as the claims fiduciary with respect to Pre-authorization review, Pre-and Post-service prescription drug benefit Claims, and first-level appeals of such Claims. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS Caremark is not responsible for the conduct of any second-level

Medical Necessity review performed by an IRO. However, CVS Caremark is responsible for the selection of the IRO in accordance with applicable law.

Affordable Care Act (ACA) – Federal Mandated External Review

Under the Patient Protection and Affordable Care Act (ACA), a plan member who receives a Final Internal Adverse Benefit Determination of a Claim for prescription drug benefits may be permitted to further appeal that denial using the ACA-mandated external review process (External Review).

Federal External Review Process (Non-Expedited)

Request for Review

A Plan member whose Claim Involving Medical Judgment or the rescission of coverage is denied may request, in writing, an External Review of such Claim within four months after receiving notice of the Final Internal Adverse Benefit Determination. The member's request should include the member's name, contact information including mailing address and daytime phone number, member ID number and a copy of the coverage denial. The member's request for External Review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
External Review Appeals Department, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Fax Number: 1-866-443-1172

Preliminary Review

Within 5 days of receiving a Plan member's request for External Review, CVS Caremark will conduct a "preliminary review" to ensure that the request qualifies for External Review. In this preliminary review, CVS Caremark will determine whether:

- The member is or was covered under the Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the member's failure to meet the Plan's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal External Review;
- The member has exhausted the Plan's internal appeals process (unless the member's Claim is "deemed exhausted" under the ACA); and

- The member has provided all the information and forms necessary to process the External Review.

In addition, CVS Caremark will review the member's request for External Review to determine whether it involves a Claim Involving Medical Judgment or rescission of coverage. If CVS Caremark determines that the request does not involve a Claim Involving Medical Judgment or a rescission of coverage, it will forward the member's request for External Review to an IRO for further review. The IRO will determine whether the member's request for External Review involves a Claim Involving Medical Judgment or a rescission of coverage as soon as possible.

Within one day after completing its preliminary review, CVS Caremark will notify the member, in writing, that either: (i) the member's request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request is not eligible for External Review is complete, but not eligible for review.

Referral to IRO

If the member's request for External Review is complete and the member's Claim is eligible for External Review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. The member will then have 10 days to provide the IRO with any additional information the member wants the IRO to consider.

The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan. The IRO may consider information beyond the records for the member's denied Claim, such as:

- The member's medical records;
- The attending health care professional's recommendations;
- Reports from appropriate health care professionals and other documents submitted by the Plan, the member, or the member's treating physician;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan (unless those terms are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medicine societies, boards, and associations;
- Any applicable clinical review criteria developed and used on behalf of the Plan (unless the criteria are inconsistent with the terms of the Plan or applicable law); and
- The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the member's request for External Review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Timing of the IRO's Determination

The IRO will provide the member and CVS Caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for External Review.

The IRO's notice will contain:

- A general description of the reason for the request for External Review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the Claim amount, if available, and the reasons for previous denials);
- The date the IRO received the External Review assignment from CVS Caremark, and the date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, that the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the member;
- A statement that the member may still be eligible to seek judicial review of any adverse External Review determination; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman available to assist the member.

Reversal of the Plan's Prior Decision

If CVS Caremark, acting on the Plan's behalf, receives notice from the IRO that it has reversed the Final Internal Adverse Benefit Determination of the member's Claim, CVS Caremark will immediately provide coverage or payment for the Claim.

Federal External Review Process (Expedited)

A member may request an expedited External Review:

- If the member received a Final Internal Adverse Benefit Determination related to a Claim Involving Medical Judgment or that involved a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, and the member has filed a request for an expedited internal appeal; or
- If the member receives a Final Internal Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves: (i) a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function; or (ii) an

admission, availability of care, continued stay or a prescription drug benefit for which the member has received emergency services, but has not been discharged from a facility.

Request for Review

If the member's situation meets the definition of "urgent" under the law, the external review of the Claim will be conducted as expeditiously as possible. In that case, the member or the member's physician may request an expedited external review by calling the Customer Care toll-free at the number on the member's benefit ID card or contacting the benefits office. [Include number?] The request should include the member's name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial.

Alternatively, a request for expedited External Review may be faxed: member contact information and coverage denial description, and supporting documentation may be faxed to the attention of the CVS Caremark External Review Appeals Department at fax number 1-866-443-1172.

All requests for expedited review must be clearly identified as "urgent" at submission.

Preliminary Review

Immediately on receipt of a member's request for expedited External Review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard External Review. Immediately upon completing this review, CVS Caremark will notify the member that either: (i) the member's request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO

Upon determining that a member's request is eligible for expedited External Review, CVS Caremark will assign an IRO to review the member's Claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for External Review, the IRO will review the member's Claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Plan during the internal claims and appeals process.

Timing of the IRO's Determination

The IRO must provide the member and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as the member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the member's request for External Review. If this notice is not provided in writing within 48 hours after providing verbal notification, the IRO will provide the member and CVS Caremark, on behalf of the Plan, with written confirmation of its decision. For individuals who are on ongoing course of treatment, the external review will be provided within 24 hours.

Deadline for Filing Lawsuits

Once you have exhausted your internal appeal and external review rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a)(1)(B) of ERISA. You have 90 days from the date of receipt of a final decision after all appeals and reviews have been utilized and exhausted. If you do not file a lawsuit within this 90 day period, you will have no further right to contest the denial of your claim. If you file a suit for benefits, the evidence that may be presented to the court will be strictly limited to the evidence timely presented to the Claims Administrator and any external reviewer, if applicable.

Important Plan Information

Qualified Medical Child Support Order

Federal law permits you to provide medical/prescription drug benefits to a child(ren) who is not in your custody. You may enroll your child(ren) in the Plan through a court order referred to as a Qualified Medical Child Support Order ("QMCSO").

If a QMCSO is issued in a divorce or legal separation proceeding requires you to provide health coverage to a child who is not in your custody, you may do so. To be considered qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under this Plan.
- Name and last known address of each child to be covered under this Plan.
- Type of coverage to be provided to each child.
- Period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

Contact the PeopleLink team for more information.

Assignment of Benefits and Responsibility for Payment

- The Plan reimburses expenses for covered medical services and supplies according to the terms of the Plan and the provider contracts. Charges that are not reimbursed by the Plan are the patient's responsibility. Generally, these would include co-payments, deductibles, coinsurance and charges for services that are not covered or greater than the allowed amount.

- No benefit, payment right, right to sue, or other interest of any covered individual under the Plan will be subject to assignment, anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution or levy of any kind (either voluntary or involuntary) by anyone (including but not limited to providers of health care services), except as otherwise required by law, such as a qualified medical child support order. Any such attempt shall be void.

  The Claims Administrator does not pay benefits directly to non-participating pharmacies, except the Claims Administrator may elect to pay benefits directly to a non-participating pharmacy as a convenience. Any payment by the Claims Administrator to a non-network pharmacy shall not constitute any assignment of benefits or any assignment of any other rights under the Plan.
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Decisions on Your Prescription Drug Care

The benefits provided under the Plan provide solely for the payment of certain prescription drug benefits. All decisions regarding your care, including decisions regarding whether to obtain care, will be solely the responsibility of each covered individual in consultation with the providers selected by the individual. The Plan only governs decisions as to the percentage of allowable expenses that will be reimbursed and whether particular treatments or medical/prescription drug expenses are eligible for reimbursement. The covered individual may dispute any decision with respect to the level of reimbursement or the coverage of a particular expense, in accordance with the Plan's claim procedure. Each covered individual may use any source of care for treatment and medical/prescription drug coverage as selected by such individual, and neither the Plan nor the University shall have any obligation for the cost or legal liability for the outcome of such care or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of benefits.

Disclosure of Information

You and your eligible dependents (if applicable) may need to provide certain information in order to receive benefits under the Plan. If so, the University expects that the information provided by you, your dependent or your provider (as appropriate) will be complete and accurate. The University reserves the right to verify all information provided in connection with any claim made. Providing inaccurate, misleading or incomplete information that the Plan Administrator determines to be material may subject you to corrective action, up to and including the termination of your

employment. It also could affect your rights (and the rights of your eligible dependents, if applicable) to elect COBRA continuation coverage.

Refund of Overpayment

The Claims Administrator has the right to recover or withhold payments whenever claims or bills are incomplete, inaccurate or fraudulent. The Claims Administrator may recover any payments made in error or overpayments from:

- Anyone who received the payments.
- Any other insurance companies.
- Any other organization.

Recoupment

Sometimes the Plan may pay you or your covered dependent the wrong amount. The Plan has the right to recover any mistaken payment, overpayment or any payment that is made to any individual who was not eligible for that payment. The Plan may withhold or offset future benefit payments, sue to recover such amounts or use any other lawful remedy to recoup any such amounts.

Administration

The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

To the fullest extent permitted by law, the Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all Plan documents and to make factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan, and to determine all questions arising in connection with the administration of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment of benefits.

The Plan Administrator has delegated the administration of benefit payments and claims to CVS Caremark who is the fiduciary of the Plan with respect to the administration of those benefits. CVS Caremark has the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if CVS Caremark decides in its sole and complete discretion that the claimant is entitled to them. These determinations shall be conclusive, final and binding.

Your Privacy Rights

NYU is committed to protecting the privacy and confidentiality of the health information for you and your covered dependents that is created or received in the administration of the Plan. Federal legislation known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the underlying privacy regulations issued by the U.S. Department of Health and Human Services, provide additional protection for individually identifiable health information (referred to as "Protected Health Information"). The University maintains a "HIPAA Notice of Health Information Privacy Practices" ("HIPAA Notice") that provides a description of how NYU and the Plan may use or disclose your Protected Health Information, as well as your health information rights under HIPAA. You may review the complete document at any time by contacting the Benefits Department.

Plan Amendments and Termination

Although the University expects to continue the Plan, it reserves the right, in its sole discretion, to amend or terminate the Plan, in whole or in part, at any time. Such amendments or termination may apply, without limitation, to any or all of the benefit coverages or required contributions described in this summary. The right to amend and terminate the Plan applies regardless of whether you are active, disabled or retired.

No one has or acquires, at any time, a vested right to continuing benefit coverage under any part of the Plan as a result of his or her length of service, disability, retirement or any other circumstances. If you have any questions about any of the information in this SPD, please contact the PeopleLink Team. .

Other Plan Limitations

Being a participant in the Plan does not give an employee the right to remain employed with the University. Also, you cannot sell, transfer or assign, either voluntarily or involuntarily, the value of a Plan benefit.

Information You Must Provide

You must provide the Plan Administrator or Claims Administrator with such documents, data or other information as the Plan Administrator or Claims Administrator considers necessary or desirable for administering the Plan. You may also be required to fully complete forms, releases or documents as necessary. The benefits payable under the Plan to you or on your behalf are conditioned on furnishing full, true and complete documents, data or other information reasonably related to the administration of the Plan requested by the Plan Administrator or Claims Administrator.

Required Legal Information

Plan Name	New York University Health and Welfare Plan
Plan Sponsor's Name And Address	New York University c/o NYU Benefits Office 105 East 17th Street New York, NY 10003 (212) 992-5465 (M-F 9 am to 6 pm) askpeoplelink@nyu.edu You may obtain a complete list of the University affiliates participating in the program by writing to the Plan Administrator (as identified in this section).
Plan Sponsor's Employer Identification Number	13-5562308
ERISA Plan Number	Active (501)
Plan Year	January 1 – December 31
Type Of Plan	Welfare Benefits Plan providing Prescription Drug Benefits
Type of Administration and Funding	Benefits under the NYU Prescription Drug Plan are administered under the terms and conditions of an administrative services contract with CVS Caremark, Inc.
Claims Administrator	CVS Caremark, Inc. Contact CVS Caremark Customer Service at 877-209-5167 or in writing at: CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072-2136
Plan Administrator and Agent for Service of Legal Process	New York University has designated responsibility for the administration of claims and the appeals of claims to CVS, Inc. The address and telephone number of the Plan Administrator is: New York University c/o NYU Benefits Office 105 East 17th Street New York, NY 10003 (212) 992-5465 (M-F 9 am to 6 pm)

	askpeoplelink@nyu.edu

Statement of ERISA Rights

As a participant in the 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 worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. 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

You can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this SPD 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 may be curtailed or eliminated if you have creditable coverage from another plan. Prior to December 31, 2014, 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, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24

months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 6 months (for employees), 12 months (for dependents) or 18 months for late enrollees after your enrollment date in your coverage.

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, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 Plan Administrator.

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 thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. 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 legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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, 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, 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.